Veterans Benefits Administration **Program Guide 21-2**
Department of Veterans Affairs **Revised**
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The Veterans Benefits Administration Program Guide 21-2 has been updated and totally replaces and **rescinds** the prior, undated version.

Regulatory Amendment Explanations 3-99-6 to 3-01-11 are added to bring Part 3 of the guide up-to-date. Regulatory Amendment Explanation 4-01-1 is also added to bring Part 4 of the guide up-to-date. The corresponding Index to Transmittal Sheets for Compensation and Pension Regulations for Parts 3 and 4 are also updated.

By Direction of the Under Secretary for Benefits

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Compensation and Pension Service

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PART I

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COMPENSATION AND PENSION REGULATIONS

38 CFR PART 3

Includes All Compensation and Pension Transmittal Sheets
From Transmittal Sheet No. 189 to 757, 760 to 763,
and 3-89-1 to 3-01-11

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Department of Veterans Affairs
Washington, DC 20420 **February 5, 2002**

PART II

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COMPENSATION AND PENSION REGULATIONS

38 CFR PART 4

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7307	12
7308	2
7309	9
7310	[No Revision since 1945 Schedule]
7311	4-01-1
7312	17; 4-01-1
7313	17; 4-01-1
7314	[No Revision since 1945 Schedule]
7315	[No Revision since 1945 Schedule]
7316	[No Revision since 1945 Schedule]
7317	[No Revision since 1945 Schedule]
7318	Ext 4
7319	9
7321	Ext 7
7322	[No Revision since 1945 Schedule]
7323	[No Revision since 1945 Schedule]
7324	[No Revision since 1945 Schedule]
7325	9
7326	9
7327	9

	7328	9; 10
	7329	9; 10
	7330	9; 10
	7331	7; 14
	7332	9
	7333	[No Revision since 1945 Schedule]
	7334	Ext 7; 9
	7335	7
	7336	Ext 4; 7; 9
	7337	[No Revision since 1945 Schedule]
	7338	Ext 9
	7339	17
	7340	[No Revision since 1945 Schedule]
	7342	[No Revision since 1945 Schedule]
	7343	17; 4-01-1
	7344	4-01-1
	7345	Ext 4; Ext 4-B; 7; 12; 4-01-1
	7346	7
	7347	16; 17
	7348	17
	7351	4-01-1
	7354	4-01-1
4.115	12; 18; 4-94-1	
4.115a	4-94-1	
4.115b	17; 4-94-1; 4-94-3(NOTE)	
	7500	Ext 7; 7; 4-94-1
	7501	[No Revision since 1945 Schedule]

7502	4-94-1
7503	4-94-1
7504	[No Revision since 1945 Schedule]
7505	Ext 7; Ext 6-A; Ext 9; 7; 14; 17
7507	[No Revision since 1945 Schedule]
7508	4-94-1
7509	4-94-1
7510	4-94-1
7511	4-94-1
7512	[No Revision since 1945 Schedule]
7513	4-94-1
7514	Ext 6-A; 7; 14; 17; 4-94-1
7515	[No Revision since 1945 Schedule]
7516	[No Revision since 1945 Schedule]
7517	[No Revision since 1945 Schedule]
7518	[No Revision since 1945 Schedule]
7519	12; 17
7520	[No Revision since 1945 Schedule]
7521	[No Revision since 1945 Schedule]
7522	[No Revision since 1945 Schedule]
7523	12
7524	Ext 7; 12; 4-94-1
7525	Ext 7; Ext 6-A; 7; 14; 17; 4-94-1
7526	4-94-1
7527	4-94-1
7528	17; 4-94-1
7529	[No Revision since 1945 Schedule]

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	7531	16; 4-94-1
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	7533	4-94-1
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	7535	4-94-1
	7536	4-94-1
	7537	4-94-1
	7538	4-94-1
	7539	4-94-1
	7540	4-94-1
	7541	4-94-1
	7542	4-94-1
4.116	12; 18; 4-95-1	
	7610	4-95-1
	7611	4-95-1
	7612	4-95-1
	7613	4-95-1
	7614	4-95-1
	7615	4-95-1
	7617	4-95-1
	7618	4-95-1
	7619	4-95-1
	7620	4-95-1
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	7623	4-95-1

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	7625	4-95-1
	7626	4-95-1
	7627	17; 4-95-1
	7628	4-95-1
	7629	4-95-1
4.116a	17; 4-95-1	
4.117	16; 4-95-2	
	7700	4-95-2
	7701	4-95-2
	7702	4-95-2
	7703	Ext 4; 4-95-2
	7704	4-95-2
	7705	4-95-2
	7706	4-95-2
	7707	4-95-2
	7709	Ext 4; Ext 9; 17; 4-95-2
	7710	Ext 4; Ext 6-A; 7; 14; 17; 4-95-2
	7711	Ext 6-A; 7; 14; 17; 4-95-2
	7712	Ext 6-A; 7; 14; 17; 4-95-2
	7713	4-95-2
	7714	16; 4-95-2
	7715	4-90-2; 4-95-2
	7716	4-95-2
4.118	16	
	7800	[No Revision since 1945 Schedule]
	7801	Ext 7; 19

	7802	Ext 7; 19
	7803	[No Revision since 1945 Schedule]
	7804	Ext 7; 7
	7805	[No Revision since 1945 Schedule]
	7806	16
	7807	[No Revision since 1945 Schedule]
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	7810	[No Revision since 1945 Schedule]
	7811	Ext 6-A; 7; 14; 17; 19
	7812	[No Revision since 1945 Schedule]
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	7819	[No Revision since 1945 Schedule]
4.119	12; 21	
	7900	21; 4-96-2
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	7902	21; 4-96-2
	7903	21; 4-96-2
	7904	21; 4-96-2
	7905	21; 4-96-2
	7907	21; 4-96-2
	7908	21; 4-96-2

	7909	21; 4-96-2
	7910	4-96-2
	7911	7; 10; 14; 17; 21; 4-96-2
	7912	4-96-2
	7913	16; 17; 21; 4-96-2
	7914	17; 4-96-2
	7915	4-96-2
	7916	4-96-2
	7917	4-96-2
	7918	4-96-2
	7919	4-96-2
4.120	12	
4.121	6; 12	
4.122	6; 12	
4.123	12	
4.124	12	
4.124a	26	
	8000	[No Revision since 1945 Schedule]
	8002	19
	8003	[No Revision since 1945 Schedule]
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8024	[No Revision since 1945 Schedule]
8025	Ext 7; 6
8045	6; 17; 26
8046	6; 26
8100	Ext 9
8103	6; 7
8104	[No Revision since 1945 Schedule]
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8107	[No Revision since 1945 Schedule]
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8540	4-91-1
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8911	6; 16
8912	6
8913	6

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4.125	6; 12; 18; 24; 4-96-5	
4.126	6; 12; 24; 4-96-5	
4.127	6; 12; 18; 24; 4-96-5	
4.128	6; 12; 4-96-5	
4.129	6; 12; 4-96-5	
4.130	6; 12; 18; 24; 4-96-5	
4.131	6; 12; 24; 4-96-5	
4.132	Ext 4; Ext 7; 6; 17; 24; 4-96-5	
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	9202	6; 17
	9203	6; 17
	9204	6; 17; 24
	9205	6; 17; 24; 4-96-5
	9206	6; 17; 24; 4-96-5
	9207	6; 24; 4-96-5
	9208	6; 17; 24; 4-96-5
	9209	6; 17; 24; 4-96-5
	9210	6; 12, 17; 24; 4-96-5
	9211	4-96-5
	9300	6; 17; 24; 4-96-5
	9301	6; 17; 24; 4-96-5
	9302	6; 17; 24; 4-96-5
	9303	6; 17; 24; 4-96-5
	9304	6; 17; 24; 4-96-5
	9305	6; 17; 24; 4-96-5
	9306	6; 17; 24; 4-96-5

9307	6; 17; 24; 4-96-5
9308	6; 17; 24; 4-96-5
9309	6; 17; 24; 4-96-5
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9312	17; 24; 4-96-5
9315	17; 24; 4-96-5
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9324	17; 24; 4-96-5
9325	17; 24; 4-96-5
9326	4-96-5
9327	4-96-5
9400	6; 17; 24
9401	6; 17; 24; 4-96-5
9402	6; 17; 24; 4-96-5
9403	6; 17; 24; 4-96-5
9404	6; 17; 24
9405	6; 17; 24; 4-96-5
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9409	17; 24; 4-96-5
9410	17
9411	20; 24
9412	4-96-5
9413	4-96-5
9416	4-96-5
9417	4-96-5
9421	4-96-5

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	9433	4-96-5
	9434	4-96-5
	9435	4-96-5
	9440	4-96-5
	9500	6; 17; 24; 4-96-5
	9501	6; 17; 24; 4-96-5
	9502	6; 17; 24; 4-96-5
	9505	17; 24; 4-96-5
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	9509	17; 24; 4-96-5
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	9511	17; 24; 4-96-5
	9520	4-96-5
	9521	4-96-5
4.133-48	[Reserved]	
4.149	4-94-2; 3-99-2	
4.150	16; 4-94-2	
	9900	Ext 7; 19; 4-94-2

9901	[No Revision since 1945 Schedule]
9903	[No Revision since 1945 Schedule]
9904	[No Revision since 1945 Schedule]
9905	19; 4-94-2
9906	[No Revision since 1945 Schedule]
9907	[No Revision since 1945 Schedule]
9908	[No Revision since 1945 Schedule]
9909	19; 21
9910	[No Revision since 1945 Schedule]
9911	[No Revision since 1945 Schedule]
9912	4-94-2
9913	4-94-2
9914	4-94-2
9915	4-94-2
9916	4-94-2

APPENDIX A

38 CFR Part 3 -- Adjudication

Regulatory Amendment Explanations

3-89-1 Through 3-01-11

REGULATORY AMENDMENT
3-89-1

Regulations Affected: 38 CFR 3.311b(a) and (b)

EFFECTIVE DATE OF REGULATION: November 17, 1989

Date Secretary Approved Regulation: September 13, 1989

Federal Register Citation: 54 FR 42802-3 (October 18, 1989)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

The Veterans' Dioxin and Radiation Exposure Compensation Standards Act, Pub. L. 98-542, required VA to promulgate regulations for the adjudication of compensation claims in which disabilities or deaths of veterans are alleged to be the result of in-service exposure to ionizing radiation. To assist VA in its effort, the law mandated the establishment of the Veterans Advisory Committee on Environmental Hazards (VACEH).

Section 3.311b. The Radiation-Exposed Veterans Compensation Act of 1989, Pub. L. 100-321, amended 38 U.S.C. 1112 to establish presumptive service connection for certain radiation-exposed veterans. 38 CFR 3.311b(a)(1) has been amended by adding a reference to § 3.309, which implemented this statutory provision.

VACEH recommended that posterior subcapsular cataracts and non-malignant thyroid nodular disease be considered "radiogenic" and that the gender restriction regarding breast cancer be deleted. VACEH also recommended the manifestation periods for cataracts and thyroid disease and that the time restriction for the manifestation of leukemia be deleted. The Secretary has accepted these recommendations. 38 CFR 3.311b(b) has been appropriately amended.

REGULATORY AMENDMENT

3-89-2

Regulations Affected: 38 CFR 3.6(c), (d) and (e)

EFFECTIVE DATE OF REGULATION: October 1, 1988

Date Secretary Approved Regulation: November 21, 1989

Federal Register Citation: 54 FR 51199-200 (December 13, 1989) as corrected by 55 FR 23930-1 (June 12, 1990)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 3.6. Section 633(c) of Pub. L. 100-456, National Defense Authorization Act, amended 38 U.S.C. 101 to require that training duty performed by members of the Senior Reserve Officers' Training Corps for periods less than four weeks, or for any period which is not a prerequisite to commissioning, is to be defined as "inactive duty training" rather than "active duty for training". Training by applicants for membership in the Senior Reserve Officers' Training Corps as defined in 5 U.S.C. 8140(g) is also included under the definition of "inactive duty training". In 38 CFR 3.6, paragraph (d)(3) is redesignated as paragraph (d)(4), paragraph (d)(2) is revised and a new paragraph (d)(3) is added. 38 CFR 3.6(c)(4) and (5), and (e) are revised.

REGULATORY AMENDMENT

3-90-1

Regulation Affected: 38 CFR 3.385

EFFECTIVE DATE OF REGULATION: May 3, 1990

Date Secretary Approved Regulation: February 22, 1990

Federal Register Citation: 55 FR 12348-9 (April 3, 1990)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 3.385. The Chief Medical Director suggested that a definition of hearing within normal limits be established consistent with the revision of 38 CFR, Part 4, on the evaluation of hearing loss which was effective December 18, 1987. New section 3.385 has been added to 38 CFR, Part 3, to define hearing within normal limits for rating purposes and to preclude service connection when hearing is within normal limits.

REGULATORY AMENDMENT

3-90-2

Regulation Affected: 38 CFR 3.313

EFFECTIVE DATE OF REGULATION: August 5, 1964

Date Secretary Approved Regulation: October 2, 1990

Federal Register Citation: 55 FR 43123-5 (October 26, 1990)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 3.313. On March 29, 1990, the Centers for Disease Control released a study entitled "The Association of Selected Cancers with Service in the U.S. Military in Vietnam." That study found that Vietnam veterans have a roughly 50 percent increased risk of developing non-Hodgkin's lymphoma (NHL) after service in Vietnam. The Secretary has determined that there is a relationship between Vietnam service and the subsequent development of NHL. 38 CFR, Part 3, has been amended to add section 3.313 to provide the criteria to be used in considering claims for service connection for NHL by Vietnam veterans.

The General Counsel held that in making a liberalizing amendment to VA regulations, the Secretary may establish an effective date earlier than the date of publication in the Federal Register. Consequently, this amendment is effective on August 5, 1964, the beginning date of the Vietnam era.

REGULATORY AMENDMENT

3-90-3

Regulations Affected: 38 CFR 3.326(a); 3.327(a), (b), (c) and (d); 3.329; and 3.655

EFFECTIVE DATE OF REGULATION: December 31, 1990

Date Secretary Approved Regulation: November 8, 1990

Federal Register Citation: 55 FR 49520-2 (November 29, 1990)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

The regulations concerning examinations, reexaminations and failure to report for examination have been reorganized in order to clarify the provision that individuals must report for VA examinations. A requirement to issue advance notice before taking adverse action because of failure to report has been added.

Section 3.326. 38 CFR 3.326 has been amended by adding an introduction to specify that the term examination includes periods of hospital observation when requested by VA. The provision requiring individuals to report for VA examinations, formerly contained in § 3.329, has been incorporated in § 3.326(a) and gender-neutral language has been substituted where appropriate.

Section 3.327. 38 CFR 3.327(a) has been amended to specify that the term reexamination includes period of hospital observation when requested by VA. Section 3.327(d) has been removed and the provision regarding VA's right to request reexaminations has been incorporated in § 3.327(a) for greater emphasis. The provision requiring individuals to report for VA examinations, formerly contained in § 3.329, has been incorporated in § 3.327(a). The language in § 3.327(b) and (c) has been modified for the sake of clarity.

Section 3.329. 38 CFR 3.329 has been removed.

Section 3.665. 38 CFR 3.655 has been rewritten and now requires that an advance notice be issued before any adverse action is taken because of an individual's failure to report for a VA examination.

REGULATORY AMENDMENT

3-90-4

Regulations Affected: 38 CFR 3.1601(a) and 3.1612(g)

EFFECTIVE DATE OF REGULATION: January 7, 1991

Date Secretary Approved Regulation: November 15, 1990

Federal Register Citation: 55 FR 50322-3 (December 6, 1990)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 3.1601. The General Counsel held in an opinion dated May 1, 1989 (O.G.C. Prec. 9-89), that the 2-year time limit for filing claims which is established in 38 CFR 3.1601(a) should not apply to claims for service-connected burial benefits under 38 U.S.C. 2307. 38 CFR 3.1601(a) has been amended to eliminate the time limit for filing claims for the service-connected burial allowance and claims for transportation expenses to the place of burial.

Section 3.1612. A subsequent opinion dated July 31, 1991 (O.G.C. Prec. 17-90), held that the 2-year time limit as applied to claims for reimbursement for the cost of transporting a veteran's body to a national cemetery under 38 U.S.C. 2308 and the 2-year time limit established in 38 CFR 3.1612(g) as applied to claims for monetary allowance in lieu of a Government-furnished headstone or marker under 38 U.S.C. 2306 are invalid. 38 CFR 3.1612(g) has been amended to eliminate the time limit for filing claims for the monetary allowance in lieu of a Government-furnished headstone or marker.

REGULATORY AMENDMENT

3-90-5

Regulation Affected: 38 CFR 3.156

EFFECTIVE DATE OF REGULATION: January 22, 1991

Date Secretary Approved Regulation: November 27, 1990

Federal Register Citation: 55 FR 52274-5 (December 21, 1990)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 3.156. The Veterans' Judicial Review Act, Pub. L. 100-687, established the United States Court of Veterans Appeals and added new section 5108, dealing with claims reopened on the basis of "new and material evidence," to title 38, United States Code. That term has been used in 38 CFR for many years without a formal definition. Because of this new statutory use of the term, and because VA claims will now be subject to judicial review, a formal definition of the term "new and material evidence" has been developed. In 38 CFR 3.156, paragraphs (a) and (b) have been redesignated as paragraphs (b) and (c) respectively, and a new paragraph (a), containing the definition of new and material evidence, has been added.

REGULATORY AMENDMENT

3-90-6

Regulation Affected: 38 CFR 3.159

EFFECTIVE DATE OF REGULATION: January 22, 1991

Date Secretary Approved Regulation: November 27, 1990

Federal Register Citation: 55 FR 52273-4 (December 21, 1990)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 3.159. It has been a long-standing VA policy to assist claimants in developing the facts pertinent to their claims. The Veterans' Judicial Review Act, Pub. L. 100-687, made this VA policy a statutory requirement and codified it at 38 U.S.C. 5107. 38 CFR 3.159 has been added to clarify VA's obligation to assist claimants in developing the facts pertinent to their claims.

REGULATORY AMENDMENT

3-91-1

Regulation Affected: 38 CFR 3.700(a)

EFFECTIVE DATE OF REGULATION: April 30, 1990

Date Secretary Approved Regulation: December 11, 1990

Federal Register Citation: 56 FR 1110-1 (January 11, 1991)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 3.700. In a recent opinion (O.G.C. Prec. 10-90) dated April 30, 1990, the General Counsel, noting that military disability pay has been substantially altered over the last few years, held that sick pay and incapacitation pay paid to a member of a reserve component can no longer be equated to active duty pay. 38 CFR 3.700(a)(1)(i) has been amended to delete the references to sick pay and incapacitation pay.

REGULATORY AMENDMENT

3-91-2

Regulation Affected: 38 CFR 3.500(n)

EFFECTIVE DATE OF REGULATION: September 10, 1990

Date Secretary Approved Regulation: January 16, 1991

Federal Register Citation: 56 FR 4729 (February 6, 1991)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 3.500. In a precedent opinion dated September 10, 1990 (O.G.C. Prec. 90-90), the General Counsel held that an individual who is living with a person of the opposite sex and holding himself or herself out to the public to be the spouse of such person remains a "child" within the meaning of 38 U.S.C. 101(4), as long as the individual does not contract a valid marriage. Consequently, subparagraph (3) of 38 CFR 3.500(n) has been removed.

REGULATORY AMENDMENT

3-91-3

Regulations Affected: 38 CFR 3.54(c) and 3.810(a)

EFFECTIVE DATE OF REGULATION: December 18, 1989

Date Secretary Approved Regulation: January 8, 1991

Federal Register Citation: 56 FR 5756 (February 13, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 3.54. Pub. L. 101-237 amended 38 U.S.C. 1318(c)(1) to reduce the time a surviving spouse must have been married to a veteran in order to be eligible for certain survivor benefits. Eligibility previously required two years of marriage. This has been reduced to one year. 38 CFR 3.54(c) has been amended to implement this new provision of law.

Section 3.810. The Veterans' Benefits Amendments of 1989, Pub. L. 101-237, amended 38 U.S.C. 1162 to expand the category of veterans entitled to receive a clothing allowance. Veterans who because of a skin condition resulting from a service-connected disability use medication which a physician has prescribed, and which the Secretary determines causes irreparable damage to the veterans' outergarments, are now eligible for this benefit. 38 U.S.C. 1162 has also been amended to eliminate the requirement that eligibility for the clothing allowance be based upon a compensable disability. 38 CFR 3.810(a) has been amended to implement these changes.

REGULATORY AMENDMENT

3-91-4

Regulation Affected: 38 CFR 3.7(x)

EFFECTIVE DATE OF REGULATION: The effective dates are August 30, 1990 (§ 3.7(x)(17) and (18)), and October 5, 1990 (§ 3.7(x)(19))

Date Secretary Approved Regulation: January 16, 1991

Federal Register Citation: 56 FR 5755-6 (February 13, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 3.7. The Secretary of the Air Force held under Pub. L. 95-202 that the service of members of the following groups is active duty for VA benefit purposes: U.S. Civilians of the American Field Service (AFS) Who Served Overseas Operationally in World War I During the Period August 31, 1917, to January 1, 1918; U.S. Civilians of the American Field Service (AFS) Who Served Overseas Under U.S. Armies and U.S. Army Groups in World War II During the Period December 7, 1941, through May 8, 1945; and U.S. Civilian Employees of American Airlines Who Served Overseas as a Result of American Airlines' Contract with the Air Transport Command During the Period December 14, 1941, through August 14, 1945. 38 CFR 3.7(x) has been amended to include these groups.

The amendments are effective August 30, 1990, for the U.S. Civilians of the American Field Service, and October 5, 1990, for the U.S. Civilian Employees of American Airlines, the dates on which such service was certified as active duty.

For historical purposes, the dates on which service was certified as active military service under Pub. L. 95-202 for the following groups are provided:

§ 3.7(x)(1) Women's Air Force Service Pilots March 8, 1979
§ 3.7(x)(2) Signal Corps Female Telephone Operators Unit of World War I May 15, 1979
§ 3.7(x)(3) Engineer Field Clerks August 31, 1979
§ 3.7(x)(4) Women's Army Auxiliary Corps March 18, 1980
§ 3.7(x)(5) Quartermaster Corps Female Clerical Employees Serving With the American Expeditionary Forces in World War I January 22, 1981
§ 3.7(x)(6) Civilian Employees of Pacific Naval Air Bases Who Actively Participated in Defense of Wake Island During World War II January 22, 1981
§ 3.7(x)(7) Reconstruction Aides and Dietitians in World War I July 6, 1981
§ 3,7(x)(8) Male Civilian Ferry Pilots July 17, 1981
§ 3.7(x)(9) Wake Island Defenders from Guam April 7, 1982
§ 3.7(x)(10) Civilian Personnel Assigned to the Secret Intelligence Element of the OSS December 27, 1982
§ 3.7(x)(11) Guam Combat Patrol May 10. 1983
§ 3.7(x)(12) Quartermaster Corps Keswick Crew on Corregidor World War II February 7, 1984
§ 3.7(x)(13) U.S. Civilian Volunteers Who Actively Participated in the Defense of Bataan February 7, 1984
§ 3.7(x)(14) United States Merchant Seamen Who Served on Blockships in Support of Operation Mulberry October 18, 1985
§ 3.7(x)(15) American Merchant Seamen in Oceangoing Service during the Period of Armed Conflict, December 7, 1941 to August 15, 1945 January 19, 1988

§ 3.7(x)(16) Civilian Navy Identification Friend or Foe Technicians Who Served in the Combat Areas of the Pacific during World War II (December 7, 1941 to August 15, 1945) August 2, 1988

REGULATORY AMENDMENT

3-91-5

Regulation Affected: 38 CFR 3.1000(g)

EFFECTIVE DATE OF REGULATION: April 24, 1991

Date Secretary Approved Regulation: March 18, 1991

Federal Register Citation: 56 FR 18732-3 (April 24, 1991), as corrected by 56 FR 24239 (May 29, 1991)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 3.1000. The current regulation governing the payment of educational assistance as an accrued benefit does not identify all educational assistance programs that result in periodic monetary benefits which may be released as accrued benefits subject to the provisions of 38 U.S.C. 5121, if they are due and unpaid on the date of the veteran's death. 38 CFR 3.1000(g) has been amended to include educational assistance under the provisions of 38 U.S.C. Chapters 30 or 32, and 10 U.S.C. Chapter 106 as potential accrued benefits.

REGULATORY AMENDMENT

3-91-6

Regulations Affected: 38 CFR 3.1(d) and 3.3(b)

EFFECTIVE DATE OF REGULATION: April 29, 1991

Date Secretary Approved Regulation: March 26, 1991

Federal Register Citation: 56 FR 19578-9 (April 29, 1991) as corrected by 56 FR 22910 (May 17, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 3.1. As a result of the following amendment to 38 CFR 3.3, the cross-reference at § 3.1(d)(2) has been amended.

Section 3.3. In a memorandum dated October 11, 1990, the General Counsel held that 38 CFR 3.3(b)(3)(iii) and 3.3(b)(4)(iii) do not clearly reflect the provisions of 38 U.S.C. 1541 and 1542; specifically, that the veteran's service must have been during a period of war. 38 CFR 3.3(b)(3) and 3.3(b)(4) have been amended to clarify this eligibility requirement.

REGULATORY AMENDMENT

3-91-7

Regulations Affected: 38 CFR 1.575(b); 3.3(a); 3.55; 3.215; 3.400(d), (u), (v) and (w); 3.501(i); 3.551(h); 3.1600(f); and 3.1612(h)

EFFECTIVE DATE OF REGULATION: November 1, 1990, except the provisions concerning Medicaid payments (§§ 3.501(i)(3) and 3.551(h)) which are effective November 5, 1990, the date that Pub. L. 101-508 was signed into law.

Date Secretary Approved Regulation: April 10, 1991

Federal Register Citation: 56 FR 25043-5 (June 3, 1991) as corrected by 56 FR 28226 (June 10, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 8053 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, amended 38 U.S.C. 5101 to authorize the Secretary to require the disclosure of the social security number of any individual, as well as those of his or her dependents, who applies for or is in receipt of compensation or pension benefits. The Secretary has decided to exercise this authority.

Section 8002 of Pub. L. 101-508 amended 38 U.S.C. 1502(a) to eliminate the presumption of total disability at age 65 for pension purposes.

Section 8004 of Pub. L. 101-508 amended 38 U.S.C. 103 to eliminate the eligibility of remarried surviving spouses and married children for reinstatement of benefits when that marital relationship terminates unless the disqualifying marital relationship was void or was annulled. Similarly, the fact that a surviving spouse of a veteran has terminated a relationship with another person, in which the surviving spouse has held himself or herself out openly to the public as the spouse of that person, has also been eliminated as a basis for the reinstatement of benefits.

Section 8003 of Pub. L. 101-508 amended 38 U.S.C. 5503 to require the reduction of pension benefits to $90 per month when a veteran, who has neither spouse nor child, is receiving Medicaid-covered nursing home care. This reduction will occur after the month of admission to the nursing home. A veteran is not liable to the United States for any payment of pension in excess of the permitted amount that is paid to or for the veteran by reason of the inability or failure of VA to reduce the pension unless such inability or failure is the result of a willful concealment by the veteran of information necessary to make the reduction. The provisions of this statutory amendment expire on September 30, 1992.

Section 8042 of Pub. L. 101-508 amended 38 U.S.C. 2303(b)(2) to eliminate eligibility for the $150 plot allowance based solely on wartime service. This change applies to deaths occurring on or after November 1, 1990.

Section 8041 of Pub. L. 101-508 amended 38 U.S.C. 2306(d) to eliminate the payment of the monetary allowance in lieu of VA-provided headstone or marker for deaths occurring on or after November 1, 1990.

Section 3.3. 38 CFR 3.3(a)(3)(v) has been amended to eliminate the presumption of total disability at age 65 for pension purposes. The reference to "vicious habits" that appears in § 3.3(a)(3)(v) has been

removed, as that term no longer appears in the statutory language (38 U.S.C. 1521 as amended by Pub. L. 95-588).

Section 3.55. The authority citation at the end of 38 CFR 3.55 has been amended to cite 38 U.S.C. 103.

Section 3.215. 38 CFR 3.215 has been amended by removing the words "On or after" where they appear, and adding, in their place, the words "With respect to claims filed prior to November 1, 1990, on or after".

Section 3.342. 38 CFR 3.342(a) has been amended by removing the words "On or after" and adding, in their place, the words "With respect to claims filed prior to November 1, 1990, on or after".

Section 3.400. 38 CFR 3.400(d) has been amended to eliminate the presumption of total disability at age 65 for pension purposes. 38 CFR 3.400(u) and (v) have been amended to eliminate the eligibility of remarried surviving spouses and married children for reinstatement of benefits when that marital relationship terminates unless the disqualifying marital relationship was void or was annulled. 38 CFR 3.400(w) has been amended to eliminate the termination of a relationship of a surviving spouse of a veteran with another person, in which the surviving spouse has held himself or herself out openly to the public as the spouse of that person, as a basis for the reinstatement of benefits.

Section 3.501. 38 CFR 3.501(i)(3) has been redesignated as § 3.501(i)(4) and a new § 3.501(i)(3) has been added to establish an effective date for the reduction of pension benefits to $90 per month when a veteran, who has neither spouse nor child, is receiving Medicaid-covered nursing home care, and to establish an effective date for the reduction of pension benefits when a veteran, who has neither spouse nor child, is receiving Medicaid-covered nursing home care, and conceals information necessary to make the reduction to $90 per month.

Section 3.551. 38 CFR 3.551(h) has been added to require the reduction of pension benefits to $90 per month when a veteran, who has neither spouse nor child, is receiving Medicaid-covered nursing home care. This reduction will occur after the month of admission to the nursing home. A veteran is not liable to the United States for any payment of pension in excess of the permitted amount that is paid to or for the veteran by reason of the inability or failure of VA to reduce the pension unless such inability or failure is the result of a willful concealment by the veteran of information necessary to make the reduction. The provisions of this statutory amendment expire on September 30, 1992.

Section 3.1600. In 38 CFR 3.1600, paragraphs (f)(2), (f)(3), and (f)(4) have been redesignated as paragraphs (f)(3), (f)(4), and (f)(5), respectively. A new § 3.1600(f)(2) has been added. In the newly redesignated § 3.1600(f)(3), the words "either served during a period of war or" have been removed.

Section 3.1612. 38 CFR 3.1612(h) has been added to eliminate the payment of the monetary allowance in lieu of VA-provided headstone or marker for deaths occurring on or after November 1, 1990.

REGULATORY AMENDMENT

3-91-8

Regulation Affected: 38 CFR 3.960(b) and (c)

EFFECTIVE DATE OF REGULATION: June 25, 1991

Date Secretary Approved Regulation: May 31, 1991

Federal Register Citation: 56 FR 28823-4 (June 25, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

In the Federal Register of September 16, 1987 (52 FR 34906-10), VA published an amendment to 38 CFR 3.26, which dealt with section 306 and old-law pension annual income computations. However, the cross-reference to § 3.26 that appears at § 3.960 concerning section 306 and old-law pension protection was not amended.

Section 3.960. In 38 CFR 3.960(b)(5), the words "§ 3.26(b)" are removed, and the words "§ 3.26(c)" are added in their place. In § 3.960(c), the words "§ 3.26(a)(1) or (2) or (b)(1)" are removed, and the words "§ 3.26(a), (b), or (c)" are added in their place.

REGULATORY AMENDMENT

3-91-9

Regulation Affected: 38 CFR 3.311a(c) and (d)

EFFECTIVE DATE OF REGULATION: September 25, 1985

Date Secretary Approved Regulation: September 16, 1991

Federal Register Citation: 56 FR 51651-3 (October 15, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Under 38 CFR 1.17(c), when VA determines that a significant statistical association exists between exposure to a herbicide containing dioxin and any disease, 38 CFR 3.311a shall be amended to provide guidelines for the establishment of service connection for the disease. These determinations are to be made after receiving the advice of the Veterans Advisory Committee on Environmental Hazards (VACEH) based on its evaluation of scientific or medical studies.

In a public meeting on May 16-17, 1990, the VACEH met in Washington, DC. At that meeting, the VACEH considered more than 80 scientific and medical documents relating to the connection, if any, between exposure to a herbicide containing dioxin and the subsequent development of soft-tissue sarcoma (STS). The VACEH found that the relative weights of valid positive and valid negative studies permitted the conclusion that it is at least as likely as not that there is a significant statistical association between exposure to a herbicide containing dioxin and STS. The Secretary has accepted that recommendation.

There is disagreement even among pathologists as to what tumors the term "soft-tissue sarcoma" encompasses. With the assistance of the Veterans Health Administration and the VACEH, we compiled a list of those tumors which we consider to be soft-tissue sarcomas and included it in the regulation. For compensation purposes, such tumors must be malignant and arise from tissue of mesenchymal origin, including muscle, fat, blood or lymph vessels, or connective tissue (but not cartilage or bone). Tumors of infancy or childhood, and those having a strong, known causal association with a specific etiology have been excluded because it is unlikely that there is a reasonable probability of a significant statistical association between such tumors and exposure to a herbicide containing dioxin.

In Nehmer, the court invalidated VA's requirement of proof of a causal relationship in determining service connection for diseases associated with dioxin exposure. Accordingly, § 3.311a(d) is currently of no force and effect.

Further, because the Nehmer decision invalidated VA's original service connection determinations in § 3.311a ab initio, and because those determinations were the original regulatory response to the mandate in section 5(a)(1) of Pub. L. 98-542, the effective date of the amendment to § 3.311a(c) is September 25, 1985, the original effective date of the section.

In order to insure equitable treatment of veterans who may have been exposed to herbicides containing dioxin during service other than in Vietnam during the Vietnam era, e.g., in activities related to testing, storage or shipping of herbicides, the restriction limiting the provisions of § 3.311a to veterans who served in Vietnam during the Vietnam era has been removed.

Section 3.311a. 38 CFR 3.311a(c) has been amended to remove the restriction limiting the provisions of § 3.311a to veterans who served in Vietnam during the Vietnam era, and to provide for service connection for STS. 38 CFR 3.311a(d) has been removed and reserved.

REGULATORY AMENDMENT

3-91-10

Regulations Affected: 38 CFR 3.311a(c) and (d)

EFFECTIVE DATE OF REGULATION: The change to § 3.311a(d) is effective September 25, 1985. The change to § 3.311a(c) is effective October 21, 1991.

Date Secretary Approved Regulation: September 13, 1991

Federal Register Citation: 56 FR 52473-4 (October 21, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Under 38 CFR 1.17(c), when VA determines that a significant statistical association exists between exposure to a herbicide containing dioxin and any disease, 38 CFR 3.311a shall be amended to provide guidelines for the establishment of service connection for the disease. These determinations are to be made after receiving the advice of the Veterans Advisory Committee on Environmental Hazards (VACEH) based on its evaluation of scientific or medical studies.

The VACEH held a public meeting on August 22-23, 1990, in Washington, DC. At that meeting, the VACEH considered 30 scientific and medical documents relating to the association, if any, between exposure to a herbicide containing dioxin and either chloracne or porphyria cutanea tarda (PCT). The VACEH found that the relative weights of valid positive and valid negative studies permit the conclusion that there is a significant statistical association between exposure to a herbicide containing dioxin and the manifestation, within nine months of such exposure, of chloracne. The VACEH also found that the relative weights of valid positive and valid negative studies do not permit the conclusion that there is a significant statistical association between exposure to a herbicide containing dioxin and the subsequent development of PCT. The Secretary has accepted these recommendations.

In Nehmer, the court invalidated VA's requirement of proof of a causal relationship in determining service connection for diseases associated with dioxin exposure. Accordingly, 38 CFR 3.311a(d) was removed and reserved pending the Secretary's determinations for other diseases, pursuant to the court's remand order, after receiving the advise of the VACEH. A revised § 3.311a(d) has been reinserted.

Further, because the Nehmer decision invalidated VA's original service connection determinations in § 3.311a ab initio, and because those determinations were the original regulatory response to the mandate in section 5(a)(1) of Pub. L. 98-542, the effective date of the revised § 3.311a(d) is September 25, 1985, the original effective date of the section.

Section 3.311a. 38 CFR 3.311a(c) has been amended to change the manifestation period for chloracne from three to nine months. 38 CFR 3.311a(d) has been reinserted to implement the Secretary's decision that there is no significant statistical association between exposure to dioxin and the subsequent development of PCT.

REGULATORY AMENDMENT

3-91-11

Regulations Affected: 38 CFR 3.2(i), 3.3(a), 3.17 and 3.54(a)

EFFECTIVE DATE OF REGULATION: April 16, 1991

Date Secretary Approved Regulation: September 24, 1991

Federal Register Citation: 56 FR 57985-6 (November 15, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 332 of the Persian Gulf War Veterans' Benefits Act of 1991, Pub. L. 102-25, amended 38 U.S.C. 101 to add the Persian Gulf War, beginning August 2, 1990, and terminating on a date to be determined by Presidential proclamation or law, as an official "period of war" for the purpose of veterans benefits.

Section 333 of Pub. L. 102-25 amended 38 U.S.C. 1501 and 1541 to provide pension eligibility for Persian Gulf War veterans and their surviving spouses.

Section 3.2. 38 CFR 3.2(i) has been added to include the Persian Gulf War as a period of war.

Section 3.3. 38 CFR 3.3(a)(3) the introductory text has been amended to include the Persian Gulf War.

Section 3.17. 38 CFR 3.17 has been amended to include the Persian Gulf War.

Section 3.54. 38 CFR 3.54(a)(3)(viii) has been added to reflect the statutory delimiting date for the surviving spouse of a Persian Gulf War veteran.

REGULATORY AMENDMENT

3-91-12

Regulations Affected: 38 CFR 3.501(n) and 3.853

EFFECTIVE DATE OF REGULATION: November 1, 1990

Date Secretary Approved Regulation: November 13, 1991

Federal Register Citation: 56 FR 65852-3 (December 19, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 8001 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, added 38 U.S.C. 5505 to prohibit the payment of compensation to or for an incompetent veteran, having neither spouse, child, nor dependent parent, whose estate, excluding the value of the veteran's home, exceeds $25,000 until the estate has been reduced to less than $10,000. If the veteran is subsequently rated competent for more than 90 days, the withheld compensation will be paid in a lump-sum payment; however, a lump-sum payment may not be made to or for a veteran who, within that 90 day period, dies or is again rated incompetent. These provisions expire on September 30, 1992.

Section 3.501. 38 CFR 3.501(n) has been added to require termination of compensation on the last day of the first month in which the veteran's estate exceeds $25,000.

Section 3.853. 38 CFR 3.853 has been added to prohibit the payment of compensation to or for an incompetent veteran, having neither spouse, child, nor dependent parent, whose estate, excluding the value of the veteran's home, exceeds $25,000 until the estate has been reduced to less than $10,000.

REGULATORY AMENDMENT

3-91-13

Regulations Affected: 38 CFR 3.342(c) and 3.1612(b), (c), and (e)

EFFECTIVE DATE OF REGULATION: December 18, 1989

Date Secretary Approved Regulation: November 13, 1991

Federal Register Citation: 56 FR 65851-2 (December 19, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 114 of the Veterans' Benefits Amendments of 1989, Pub. L. 101-237, amended 38 U.S.C. 1524 (formerly 524) to lower from 50 years to 45 years the maximum age at which veterans awarded pension must undergo an evaluation to determine whether achievement of a vocational goal is reasonably feasible through a program of vocational training. 38 U.S.C. 1524 was also amended to protect the permanent and total evaluation of a veteran, who secures employment within the scope of the vocational goal identified by his or her vocational rehabilitation plan, from termination by reason of employability, until the veteran has maintained this employment for not less than 12 consecutive months.

Section 501 of Pub. L. 101-237 amended 38 U.S.C. 2306(d) to authorize payment of the monetary allowance in lieu of furnishing a headstone or marker at Government expense when the headstone or marker is purchased prior to the veteran's death. Since this benefit is available when the headstone is purchased prior to the veteran's death, VA will discontinue making reimbursement for the cost of adding the veteran's identifying information to an existing headstone or marker if death occurred on or after December 18, 1989. It should be noted that section 8041 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, eliminated the payment of the monetary allowance in lieu of VA-provided headstone or marker for deaths occurring on or after November 1, 1990.

Section 3.342. 38 CFR 3.342(c)(1) and (c)(2) have been amended to lower from 50 years to 45 years the maximum age at which veterans awarded pension must undergo an evaluation to determine whether achievement of a vocational goal is reasonably feasible through a program of vocational training. 38 CFR 3.342(c)(3) has been added to protect the permanent and total evaluation of a veteran, who secures employment within the scope of the vocational goal identified by his or her vocational rehabilitation plan, from termination by reason of employability, until the veteran has maintained this employment for not less than 12 consecutive months.

Section 3.1612. In 38 CFR 3.1612, paragraph (e)(3) is redesignated as paragraph (e)(4), and paragraph (e)(2)(iii) is redesignated as paragraph (e)(3). 38 CFR 3.1612(b)(3), (c), (e)(1), and (e)(2)(i) have been amended to authorize payment of the monetary allowance in lieu of furnishing a headstone or marker at Government expense when the headstone or marker is purchased prior to the veteran's death, and to discontinue the reimbursement for the cost of adding the veteran's identifying information to an existing headstone or marker if death occurred on or after December 18, 1989.

REGULATORY AMENDMENT

3-91-14

Regulation Affected: 38 CFR 3.272(k)

EFFECTIVE DATE OF REGULATION: January 21, 1992

Date Secretary Approved Regulation: November 13, 1991

Federal Register Citation: 56 FR 65846-7 (December 19, 1991)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

On December 13, 1979, 42 U.S.C. 5044(g) was amended by section 9 of the Domestic Volunteer Service Act Amendments of 1979, Pub. L. 96-143, to provide that payments under a Domestic Volunteer Service Act (DVSA) program be excluded from consideration when determining entitlement to other governmental programs unless the Director of the ACTION Agency determines that a volunteer's payments equal or exceed the minimum wage. As a result, VA published in the Federal Register of January 29, 1981 (46 FR 9579-80), an amendment to 38 CFR 3.272 which added paragraph (k) for the purposes of excluding such payments from countable income under the Improved Pension Program. That rulemaking, however, erroneously listed the Older American Community Service Program as a DVSA program.

Section 3.272. 38 CFR 3.272(k) has been amended to remove the Older American Community Service Program.

REGULATORY AMENDMENT

3-91-15

Regulation Affected: 38 CFR 3.500(q)

EFFECTIVE DATE OF REGULATION: January 21, 1992

Date Secretary Approved Regulation: November 13, 1991

Federal Register Citation: 56 FR 65847 (December 19, 1991)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

38 U.S.C. 5306 requires that, upon the filing of a written renouncement, payment of monetary benefits will be terminated. Formerly, 38 CFR 3.500(q) provided that the effective date of discontinuance when benefits are renounced was the date of last payment. Because of differences in workload among regional offices, as well as fluctuations within the same office, some renouncements were processed less expeditiously than others, and claims received by VA on the same date resulted in benefits being terminated on different dates. A later effective date might not be advantageous to some beneficiaries who, for whatever reason, wish to terminate VA benefits without delay.

Section 3.500. 38 CFR 3.500(q) has been amended to provide for the termination of benefits on the last day of the month in which the renouncement is received.

REGULATORY AMENDMENT

3-91-16

Regulations Affected: 38 CFR 3.104(a) and 3.105(a)

EFFECTIVE DATE OF REGULATION: January 21, 1992

Date Secretary Approved Regulation: November 13, 1991

Federal Register Citation: 56 FR 65845-6 (December 19, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

The current rulemaking establishes by regulation the point at which a decision becomes final and binding upon all VA field offices. That point is reached when VA issues written notification on any issues for which it is required that VA provide notice to the claimant in accordance with 38 U.S.C. 5104. Once VA issues such notice, the decision may be changed only upon a showing of clear and unmistakable error or upon review by duly constituted appellate authorities.

Section 3.104. 38 CFR 3.104(a) has been amended to provide that a decision becomes final and binding upon all VA field offices when VA issues written notification on any issues for which it is required that VA provide notice to the claimant in accordance with 38 U.S.C. 5104.

Section 3.105. 38 CFR 3.105(a) has been amended by removing the words "determinations on which an action was predicated", and adding, in their place, the words "determinations which are final and binding."

REGULATORY AMENDMENT

3-91-17

Regulation Affected: 38 CFR 3.7(x)

EFFECTIVE DATE OF REGULATION: The effective dates are April 8, 1991 (§ 3.7(x)(20)) and May 3, 1991 (§ 3.7(x)(21)).

Date Secretary Approved Regulation: November 18, 1991

Federal Register Citation: 56 FR 65847-8 (December 19, 1991)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

The Secretary of the Air Force held under Pub. L. 95-202 that the service of members of the following groups is active duty for VA benefit purposes: Civilian Crewmen of the United States Coast and Geodetic Survey Vessels Who Performed Their Service in Areas of Immediate Military Hazard While Conducting Cooperative Operations with and for the United States Armed Forces Within a Time Frame of December 7, 1941 to August 15, 1945; and Honorably Discharged Members of the American Volunteer Group (Flying Tigers) Who Served During the Period December 7, 1941 to July 18, 1942. The effective dates are April 8, 1991 for Civilian Crewmen of the United States Coast and Geodetic Survey Vessels, and May 3, 1991 for Honorably Discharged Members of the American Volunteer Group (Flying Tigers).

Section 3.7. 38 CFR 3.7(x)(20) and (21) have been added to include service performed by Civilian Crewmen of the United States Coast and Geodetic Survey Vessels and Honorably Discharged Members of the American Volunteer Group (Flying Tigers) as active military service.

REGULATORY AMENDMENT

3-91-18

Regulations Affected: 38 CFR 3.454(b), (c), and (d); 3.501(i); and 3.551(a), (b), (c), (d), (e), (f), (g), and (h)

EFFECTIVE DATE OF REGULATION: The amendments that pertain to Improved Pension rates for certain veterans receiving institutional care are effective February 1, 1990. The amendments pertaining to veterans receiving Section 306 pension who are institutionalized are effective January 21, 1992.

Date Secretary Approved Regulation: November 13, 1991

Federal Register Citation: 56 FR 65848-51 (December 19, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 111 of the Veterans' Benefits Amendments of 1989, Pub. L. 101-237 amended 38 U.S.C. 5503(a)(1) to require reduction of Improved Pension for veterans without dependents only if they are admitted to a domiciliary or nursing home by VA or at VA expense. Under these conditions, a veteran's monthly pension may not exceed $90 effective the end of the third full calendar month following the month of admission. Section 101 of the Veterans' Benefits Programs Improvement Act of 1991, Pub. L. 102-86, amended 38 U.S.C. 5503 to provide for reduction of Improved Pension to $90 rather than $60 monthly for veterans without dependents effective the first of the month following readmission to a domiciliary or nursing home by VA or at VA expense when the readmission is within six months of a period during which there was a required reduction.

In passing Pub. L. 101-237, Congress clearly intended to eliminate pension reductions due to hospitalization and to increase the maximum monthly pension payable to veterans who are receiving long-term domiciliary or nursing home care at VA expense without creating a large estate. In order to achieve those goals, when a veteran with no dependents who is receiving domiciliary or nursing home care is transferred to a hospital and then returns to the domiciliary or nursing home, the entire period will be treated as continuous domiciliary or nursing home care if the period of hospitalization is for less than six months. Likewise, if a veteran dies after transfer from a domiciliary or nursing home to a hospital, the period of hospitalization will be considered as continuous domiciliary or nursing home care. If hospitalization of less than six months results in the discharge of the veteran from care at VA expense, then his or her full rate of pension will be restored effective the date of transfer to the hospital.

In an opinion dated June 15, 1990 (O.G.C. Prec. 19-90), the General Counsel held that the previous amendments to 38 U.S.C. 5503(a)(1) have been erroneously applied to veterans receiving pension under section 306 of Pub. L. 95-588. Consequently, the rate payable for veterans without dependents receiving section 306 pension who are institutionalized at VA expense for the requisite period may not exceed $50 per month. In addition, the effective date for reduction for such admissions will be the end of the second full calendar month following the month of admission and, for readmissions within six months following termination of a period of treatment or care of not less than two full calendar months, reduction will be from date of readmission.

Section 3.454. In 38 CFR 3.454(b)(1) and (c), remove the dollar amount "$60", wherever it appears, and add, in its place, the dollar amount "$50". In § 3.454(b)(2) and (d), remove "§ 3.551(c)" and add, in its place, "§ 3.551(d) or (e)(2)". In § 3.454(d), after the word "monthly" add the words "if reduction is under § 3.551(d) or (e)(2), or $90 monthly if reduction is under § 3.551(e)(1)". 38 CFR 3.454(b)(3) is

added to provide for an apportionment when a married veteran's improved pension under 38 U.S.C. 1521(b) (formerly 521(b)) is reduced to $90 monthly under 38 CFR 3.551(e)(1).

Section 3.501. 38 CFR 3.501(i) has been amended to provide effective dates for reduction upon readmission, and to conform with the newly adopted amendments to 38 CFR 3.551. 38 CFR 3.501(i)(3) and (4) are redesignated as paragraphs (6) and (7) respectively, new paragraphs (3), (4) and (5) are added, and paragraphs (1) and (2) are revised.

Section 3.551. In 38 CFR 3.551(b), the existing text is designated as (b)(1), and new paragraphs (b)(2) and (3) are added concerning the reduction of old-law pension upon readmission. Paragraphs (d), (f), and (g) are redesignated as (f), (g), and (h), respectively, a new paragraph (d) concerning improved pension prior to February 1, 1990, is added, paragraph (e) is revised to pertain to improved pension after January 31, 1990, and redesignated paragraph (h)(1) is revised to reflect the reduction of improved pension upon hospitalization. In § 3.551(a), in the first sentence, after the word "reduction" and before the word "when" add the words "as specified below". In redesignated § 3.551(b)(1), remove the phrase ", and service pension based on entitlement prior to July 1, 1960" from the heading. In § 3.551(c), remove the phrase ", improved pension, and service pension based on entitlement after June 30, 1960" from the heading. In § 3.551(c)(1), after the word "furnished" and before the word "domiciliary" add the words "hospital, nursing home or", remove the dollar amount "$60" and add, in its place, the dollar amount "$50". Remove paragraphs (c)(2) and (4), (6) and (7), and redesignate paragraphs (c)(3) and (c)(5) as (c)(2) and (c)(3), respectively. In the newly redesignated paragraph (c)(2), remove the words "or (2)". In the newly redesignated paragraphs (c)(2) and (c)(3), remove the dollar amount "$60" wherever it appears, and add, in its place, the dollar amount "$50". In the newly redesignated paragraph (h)(2), remove the paragraph designations "(c)(2)", "(c)(3)", and "(g)(1)" wherever they appear, and add, in their place, the paragraph designations "(d)", "(e)", and "(h)(1)", respectively. In the newly redesignated paragraph (h)(3), after the word "monthly" and before the word "payable" add the phrase "or $90, if reduction is under paragraph (e)(1)".

REGULATORY AMENDMENT

3-92-1

Regulations Affected: 38 CFR 3.216 and 3.500(w)

EFFECTIVE DATE OF REGULATION: November 5, 1990

Date Secretary Approved Regulation: November 13, 1991

Federal Register Citation: 57 FR 8267-8 (March 9, 1992)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 8053 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, amended 38 U.S.C. 5101 (formerly 3001) by authorizing the Secretary to require any person who applies for or receives compensation or pension benefits to disclose his or her social security number, and the social security numbers of any dependents for whom benefits are being paid, to VA upon request. An individual is not required to furnish VA with a social security number for any person to whom a social security number has not been assigned. VA will discontinue benefits when a beneficiary fails to disclose his or her social security number, or those of his or her dependents, within 60 days of the date of request. This time period is consistent with § 3.103(b)(2).

Section 3.216. New section 3.216 has been added to require any person who applies for or receives compensation or pension benefits to disclose his or her social security number, and the social security numbers of any dependents for whom benefits are being paid, to VA upon request.

Section 3.500. New paragraph (w) has been added to provide the effective date of termination or reduction of benefits when a beneficiary fails to furnish a required social security number.

REGULATORY AMENDMENT

3-92-2

Regulations Affected: 38 CFR 3.30(a, b, c, d, e, and f); 3.55(b, c, d,and e); 3.215; 3.309(d); 3.343(d); 3.400(u, v, and w); and 3.951

EFFECTIVE DATE OF REGULATION: August 14, 1991

Date Secretary Approved Regulation: February 7, 1992

Federal Register Citation: 57 FR 10424-26 (March 26, 1992)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 102 of the Veterans' Benefits Programs Improvement Act of 1991, Pub. L. 102-86, amended 38 U.S.C. 1315 to authorize the Secretary to make payment of parents' DIC less frequently than monthly if the amount of the annual benefit is less than 4 percent of the maximum annual rate payable under 38 U.S.C. 1315. The Secretary has decided to exercise that authority by authorizing semiannual payments.

Section 8004 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, eliminated the eligibility of remarried surviving spouses and married children for reinstatement of benefits when that marital relationship terminates unless the disqualifying marital relationship was void or was annulled. Similarly, the fact that a surviving spouse of a veteran terminated a relationship with another person, in which the surviving spouse held himself or herself out openly to the public as the spouse of that person, was also eliminated as a basis for the reinstatement of benefits. These provisions apply to claims filed after October 31, 1990. Section 502 of Pub. L. 102-86 provides that the amendments made by section 8004 of Pub. L. 101-508 do not apply with respect to any individual who on October 31, 1990, was a surviving spouse or child within the meaning of title 38, United States Code, unless after that date that individual marries or, in the case of a surviving spouse, begins to live with another person while holding himself or herself out openly to the public as that person's spouse.

Section 2 of the Radiation-Exposed Veterans Compensation Act of 1986, Pub. L. 100-321, provided a 40-year presumptive period for all but one of the conditions for which presumptive service connection may be granted based upon participation in a radiation-risk activity during active military service; a 30-year presumptive period was provided for leukemia. Under Pub. L. 100-321, reservists who participated in a radiation-risk activity while on active duty for training or inactive duty training are not entitled to presumptive service connection. Section 104 of Pub. L. 102-86 amended 38 U.S.C. 1112 (formerly 312) to provide for a 40-year presumptive period for the occurrence of leukemia in veterans exposed to radiation, and section 105 of Pub. L. 102-86 extended presumptive service connection to individuals who were engaged in a radiation-risk activity during active duty for training or inactive duty training.

The General Counsel, in O.G.C. Prec. 66-90, determined that VA had no authority to "grandfather" or protect disability evaluations assigned under superceded rating criteria. Section 103 of Pub. L. 102-86 amended 38 U.S.C. 1155 to provide that a modification to the rating schedule occurring after August 14, 1991, will not result in a reduction of any disability evaluation unless that disability has actually improved.

Section 3.30. The section heading, introductory text and paragraph headings for paragraphs (a), (b), (c) and (d) have been revised. Paragraph (e) has been redesignated as paragraph (f), and a new paragraph (e)

has been added. These amendments implement the Secretary's decision to authorize semiannual payments for parents' DIC.

Section 3.55. 38 CFR 3.55(b), (c), (d), and (e) have been amended to authorize the reinstatement of benefits to any individual who on October 31, 1990, was a surviving spouse or child within the meaning of title 38, United States Code, unless after that date that individual marries or, in the case of a surviving spouse, begins to live with another person while holding himself or herself out openly to the public as that person's spouse.

Section 3.215. 38 CFR 3.215 has been amended to provide for the reinstatement of benefits to any individual who on October 31, 1990, was a surviving spouse within the meaning of title 38, United States Code, unless after that date that individual marries or begins to live with another person while holding himself or herself out openly to the public as that person's spouse.

Section 3.309. 38 CFR 3.309(d)(3) has been amended to provide a 40-year presumptive period for leukemia. 38 CFR 3.309(d)(4)(i) has been amended to extend presumptive service connection to individuals who were engaged in a radiation-risk activity during active duty for training or inactive duty training.

Section 3.343. 38 CFR 3.343(d) has been removed since that paragraph is no longer relevant.

Section 3.400. 38 CFR 3.400(u)(3), (u)(4), (v)(3), (v)(4) and (w) have been amended to reflect the statutory provision for the reinstatement of benefits to any individual who on October 31, 1990, was a surviving spouse or child within the meaning of title 38, United States Code, unless after that date that individual marries or, in the case of a surviving spouse, begins to live with another person while holding himself or herself out openly to the public as that person's spouse.

Section 3.951. The current text is designated as paragraph (b) and a new paragraph (a) is added to provide that a modification to the rating schedule occurring after August 14, 1991, will not result in a reduction of any disability evaluation unless that disability has actually improved.

REGULATORY AMENDMENT

3-92-3

Regulations Affected: 38 CFR 3.1610

EFFECTIVE DATE OF REGULATION: June 30, 1992

Date Secretary Approved Regulation: May 27, 1992

Federal Register Citation: 57 FR 29025 (June 30, 1992)

The purpose of the following comments on the changes included in this amendment to VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

VA regional office Directors currently are authorized to arrange for the burial of unclaimed bodies of veterans in national cemeteries. Several states do not have national cemeteries or have national cemeteries that are inconvenient to some locations. Many states, however, do operate cemeteries or cemetery sections used solely for the burial of those eligible for burial in national cemeteries. Where these cemeteries meet the high standards of operation currently required of national cemeteries, they may prove to be acceptable alternatives to national cemeteries.

Under this amendment, regional office Directors are authorized to pay the cost of transporting unclaimed bodies to certain state-owned cemeteries or cemetery sections as well as to national cemeteries, provided that the total amount paid by VA does not exceed the total amount payable if burial had been in a national cemetery. The nonservice-connected plot allowance may be included as part of the total amount payable if entitlement is otherwise established. A state is not obligated to allow burial, and regional office Directors are not required to arrange for burial in state-owned cemeteries. The amendment offers an option that may be exercised if an acceptable alternative is available.

Section 3.1610. This section is revised to allow regional office Directors to pay the cost of transporting unclaimed bodies to certain state-owned cemeteries or cemetery sections as well as to national cemeteries in certain circumstances.

REGULATORY AMENDMENT

3-92-4

Regulations Affected: 38 CFR 3.316

EFFECTIVE DATE OF REGULATION: July 31, 1992

Date Secretary Approved Regulation: May 27, 1992

Federal Register Citation: 57 FR 29025 (July 31, 1992)

The purpose of the following comments on the changes included in this amendment to VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Some Naval personnel were experimentally exposed to mustard gas during full-body, field or chamber tests of protective equipment and clothing conducted at the Naval Research Laboratory between 1943 and 1945. Similar testing was conducted at other locations during World War II. These World War II tests were classified, participants were instructed not to discuss their involvement, and medical records associated with the tests are generally unavailable. No long-term follow-up examinations were conducted. For these reasons, some participants may not have filed claims with VA for disabilities resulting from mustard gas poisoning, or, if they did file claims, may have experienced difficulty in establishing entitlement to benefits.

The special circumstances surrounding these World War II testing programs have placed veterans who participated in them at a disadvantage when attempting to establish entitlement to compensation for disability or death resulting experimental exposure. This regulation has been added to specify that if exposure occurred under these circumstances, disabilities or deaths resulting from certain diseases are to be recognized as connected to a veteran's exposure in-service.

A review of the available medical literature by Veterans Health Administration personnel indicates that the chronic, long-term effects of acute mustard gas poisoning may include laryngitis, bronchitis, emphysema, asthma, conjunctivitis, keratitis, and corneal opacities. Chronic forms of these conditions which developed subsequent to experimental exposure during World War II will be service-connected.

Section 3.316. This section is added to 38 CFR Part 3 to provide that exposure to mustard gas while participating in full-body, field or chamber experiments to test protective clothing or equipment during World War II, together with the development of a chronic form of any of the following conditions manifested subsequent thereto, is sufficient to establish service connection for that condition: laryngitis, bronchitis, emphysema, asthma, conjunctivitis, keratitis, and corneal opacities.

REGULATORY AMENDMENT

3-92-5

Regulation Affected: 38 CFR 3.7(x)

EFFECTIVE DATE OF REGULATION: The effective date is May 13,1992.

Date Secretary Approved Regulation: July 31, 1992

Federal Register Citation: 57 FR 43904-05 (September 23, 1992)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

The Secretary of the Air Force held under Pub. L. 95-202 that the service of members of the following groups is active duty for VA benefit purposes: U.S. Civilian Flight Crew and Aviation Ground Support Employees of United Air Lines (UAL), Who Served Overseas as a Result of UAL's Contract With the Air Transport Command During the Period December 14, 1941, through August 14, 1945; and U.S. Civilian Flight Crew and Aviation Ground Support Employees of Transcontinental and Western Air (TWA), Inc., Who Served Overseas as a Result of TWA's Contract With the Air Transport Command During the Period December 14, 1941, through August 14, 1945.

Section 3.7. 38 CFR 3.7(x)(22) and (23) have been added to include service performed by members of U.S. Civilian Flight Crew and Aviation Ground Support Employees of United Air Lines (UAL), Who Served Overseas as a Result of UAL's Contract With the Air Transport Command and members of U.S. Civilian Flight Crew and Aviation Ground Support Employees of Transcontinental and Western Air (TWA), Inc., Who Served Overseas as a Result of TWA's Contract With the Air Transport Command.

REGULATORY AMENDMENT

3-92-6

Regulation Affected: 38 CFR 3.103(b)(1), 3.103(f), and 3.105(h)(2)

EFFECTIVE DATE OF REGULATION: The effective date is December 2,1992.

Date Secretary Approved Regulation: October 6, 1992

Federal Register Citation: 57 FR 56992-93 (December 2, 1992)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

38 U.S.C. 5104(a) provides that when the Secretary of Veterans Affairs makes a decision affecting the provision of benefits to a claimant, a notice of that decision must be sent to the claimant and the claimant's representative. It has been a long-standing VA policy to provide a claimant's representative with a copy of each notice to the claimant affecting adjudication of a claim, which clearly includes notice of decisions as well as requests for information, etc. (See 38 CFR 1.525(d)). We believe it is appropriate, however, to amend regulatory language at 38 CFR 3.103(b)(1), 3.103(f), and 3.105(h)(2) to clearly reflect the statutory requirement that notice of a decision affecting the provision of benefits be sent not only to the claimant, but also to the claimant's representative. This amendment is made for the sake of clarity and the convenience of the user. Additionally, the reference to part 19, subpart B in § 3.103(f) has been amended to conform with final Board of Veterans Appeals regulations published on February 3, 1992 (57 FR 4088-4130).

Section 3.103. In § 3.103(b)(1), in the first sentence, after the word "Claimants" add the words "and their representatives". In § 3.103(f), in the first sentence, after the word "beneficiary" add the words "and his or her representative". In the parenthetical remarks after the last sentence, remove the words "part 19, subpart B" and add, in their place, the words "part 20".

Section 3.105. In § 3.105(h)(2), in the fifth sentence, after the word "beneficiary" add the words "and his or her representative".

REGULATORY AMENDMENT

3-92-7

Regulation Affected: 38 CFR 3.306

EFFECTIVE DATE OF REGULATION: The effective date is May 1, 1974.

Date Secretary Approved Regulation: October 6, 1992

Federal Register Citation: 57 FR 59296 (December 15, 1992)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

In a memorandum dated May 18, 1992, VA's Office of General Counsel pointed out that parts of 38 CFR 3.306 are outdated since they fail to reflect the changes in law which made the wartime aggravation criteria applicable to peacetime service after December 31, 1946. In 1966, Congress added section 1137 to title 38, United States Code, to apply the wartime presumption of sound condition upon entry onto active duty to all veterans having service after January 31, 1955 (See section 7 of Pub. L. 89-358, 80 Stat. 12, 27). In 1974, section 205 of the Veterans Disability Compensation and Survivor Benefits Act of 1974 (Pub. L. 93-295, 88 Stat. 180, 183), amended 38 U.S.C. 1137 to strike out the date January 31, 1955, and substitute December 31, 1946. As a result of this amendment, the provisions of 38 U.S.C. 1132, which provide a less generous presumption of soundness for veterans with peacetime service, do not apply to veterans with service after December 31, 1946. Rather, the same presumption of soundness for wartime veterans applies to these veterans. No conforming amendments were made to 38 CFR 3.306, however, and we are now correcting that oversight.

Section 3.306. In § 3.306, remove the heading for paragraph (b) and insert, in its place, the heading "Wartime service; peacetime service after December 31, 1946"; remove the heading for paragraph (c), and insert, in its place the heading "Peacetime service prior to December 7, 1941".

REGULATORY AMENDMENT

3-92-8

Regulations Affected: 38 CFR 3.261, 3.262, 3.263, 3.271, 3.272, 3.273, 3.275, 3.277, 3.660, and 3.661.

EFFECTIVE DATE OF REGULATION: January 14, 1993, except for provisions regarding exclusion of Agent Orange settlement payments, which are effective January 1, 1989; provisions regarding exclusion of the DOD annuity under Public Law 100-456, which are effective September 29, 1988; provisions regarding exclusion of payments for casualty loss under Public Law 100-687, which are effective November 18, 1988; and provisions concerning exclusion of restitution to individuals of Japanese ancestry, which are effective August 10, 1988.

Date Secretary Approved Regulation: October 30, 1992

Federal Register Citation: 57 FR 59296-300 (December 15, 1992)

The purpose of the following comments on the changes included in these amendments of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

VA regulations regarding exclusions from income for pension and parents' DIC purposes have been amended to exclude income from the following four additional sources:

(1) An annuity, authorized by section 653, Public Law 100-456, paid by the Department of Defense to qualified surviving spouses of veterans who died before November 1, 1953, and who were entitled to retired or retainer pay on the date of death.

(2) Any payment received pursuant to the settlement in the case of In re Agent Orange Product Liability Litigation in the United States District Court for the Eastern District of New York (MDL No. 381). These payments are also excluded from consideration in estate computations. This provision of Public Law 101-201 is effective retroactively to January 1, 1989.

(3) All reimbursements for any casualty loss up to an amount equaling the greater of either the fair market value or reasonable replacement value of the property lost. This provision, which expands on the previous exclusion of proceeds from fire insurance, applies only to the improved pension and parents' DIC programs. For section 306 and old law pension, only the proceeds from fire insurance are excluded from income computation.

(4) Any payment made as restitution under Public Law 100-383, the Civil Liberties Act of 1988, to individuals of Japanese ancestry who were interned, evacuated, or relocated during the period December 7, 1941, through June 30, 1946, pursuant to any law, Executive order, Presidential proclamation, directive, or other official action respecting these individuals. This provision is effective August 10, 1988, and applies only to recipients of improved pension, parents' DIC, and parents' death compensation. (Public Law 102-371, the Civil Liberties Act Amendment of 1992, has now extended the exclusion to all VA programs. A later regulatory change, to be issued shortly, will implement this change.)

We also have provided definitions of recurring, nonrecurring, and irregular income, and have added consistency of procedure for computing these types of income in determining pension entitlement (38 CFR 3.271 and 3.273).

We have amended 38 CFR 3.271 to establish procedures in improved pension cases where dependents with income cannot be included on awards of benefits due to a lack of necessary evidence to confirm the relationship. This rule will preclude creation of overpayments when dependency is established retroactively.

We also have made technical amendments throughout to update terminology and make language gender neutral. The update in terminology will bring the text of the regulations into conformity with procedures and concepts introduced with the improved pension program and will serve to avoid confusion over references to periods of time as they relate to improved pension or previously existing pension programs.

Section 3.261. The table has been subdivided into parts (a), (b), and (c). Part (a) deals with income, and parts (b) and (c) deal with deductible expenses and corpus of estate, respectively. The language of the columnar headings has been modified to reflect gender-neutral language and to incorporate language specific to section 306 and old law pension. Item (14) has been modified to reflect exclusion for the DOD annuity under Public Law 100-456; item (28) has been modified to reflect exclusion for casualty loss under Public Law 100-687; and items (35) and (36) have been added to reflect exclusions of the Agent Orange settlement payments and restitution to individuals of Japanese ancestry, respectively.

Section 3.262. Paragraphs (g), (h), (j), and (k) through (p) have been amended to incorporate terminology specific to section 306 and old law pension and gender-neutral language. Authority citations have been revised or added as required. Paragraphs (r) through (u) have been added to implement the four new income exclusions under the appropriate programs.

Section 3.263. Paragraph (a) has been amended to incorporate gender-neutral language. Paragraphs (e) and (f) have been added to exclude from corpus of estate determinations under the appropriate programs Agent Orange settlement payments (par. (e)) and restitution to individuals of Japanese ancestry (par. (f)).

Section 3.271. Paragraphs (a)(1) through (a)(3) have been added to define recurring, irregular, and nonrecurring income, respectively, and to provide procedures for computing such income in determining entitlement to benefits. In paragraph (f), the pre-existing text has been redesignated as paragraph (f)(1), and paragraph (f)(2) has been added to establish procedures in improved pension cases where dependents with income cannot be included on awards of benefits due to a lack of necessary evidence to confirm the relationship.

Section 3.272. Paragraph (d) has been revised to provide exclusion from income for improved pension purposes of reimbursement of any kind due to any casualty loss. The excludable amount is not to exceed the greater of either the fair market value or the reasonable replacement value of the property lost. This provision expands the previous exclusion of proceeds from fire insurance. The term "casualty loss" is defined in this paragraph. Paragraphs (n) through (p) have been added to exclude from countable income under improved pension the survivor benefit annuity under Public Law 100-456, Agent Orange settlement payments, and restitution to individuals of Japanese ancestry.

Section 3.273. An introductory text to the section and a sentence at the end of paragraph (a) have been added to provide instructions concerning recomputation of the rate of improved pension due to income changes or changes in the maximum annual pension rate. Paragraph (d) has been added to instruct that rate computations involving recurring or irregular income are subject to the provisions of 38 CFR 3.660(a)(2). Minor language changes have been made in paragraphs (a), (b), and (c) for clarification and conformity with income computation practice in improved pension.

Section 3.275. Paragraphs (f) and (g) have been added to provide that for improved pension purposes, Agent Orange settlement payments and restitution to individuals of Japanese ancestry, respectively, are excluded from corpus of estate computations.

Section 3.277. The authority citation at the end of this section has been revised.

Section 3.660. The paragraph heading to paragraph (a)(2) has been changed to read "Effective dates," since this heading more accurately describes the paragraph contents. In paragraph (b) language changes have been made to replace references to "year" or "calendar year" with references to "12-month annualization period," so that the regulation conforms to all pension programs and parents' DIC. It is important to note that in paragraph (b)(1) an exception to these changes exists. The final phrase of the paragraph, "the same or the next calendar year.", is required by the statutory language in 38 U.S.C. 5110(h).

Section 3.661. The section heading has been changed to read "Eligibility Verification Reports." In paragraph (a)(1) and the heading of paragraph (b), the word "report" has replaced the word "questionnaire." In paragraph (b)(2) the term "Eligibility Verification Report" has replaced the term "income questionnaire." These changes conform to the current terminology for the periodic income and net worth reports required of pension and parents' DIC recipients. In paragraph (b)(1) the word "calendar" has been placed before the word "year" each time it appears. In paragraph (b)(2) the word "year" has been replaced by the words "12-month annualization period." These changes reflect the differences in the reporting requirements of the respective programs concerned.

REGULATORY AMENDMENT

3-92-9

Regulation affected: 38 CFR 3.7(x)

EFFECTIVE DATE OF REGULATION: The effective date for § 3.7(x)(24) and (26) is June 29, 1992, the effective date for § 3.7(x)(25) is July 16, 1992.

Date Secretary Approved Regulation: November 4, 1992

Federal Register Citation: 57 FR 60734-35 (December 22, 1992)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

The Secretary of the Air Force held under Pub. L. 95-202 that the service of members of the following groups is active duty for VA benefit purposes: U.S. Civilian Flight Crew and Aviation Ground Support Employees of Consolidated Vultree Aircraft Corporation (Consairway Division) Who Served Overseas as a Result of a Contract With the Air Transport Command During the Period December 14, 1941, through August 14, 1945; U.S. Civilian Flight Crew and Aviation Ground Support Employees of Pan American World Airways and Its Subsidiaries and Affiliates, Who Served Overseas as a Result of Pan American's Contract With the Air Transport Command and Naval Air Transport Service During the Period December 14, 1941 through August 14, 1945 and Honorably Discharged Members of the American Volunteer Guard, Eritrea Service Command During the Period June 21, 1942 to March 31, 1943.

Section 3.7 38 CFR 3.7(x)(24), (25) and (26) have been added to include service performed by members of U.S. Civilian Flight Crew and Aviation Ground Support Employees of Consolidated Vultree Aircraft Corporation (Consairway Division) Who Served Overseas as a Result of a Contract With the Air Transport Command, U.S. Civilian Flight Crew and Aviation Ground Support Employees of Pan American World Airways and Its Subsidiaries and Affiliates, Who Served Overseas as a Result of Pan American's Contract With the Air Transport Command and Naval Air Transport Service and Honorably Discharged Members of the American Volunteer Guard, Eritrea Service Command.

REGULATORY AMENDMENT

3-93-1

Regulation affected: 38 CFR 3.311b

EFFECTIVE DATE OF REGULATION: March 26, 1993

Date Secretary Approved Regulation: March 3, 1993

Federal Register Citation: 58 FR 16358-59 (March 26, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

The Veterans' Dioxin and Radiation Exposure Compensation Standards Act, Pub. L. 98-542, required VA to publish regulations for the adjudication of compensation claims in which disabilities or deaths of veterans are alleged to be the result of in-service exposure to ionizing radiation. It also required that the regulations be based on sound scientific and medical evidence. To assist VA in this effort, the law mandated the establishment of the Veterans Advisory Committee on Environmental Hazards (VACEH). On December 1, 1988, VA published in the Federal Register (53 FR 48551-2) a proposal to amend 38 CFR 3.311a(g) and 3.311b(h) to specify the other provisions under which service connection may be established for injury or disease claimed to be the result of exposure to ionizing radiation or to herbicides containing dioxin are those governing direct service connection, service connection by aggravation, or presumptive service connection. However, in Nehmer v. United States Veterans Administration, 712 F. Supp. 1404 (N.D. Cal., 1989), the court concluded that VA incorrectly required that, in determining whether diseases would be service connected based on dioxin exposure, scientific evidence demonstrate a cause-and-effect relationship between the disease and exposure, rather than only a significant statistical association. In view of that decision, VA withdrew the proposed amendments of §§ 3.311a(g) and 3.311b(h) as they made reference to the causal relationship standard (See 54 FR 42802-03).

We have now amended § 3.311b(h) to clarify when service connection can be established based upon exposure to ionizing radiation. 38 CFR 3.311b(b)(2) is meant to be an exclusive list of radiogenic conditions for which service connection maybe granted under the provisions of Pub. L. 98-542. The previous wording of § 3.311b(h) might have been misinterpreted to mean that a veteran, rather than VA, may establish that a disease not included in § 3.311b(b)(2) resulted from exposure to ionizing radiation and should therefore be service-connected based on "sound scientific or medical evidence." Such an interpretation of § 3.311b(h) would be contrary to section 5(b)(2) of Pub. L. 98-542 which clearly stipulates that VA, after receiving the advice and recommendation of the VACEH, will publish regulations which list each disease for which it finds sound scientific or medical evidence of a connection to ionizing radiation.

Service connection may be established for any condition, regardless of cause, shown to have been incurred or aggravated during active service by applying the provisions of 38 CFR 3.303, 3.304, or 3.306. For certain conditions which manifest themselves within specified periods following a veteran's discharge from active military service, service connection may be established under the provisions of 38 CFR 3.307. Under each of these regulations, service connection is established not by what caused the condition, but by when it becomes manifest, i.e., service connection is established by the appearance of a combination of signs and symptoms sufficient to identify the condition during, or within a specified period following, the veteran's active military service. Service connection for disabilities or deaths alleged to be the result of exposure to ionizing radiation which first manifest themselves after the periods specified in § 3.307, however, must be established under the provisions of 38 CFR 3.311b unless service connection may be established either by applying the presumptions established by

Congress in Pub. L. 100-321 (38 CFR 3.309(d)), or because the condition is proximately due to or the result of a service-connected disease or injury (38 CFR 3.310(a)).

By enacting Pub. L. 98-542, Congress clearly intended to establish an avenue for VA to compensate veterans for disabilities or deaths caused by ionizing radiation exposure, since existing statutes and regulations had proven inadequate for that purpose. Just as clearly, 38 CFR 3.311b(h), which implements the radiation provisions of Pub. L. 98-542, does not preclude awards of service connection under §§ 3.303, 3.304, 3.306, or 3.307, since it is applied only after service connection under those regulations has already been precluded because a condition manifested itself beyond the time frames they impose.

In a public meeting on August 22-23, 1990, the VACEH met in Washington, DC. At that meeting, the VACEH considered 11 papers relating to the health effects of exposure to ionizing radiation focusing primarily on the fifth report of the Committee on Biological Effects of Ionizing Radiation (BEIR V). Based on its review of this literature, the VACEH recommended that ovarian cancer be added to the list of diseases that VA will recognize as being radiogenic. The Secretary has accepted that recommendation and 38 CFR 3.311b(b)(2) has been amended to implement the Secretary's decision.

In a public meeting on January 30-31, 1991, the VACEH met in Washington, DC. At that meeting, the VACEH reviewed the relevant animal and human data and expressed the opinion that the data clearly implicate high dose irradiation as a causal factor in the pathogenesis of hyperparathyroidism and parathyroid tumors. Based on this review, the VACEH recommended that parathyroid adenoma be added to the list of diseases that VA will recognize as being radiogenic. The Secretary has accepted that recommendation and 38 CFR 3.311b(b)(2) has been amended to implement the Secretary's decision.

Section 3.311b. Paragraph (b)(2) has been amended to include ovarian cancer and parathyroid adenoma. Paragraph (h) has been amended to clarify when service connection can be established based upon exposure to ionizing radiation, and to provide that nothing in 38 CFR 3.311b will be construed to prevent the establishment of service connection for any disease or injury shown to have been incurred or aggravated during active service in accordance with §§ 3.304, 3.306, 3.307, or 3.309. However, service connection will not be established under § 3.311b, or any other section except for §§ 3.309(d) or 3.310(a), on the basis of exposure to ionizing radiation and the subsequent development of any disease not specified in § 3.311b(b)(2).

REGULATORY AMENDMENT

3-93-2

Regulation affected: 38 CFR 3.103(c)

EFFECTIVE DATE OF REGULATION: March 26, 1993

Date Secretary Approved Regulation: March 3, 1993

Federal Register Citation: 58 FR 16359-60 (March 26, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

If a claimant requests a hearing on an issue pending before VBA, the previous wording of 38 CFR 3.103(c)(1) provided that the hearing be held "in the VA office having original jurisdiction over the claim or at the VA office nearest the claimant's home having adjudicative functions." That wording did not allow VA sufficient flexibility to provide hearings at alternative sites, such as other VA facilities or federal buildings at which suitable hearing facilities are available, even though such an option would allow VBA to better serve its claimants.

This amendment will ease this restriction and allow VBA managers the latitude to authorize hearings at remote sites, solely at VA option and subject to available resources. Additionally, the reference to § 19.174 that appears in the first sentence of § 3.103(c)(1) has been amended to conform with final Board of Veterans Appeals regulations published on February 3, 1992 (See 57 FR 4088-4130).

Section 3.103. In § 3.103(c)(1), the first sentence, remove the numbers "19.174", and add, in their place, the numbers "20.1304". In § 3.103(c)(1), the second sentence, after the words "claimant's home having adjudicative functions," add the words "or, subject to available resources and solely at the option of VA, at any other VA facility or federal building at which suitable hearing facilities are available." Remove the words "and will provide VA personnel" and add, in their place, the words "VA will provide personnel".

REGULATORY AMENDMENT

3-93-3

Regulation affected: 38 CFR 3.5(e)

EFFECTIVE DATE OF REGULATION: January 1, 1993

Date Secretary Approved Regulation: February 12, 1993

Federal Register Citation: 58 FR 25561-62 (April 27, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Under 38 U.S.C. 1310, VA pays DIC to surviving spouses of veterans who died from disease or injury incurred or aggravated during active military service. Prior to January 1, 1993, 38 U.S.C. 1311(a) provided that the surviving spouse's basic DIC rate be determined by the deceased veteran's military pay grade. The Dependency and Indemnity Compensation Reform Act of 1992, Section 102 of the Veterans' Benefits Act of 1992, Pub. L. 102-568, amended 38 U.S.C. 1311(a) to provide surviving spouses eligible for DIC with a basic monthly rate of $750, without regard to the deceased veteran's military pay grade. This basic rate is increased by $165 monthly in the case of a veteran who at the time of death was receiving or entitled to receive compensation for a service-connected disability evaluated as totally disabling for a continuous period of at least eight years immediately preceding death. In determining the eight year period, only periods during which the veteran was married to the surviving spouse will be considered.

Under the statute, beneficiaries have no option to elect DIC benefits as provided prior to the enactment of Pub. L. 102-568. Surviving spouses of veterans who die before January 1, 1993, will receive DIC either based upon the veteran's military pay grade or under the new formula, whichever provides the greater benefit. Surviving spouses of veterans who die on or after January 1, 1993, will receive DIC only under the formula provided by Pub. L. 102-568.

Pub. L. 102-568 also amended 38 U.S.C. 1311(b) to increase the additional amount of DIC payable to a surviving spouse with dependent children of the deceased veteran to $100 monthly for each dependent child beginning January 1, 1993; to $150 monthly during Fiscal Year 1994; and to $200 monthly thereafter.

Section 3.5. 38 CFR 3.5(e)(1) has been amended to reflect the DIC rate for a surviving spouse when death occurred on or after January 1, 1993. 38 CFR 3.5(e)(2) has been amended to reflect the DIC rate for a surviving spouse when death occurred prior to January 1, 1993.

REGULATORY AMENDMENT

3-93-4

Regulation affected: 38 CFR 3.201(a)

EFFECTIVE DATE OF REGULATION: May 27, 1993

Date Secretary Approved Regulation: March 3, 1993

Federal Register Citation: 58 FR 25562 (April 27, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 601 of the Servicemen's and Veterans' Survivor Benefits Act, Pub. L. No. 881, 70 STAT. 857, 886 (1956) added 38 U.S.C. 5105 which authorized the Administrator of Veterans Affairs (now the Secretary of Veterans Affairs) and the Secretary of Health, Education, and Welfare (now the Secretary of Health and Human Services (HHS)) to jointly prescribe forms for use by survivors of members and former members of the uniformed services in filing applications for dependency and indemnity compensation (DIC) from VA and benefits under title II of the Social Security Act. That statute also stipulated that an application on such form filed with either VA or the Secretary of HHS would be deemed an application for both benefits, and it provided for transmission of applications and supporting documentation between VA and HHS. The purposes of section 601 were to obviate the necessity for a claimant to file more than one basic application for benefits under the Social Security Act and the DIC program and to avoid, to the maximum feasible extent, the necessity for a claimant to file any particular item of documentary evidence substantiating a claim more than once. VA published regulations at 38 CFR 3.201(a) to put this statutory directive into effect.

The central purpose of § 3.201(a) is to spare claimants the inconvenience of filing duplicate claims or furnishing duplicate evidence. It also establishes the date that the application or evidence is considered to have been received by VA (See 38 CFR 3.156(a), 3.158(a), and 3.400(q)(1)(i)). It is not, however, intended to require that evidence before the SSA be treated as if it were part of the record before VA, or to require that VA affirmatively seek such evidence from SSA in the absence of a request from the claimant, or to apply to claims for any VA benefit other than DIC.

Section 3.201. 38 CFR 3.201(a) has been amended to provide that a claimant for DIC may elect to furnish VA in support of that claim copies of evidence which was previously furnished to the Social Security Administration or to have the Department of Veterans Affairs obtain such evidence from the Social Security Administration. For the purpose of determining the earliest effective date for payment of dependency and indemnity compensation, such evidence will be deemed to have been received by the Department of Veterans Affairs on the date it was received by the Social Security Administration.

REGULATORY AMENDMENT

3-93-5

Regulation affected: 38 CFR 3.272(l)

EFFECTIVE DATE OF REGULATION: November 4, 1992

Date Secretary Approved Regulation: February 12, 1993

Federal Register Citation: 58 FR 25563 (April 27, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

38 U.S.C. 1718 previously provided that payments as a result of participation in a VA therapeutic or rehabilitation activity be considered a donation from a public or private relief or welfare organization and not countable as income for pension purposes. Section 401 of the Veterans' Health Care Act of 1992, Pub. L. 102-585, amended 38 U.S.C. 1718 to consider payments to a veteran as a result of participation in a program of rehabilitative services provided as part of the care furnished by a State home and which is approved by VA as conforming to standards for activities under 38 U.S.C. 1718 to be a donation from a public or private relief or welfare organization, and, therefore, excluded from countable income under the Improved Pension program.

Section 3.272. 38 CFR 3.272(l) has been amended to exclude as income for pension purposes payments to a veteran as a result of participation in a program of rehabilitative services provided as part of the care furnished by a State home and which is approved by VA as conforming to standards for activities under 38 U.S.C. 1718.

REGULATORY AMENDMENT

3-93-6

Regulation affected: 38 CFR 3.309

EFFECTIVE DATE OF REGULATION: October 1, 1992

Date Secretary Approved Regulation: February 11, 1993

Federal Register Citation: 58 FR 25563-64 (April 27, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 2 of the Veterans' Radiation Exposure Amendments of 1992, Pub. L. 102-578, amended 38 U.S.C. 1112(c) to repeal the requirement that, to be presumed service connected, specified diseases of veterans who participated in a radiation-risk activity become at least 10 percent disabling within 40 years after the veterans' last exposure to radiation. Pub. L. 102-578 also added cancer of the salivary gland and cancer of the urinary tract to the list of conditions for which presumptive service connection is authorized for veterans who participated in a radiation-risk activity.

Section 3.309. In § 3.309(d)(1), remove the words "to a degree of 10 percent or more within the presumptive period specified in paragraph (d)(3) of this section". In § 3.309(d)(2), paragraphs (xiv) and (xv) have been added to include cancer of the salivary gland and cancer of the urinary tract. In § 3.309(d), remove paragraph (3) and redesignate paragraph (4) as paragraph (3).

REGULATORY AMENDMENT

3-93-7

Regulation affected: 38 CFR 3.500(x) and 3.715

EFFECTIVE DATE OF REGULATION: October 15, 1990

Date Secretary Approved Regulation: February 4, 1993

Federal Register Citation: 58 FR 25564-65 (April 27, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

The Radiation Exposure Compensation Act of 1990 (RECA), Pub. L. 101-426, 104 Stat. 920, as amended by Pub. L. 101-510, section 3139, 104 Stat. 1835 (42 U.S.C. 2210 note) authorized the Attorney General of the United States to establish procedures for making payments as restitution to all eligible individuals, who may have contracted one of a specified group of radiation-related diseases as a result of the federal government's atmospheric nuclear testing program and to certain of their survivors. RECA authorized the Attorney General to make payments to a limited class of individuals with radiation-related diseases who had been employed during a specified period in uranium mines in Colorado, Utah, Arizona, Wyoming or New Mexico, or who had been present during designated periods at, or in, certain specified areas downwind of, the Nevada Test Site, the Pacific Proving Grounds, and the Trinity Test Site at Alamogordo, New Mexico. The Department of Justice published final regulations implementing RECA in the Federal Register of April 10, 1992 (57 FR 12428-61).

RECA has clear implications for VA beneficiaries receiving compensation or DIC based on disability or death resulting from a radiogenic disease. Section 6(e) of RECA provides that when an individual accepts a RECA payment, that payment represents full satisfaction of all claims of or on behalf of that individual against the United States based upon a condition that arises out of exposure to radiation as a result of onsite participation in a test involving the atmospheric detonation of a nuclear device. It is clear that under section 6(e) a veteran who accepts a RECA payment based on a radiogenic condition which developed after he or she participated onsite in an atmospheric test, is thereafter barred from receiving disability compensation under chapter 11 of title 38, United States Code, for the same condition. Similarly, a survivor who accepts a RECA payment based on the death of a veteran resulting from a radiogenic condition would thereafter be disqualified from receiving DIC based on death resulting from the same condition.

Section 3.500. 38 CFR 3.500(x) has been added to provide that the termination date for an award of compensation or DIC is the last day of the month preceding the month in which payment under the Radiation Exposure Compensation Act of 1990 is issued.

Section 3.715. 38 CFR 3.715 has been added to provide that payment to any individual under the provisions of the Radiation Exposure Compensation Act of 1990 (Pub. L. 101-426 as amended by Pub. L. 101-510) based upon disability or death resulting from a specific disease shall bar payment, or further payment, of compensation or DIC to or on behalf of that individual based upon disability or death resulting from the same disease.

REGULATORY AMENDMENT

3-93-8

Regulation affected: 38 CFR 3.307(a) and 3.309(e)

EFFECTIVE DATE OF REGULATION: February 6, 1991

Date Secretary Approved Regulation: March 17, 1993

Federal Register Citation: 58 FR 29107-09 (May 19, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 2 of the Agent Orange Act of 1991, Pub. L. 102-4, added 38 U.S.C. 1116 to establish a presumption of service connection for veterans with service in the Republic of Vietnam during the Vietnam era who subsequently develop, to a degree of 10 percent or more, non-Hodgkin's lymphoma, soft-tissue sarcoma (subject to specified statutory exceptions), and chloracne or other acneform disease consistent with chloracne, even though there is no record of that disease during military service. Qualifying skin conditions must have become manifest to a degree of 10 percent or more within one year of the last date of service in the Republic of Vietnam during the Vietnam era.

The term "soft-tissue sarcoma" is an imprecise term and there is no standard list of conditions which is universally accepted within the medical community as a definitive listing of "soft-tissue sarcomas". Although Congress has specifically excluded osteosarcoma, chondrosarcoma, Kaposi's sarcoma, and mesothelioma by statute, they have offered no specific guidance as to which other tumors they consider to be soft-tissue sarcomas.

VA has previously addressed the issue of what the term soft-tissue sarcoma encompasses for the purpose of amending 38 CFR 3.311a, to implement a determination by the Secretary of Veterans Affairs in accordance with the Veterans' Dioxin and Radiation Exposure Compensation Standards Act, Pub. L. 98-542. Pub. L. 98-542 provided that the Secretary, after receiving the advice of the Veterans Advisory Committee on Environmental Hazards (VACEH), will make a determination based upon "sound medical and scientific evidence", with respect to whether service connection will be granted for a particular disease. Based upon advice from VACEH and the Veterans Health Administration (VHA), the Secretary concluded that soft-tissue sarcomas should be classified by tumor type rather than tumor location and further, that in order to be recognized as "soft-tissue" sarcomas by VA, tumors must be malignant and arise from tissue of mesenchymal origin, including muscle, fat, blood or lymph vessels, or connective tissue (but not cartilage or bone), but that tumors of infancy or childhood, and those having a strong, known causal association with a specific etiology should not be included. The list of tumors which meet those criteria was published as part of the revision to 38 CFR 3.311a(c) (See the Federal Register of October 15, 1991 (56 FR 51651-3)).

Those same criteria are consistent with the statutory language of Pub. L. 102-4 to the extent that when they are applied, osteosarcoma, chondrosarcoma, Kaposi's sarcoma, and mesothelioma are not considered soft-tissue sarcomas for VA purposes. However, since it provides presumptive service connection for "each" soft-tissue sarcoma becoming manifest to a degree of 10 percent or more, the statutory language of Pub. L. 102-4 clearly encompasses a broader category of tumors than that listed in 38 CFR 3.311a by not excluding tumors of infancy and childhood.

To implement these provisions of Pub. L. 102-4, we have cited the list of tumors that appears at 38 CFR 3.311a(c)(2) and have augmented it with the following tumors: Extraskeletal Ewing's sarcoma, congenital and infantile fibrosarcoma, and malignant ganglioneuroma. These additional soft-tissue

sarcomas are generally considered tumors of infancy and childhood which rarely, if ever, occur initially in an individual old enough to have been accepted for military service. They will be included in this regulation, however, in order to satisfy the requirements established by the statutory language of Pub. L. 102-4.

Section 3.307. The heading has been revised to include diseases associated with service in the Republic of Vietnam. A new paragraph (a)(6) has been added to provide presumptive service connection the diseases listed in § 3.309(e) which become manifest to a degree of 10 percent or more at any time after service in Vietnam during the Vietnam era, except that chloracne or another acneform disease consistent with chloracne must become manifest to a degree of 10 percent or more within a year after the last date on which the veteran performed active military, naval, or air service in the Republic of Vietnam during the Vietnam era. "Service in the Republic of Vietnam" includes service in the waters offshore and service in other locations if the conditions of service involved duty or visitation in the Republic of Vietnam. In § 3.307(a), the first sentence, remove the words "or prisoner of war related disease", and add, in their place, the words ", prisoner of war related disease, or a disease associated with service in the Republic of Vietnam". In § 3.307(a)(1), after the words "§ 3.309(c)" add the words "and (e)".

Section 3.309. New paragraph (e) has been added to provide that, if a veteran, during active military, naval, or air service, served in the Republic of Vietnam during the Vietnam era, the following diseases will be service-connected if the requirements of § 3.307(a)(6) are satisfied even though there is no record of such disease during service, provided further that the rebuttable presumption provisions of § 3.307(d) are also satisfied:

Chloracne
Non-Hodgkin's lymphoma
Soft-tissue sarcoma (other than osteosarcoma, chondrosarcoma, Kaposi's sarcoma, or mesothelioma)

NOTE: The term "soft-tissue sarcoma" includes those tumors listed at § 3.311a(c)(2). For the purposes of this section only, the following tumors of infancy and childhood, although rarely if ever occurring in an individual old enough to have been accepted for military service, will also be included:

Extraskeletal Ewing's sarcoma
Congenital and infantile fibrosarcoma
Malignant ganglioneuroma

REGULATORY AMENDMENT

3-93-9

Regulation affected: 38 CFR 3.304(f)

EFFECTIVE DATE OF REGULATION: May 19, 1993

Date Secretary Approved Regulation: March 18, 1993

Federal Register Citation: 58 FR 29109-10 (May 19, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

In a precedent opinion dated March 17, 1992 (O.G.C. Prec. 7-92), VA's General Counsel held that certain provisions of the Adjudication Procedure Manual, M21-1, Part I, regarding the development of evidence in claims involving PTSD constitute substantive rules which were not promulgated in accordance with the rulemaking procedures prescribed by 5 U.S.C. 552(a)(1), 553 and 38 CFR 1.12.

PTSD is an anxiety disorder resulting from a traumatic event outside the range of usual human experience which is characterized by recurrent episodes of reexperiencing the traumatic event, numbing of emotional responsiveness, and increased restlessness. In order to establish service connection for PTSD, VA must have medical evidence supporting a clear diagnosis of the condition, credible evidence that the claimed inservice stressor actually occurred, and medical evidence establishing a link between the current symptomatology and the claimed inservice stressor.

Under the provisions of 38 U.S.C. 501(a), the Secretary of Veterans Affairs has authority to prescribe regulations with respect to the nature and extent of proof and evidence required in order to establish entitlement to benefits. The Secretary has determined that for cases of PTSD certain types of evidence are sufficient to substantiate the occurrence of the claimed inservice stressor under specific circumstances where events can never be fully documented. Combat, for example, is inherently life-threatening, and the brutal and horrific events associated with active armed combat are indisputably the types of stressful events that could produce PTSD. The chaotic circumstances of combat, however, preclude the maintenance of detailed records. Consequently, the Secretary has determined that when service department records indicate that the veteran engaged in combat or was awarded a combat citation and the claimed stressor is related to the combat experience, further development to document the occurrence of the claimed stressor is unnecessary.

Similarly, when a veteran is considered a former prisoner-of-war under the provisions of 38 CFR 3.1(y), the Secretary has determined that no additional evidence is necessary to verify the occurrence of an inservice stressor. Typically, former prisoners-of-war were forcibly detained or interned under circumstances that included physical or psychological hardships or abuse, malnutrition, and unsanitary conditions. The prolonged and chronic stress of exposure to such conditions plus the uncertainty of not knowing how long one must endure them are types of overwhelming stress that could certainly produce PTSD.

When VA has the types of evidence discussed above, additional development would only serve to delay the authorization of benefits to which the claimants are entitled.

Section 3.304. A new paragraph (f) has been added to provide that service connection for PTSD requires medical evidence establishing a clear diagnosis of the condition, credible supporting evidence that the claimed inservice stressor actually occurred, and a link, established by medical evidence, between current symptomatology and the claimed inservice stressor. If the claimed stressor is related

to combat, service department evidence that the veteran engaged in combat or that the veteran was awarded the Purple Heart, Combat Infantryman Badge, or similar combat citation will be accepted, in the absence of evidence to the contrary, as conclusive evidence of the claimed inservice stressor. Additionally, if the claimed stressor is related to the claimant having been a prisoner-of-war, prisoner-of-war experience which satisfies the requirements of § 3.1(y) will be accepted, in the absence of evidence to the contrary, as conclusive evidence of the claimed inservice stressor.

REGULATORY AMENDMENT

3-93-10

Regulation affected: 38 CFR 3.55, 3.115, 3.215, 3.341(c), 3.342(c), 3.343(c), 3.502(f) and 3.551(i)

EFFECTIVE DATE OF REGULATION: The amendments to §§ 3.502 and 3.551 are effective October 1, 1992. The remaining amendments are effective October 29, 1992.

Date Secretary Approved Regulation: April 19, 1993

Federal Register Citation: 58 FR 32443-45 (June 10, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 8004 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, rescinded VA's authority to reinstate the benefits eligibility of remarried surviving spouses when the marital relationship terminates. These provisions applied to claims filed after October 31, 1990. Section 502 of the Veterans' Benefits Programs Improvement Act of 1991, Pub. L. 102-86, stipulated that the rescission of VA's authority to reinstate benefits eligibility does not apply to any individual who on October 31, 1990, was a surviving spouse within the meaning of title 38, United States Code, unless after that date that individual marries. Section 103 of the Veterans' Benefits Act of 1992, Pub. L. 102-568, further stipulated that the rescission of VA's authority to restore benefits eligibility does not apply to any case in which a legal proceeding to terminate the disqualifying marital relationship was begun before November 1, 1990, if that proceeding directly resulted in the termination of the disqualifying marital relationship. Since the recent amendment applies to surviving spouses but not to children, we are revising 38 CFR 3.55 to implement this revised statutory provision and reorganizing it into separate paragraphs for surviving spouses and children. We have also revised the heading to § 3.55 to read "Reinstatement of benefits eligibility based upon terminated marital relationships" which more accurately reflects the content of the regulation than the previous heading, "Terminated marital relationships." Additionally, we have made a revision to § 3.215 so that this section resembles § 3.55 in terminology and structure.

In 38 U.S.C. 1163, Congress established a temporary program for trial-work periods and vocational rehabilitation services to certain veterans who have service-connected disabilities not rated as totally disabling but who have been awarded a rating of total disability by reason of individual unemployability. Under this temporary program, such a veteran who starts a substantially gainful occupation may not have his or her disability rating reduced on the basis of having obtained and continued that employment unless he or she maintains that employment for 12 consecutive months. Section 401 of Pub. L. 102-568 makes the program permanent and we have amended 38 CFR 3.341(c) and 3.343(c)(2) to reflect that change.

38 U.S.C. 1524 provides for a temporary vocational training program for veterans under the age of 45 who are awarded pension during the program period. Section 402 of Pub. L. 102-568 extends the program until December 31, 1995 and eliminates the statutory requirement that VA suspend benefits if a veteran fails to participate in the program. We have amended 38 CFR 3.342(c)(1) and (2) to reflect the revised ending date and the elimination of the requirement to suspend benefits for failure to participate in the program.

Section 8003 of Pub. L. 101-508 required VA to reduce the pension benefits of any veteran having neither spouse nor child who receives Medicaid-covered nursing home care to $90 per month. These statutory provisions expired September 30, 1992. Section 601 of Pub. L. 102-568 extends this requirement until September 30, 1997, and requires an identical reduction in death pension payments to

surviving spouses having no children who receive Medicaid-covered nursing home care. We have amended 38 CFR 3.502 and 3.551(i) to reflect these statutory changes. The dates for reduction of death pension benefits under these circumstances have been added at 38 CFR 3.502. The language in this paragraph, except for benefit specific references, is identical to the language that appears at § 3.501(i)(6) regarding the dates that disability pension will be reduced under the same circumstances. Inclusion in § 3.502 of a reference to a reduction effective the last day of the month following 60 days after issuance of a prereduction notice required under § 3.103(b) reflects the fact that a surviving spouse may not generally be held liable for any overpayment created by operation of the statute. This action is not intended to imply that provision of a 60-day prereduction notice period creates entitlement to benefits for that period.

The Right to Financial Privacy Act of 1978, codified at 12 U.S.C. 3401 through 3422, generally prohibits federal agencies from gaining access to or obtaining copies of information contained in a financial institution's customer records. Section 603 of Pub. L. 102-568 amends 12 U.S.C. 3413 to specifically permit financial institutions to disclose to VA the names and addresses of customers where the disclosure is necessary for the proper administration of benefit programs under laws administered by VA and the information will be used solely for that purpose. The Secretary of Veterans Affairs may request such information only upon making a determination that it is necessary for the administration of laws administered by VA and that it cannot be obtained by a reasonable search of VA records and information. We have added a new section, § 3.115, to 38 CFR Part 3 in order to implement this new statutory provision.

Section 3.55. Since this amendment applies to surviving spouses but not to children, we are revising 38 CFR 3.55 to implement this revised statutory provision and reorganizing it into separate paragraphs for surviving spouses and children.

Section 3.115. This section has been added to specifically permit financial institutions to disclose to VA the names and addresses of customers where the disclosure is necessary for the proper administration of benefit programs under laws administered by VA and the information will be used solely for that purpose.

Section 3.215. In § 3.215, the first sentence, remove the words "With respect to marriages terminated on" and insert, in their place, the word "On". In § 3.215, the first sentence, remove the words "but prior to November 1, 1990,". In § 3.215, the first sentence, remove the words "unless the same or similar conduct or relationship resumes after October 31, 1990" and insert, in their place, the words "if the relationship terminated prior to November 1, 1990".

Section 3.341. In § 3.341(c), the heading, remove the words "Temporary program", and insert, in their place, the word "Program". In § 3.341(c), the text, remove the words "on February 1, 1985 and ending on January 31, 1992," and insert, in their place, the words "after January 31, 1985,".

Section 3.342. In § 3.342(c)(1), the first sentence, remove the words "January 31, 1992," and insert, in their place, the words "December 31, 1995,". In § 3.342(c)(1), the first sentence, remove the words "as required by § 21.6050" and insert, in their place, the words "as provided in § 21.6050". In § 3.342(c)(1), remove the second sentence. In § 3.342, remove paragraph (c)(2) and redesignate paragraph (c)(3) as the new paragraph (c)(2).

Section 3.343. In § 3.343(c)(2), remove the words "on February 1, 1985, and ending on January 31, 1992," and insert, in their place, the words "after January 1, 1985,".

Section 3.502. This new section has been added to provide for reduction in death pension payments to surviving spouses having no children who receive Medicaid-covered nursing home care.

Section 3.551. In § 3.551(i), in the heading, after the word "veterans" add the words "and surviving spouses"; in the first sentence, remove the words "September 30, 1992," and insert, in their place, the words "September 30, 1997,"; in the first sentence, after the words "nor child" add the words ", or a surviving spouse having no child,"; in the first sentence, after the words "no pension" insert the words "or death pension"; in the first sentence, after the words "to or for the veteran" add the words "or the surviving spouse"; in the second sentence, after the words "A veteran" and "by the veteran" add the words "or surviving spouse".

REGULATORY AMENDMENT

3-93-11

Regulations Affected: 38 CFR 3.261(a), 3.262(u), and 3.263(f).

EFFECTIVE DATE OF REGULATIONS: These amendments are effective August 10, 1988, the date authorized by Public Law 102-371.

Date Secretary Approved Regulations: February 5, 1993

Federal Register Citation: 58 FR 33766-67 (June 21, 1993)

The purpose of the following comments on the changes included in these amendments of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Title I of Public Law 100-383, the Civil Liberties Act of 1988, provided redress in the amount of $20,000.00 to certain individuals of Japanese ancestry who were interned or relocated by the Federal government during WWII. The bill expressly provided that these payments shall not be included as income or resources for determining eligibility to benefits described in 31 U.S.C. 3803(c)(2)(C). An opinion of VA's General Counsel (O.G.C. Prec. 3-92) held that these payments are not countable as income or for net worth determinations for the purposes of improved pension and parents' DIC, which are found in those chapters of title 38 U.S.C. referenced by the cited section of title 31. The opinion further stated that these payments were countable as income and net worth under 306 pension and old law pension, because these benefits are no longer in force under title 38, but under the savings provision (section 306) of Public Law 95-588. In a previous regulatory amendment we amended 38 CFR §§ 3.261, 3.263, 3.262, 3.272, and 3.275 to implement Public Law 100-383 and the opinion of the General Counsel.

On September 27, 1992, the President signed Public Law 102-371, the Civil Liberties Act Amendments of 1992. This law amended Public Law 100-383 by extending the income exemption of the Japanese-American restitution payments to include exclusion from countable income or in determining net worth for any program administered by VA, effective August 10, 1988, the date of the original law. Our current amendments implement these provisions of Public Law 102-371.

Sections 3.261 and 3.262. Paragraphs 3.261(a)(36) and 3.262(u) have been revised to show that the Japanese-American restitution payments are not countable income for section 306 and old law pension.

Section 3.263. Paragraph(f) has been revised to show that the Japanese-American restitution payments are excluded from net worth computations under section 306 pension.

REGULATORY AMENDMENT

3-93-12

Regulation affected: 38 CFR 3.558(c)

EFFECTIVE DATE OF REGULATION: March 11, 1993

Date Secretary Approved Regulation: May 25, 1993

Federal Register Citation: 58 FR 34224-25 (June 24, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

38 U.S.C. 5503(b)(1)(A) precludes the payment of compensation when a veteran is without spouse or child; is receiving hospital treatment, institutional care, or domiciliary care without charge or otherwise from the U.S. or any political subdivision of the U.S.; is rated incompetent by the Secretary in accordance with regulations; and his or her estate (excluding, generally, the value of his or her home) exceeds $1,500. While subparagraph (A) requires suspension of compensation when all four prerequisites exist, if the veteran is held competent by VA for a period of six months, subparagraph (B) imposes the additional requirement that the suspended benefits be paid in a lump sum.

The Secretary has prescribed at 38 CFR 3.558(c)(2) an additional requirement that a veteran rated competent for six months or longer and thereafter re-rated as incompetent must have a spouse or child in order to be eligible for the lump-sum payment. In Felton v. Brown, U.S. Vet. App. No. 90-965, COVA held that the requirement found at 38 CFR 3.558(c)(2) is an unauthorized limitation on the scope of 38 U.S.C. 5503, and is, therefore, neither "appropriate to carry out" nor "consistent with" the law under 38 U.S.C. 501(a). We have amended § 3.558 to delete paragraph (c)(2) effective March 11, 1993, the date of the COVA decision.

Additionally, we have amended the remaining text of § 3.558 to clarify that the sole criterion for determining whether a veteran is entitled to a lump-sum payment is that he or she must have been subsequently rated competent by VA for a period of not less than six months. VA believes that this interpretation of the statute is consistent with the COVA decision in Felton v. Brown, which held that 38 U.S.C. 5503(b)(1)(B) clearly mandates a lump-sum payment after the expiration of a six-month period following competency.

Section 3.558. Paragraph (c) has been revised to provide that any amount not paid because of the provisions of § 3.557(b),and any amount of compensation or retirement pay withheld pursuant to the provisions of § 3.551(b) (and/or predecessor regulatory provisions) as it was constituted prior to August 1, 1972, and not previously paid because of the provisions of § 3.557(b), will be awarded to the veteran if he or she is subsequently rated competent by VA for a period of not less than six months.

REGULATORY AMENDMENT

3-93-13

Regulation affected: 38 CFR 3.812(f)

EFFECTIVE DATE OF REGULATION: June 28, 1993

Date Secretary Approved Regulation: March 17, 1993

Federal Register Citation: 58 FR 34524-25 (June 28, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

The Omnibus Budget Reconciliation Act of 1981 amended title 42, United States Code, to discontinue payment of the social security mother's and child's insurance benefits at the point at which the child reached age sixteen. Previously, such benefits had terminated when the child reached age eighteen. Section 156 of Pub. L. 97-377 restored such benefits for surviving spouses and children of individuals who died on active duty prior to August 13, 1981, or died as a result of service-connected disability incurred or aggravated prior to that date. This law, which established the Restored Entitlement Program for Survivors (REPS), provided that payment of the mother's and child's benefits would be in the amount, if any, that beneficiaries would have received under section 202 of the Social Security Act (codified at 42 U.S.C. 402) if the child were under sixteen years of age. Section 202(j) of the Social Security Act provides that the mother's (or father's) and child's benefits may be paid from the beginning of the first month in which eligibility arose, where application for benefits is filed prior to the end of the sixth month immediately succeeding that month.

VA issued an implementing regulation, codified at 38 CFR 3.812(f)(2), providing that benefits could be paid from the first day of the month in which the claimant first became eligible, if application was filed within eleven months following that month. However, in view of the sua sponte ruling by the Court of Veterans Appeals in Cole v. Derwinski, U.S. Vet. App. No. 89-30 (judgment entered July 27, 1992), invalidating this regulation, VA reviewed the statutory authority for payment of benefits under this program. As a result of this review, we now believe that the six-month application period for payment of benefits from the month in which eligibility arose, provided by the social security statutes, must be applied under the REPS program. This amendment corrects the regulation in this regard.

Since the provisions of the Social Security Act requires that application be filed within six months after the month in which eligibility arose in order for payment to be made from that month, there was no authority under section 156 to make such payment to those persons who applied after six months but before eleven months from the month in which eligibility arose. However, persons who have been paid benefits pursuant to 38 CFR 3.812(f)(2) from the month in which eligibility arose, based on applications filed within eleven months, but not within the six months, of that month, will be permitted to keep those benefits since payment was based on administrative error and, under 38 U.S.C. 5112(b)(10) and 38 CFR 3.500(b)(2), the effective date for reduction of benefits in such situations is the date of last payment. We realize that there may be persons who first became eligible for REPS benefits within eleven months prior to the month in which this amendment became effective but who did not or will not apply for benefits within the required six-month period because of reliance upon the eleven-month filing period specified in the former regulation. This amendment establishes a policy under which equitable relief will be provided to such persons under 38 U.S.C. 503(a), if they can establish to the satisfaction of the Secretary that they did not make application within the required six-month period due to reliance on the former regulation. Section 503(a) authorizes the Secretary to provide equitable relief to persons denied benefits by reason of administrative error on the part of the Federal Government.

Section 3.812. In § 3.812, remove the words "11 months" in paragraph (f)(2) and add, in their place, the words "6 months"; redesignate paragraph (f)(4) as paragraph (f)(5), and add a new paragraph (f)(4) to provide equitable relief for certain persons who relied upon the prior regulatory provision.

REGULATORY AMENDMENT

3-93-14

Regulations Affected: 38 CFR 3.353

EFFECTIVE DATE OF REGULATION: This amendment is effective August 13, 1993.

Date Secretary Approved Regulation: May 20, 1993

Federal Register Citation: 58 FR 37856 (July 14, 1993)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

The definition of a mentally incompetent person for VA purposes is one who, because of injury or disease, lacks the mental capacity to contract or to manage his or her own affairs, including disbursement of funds without limitation (38 CFR 3.353(a)). This definition represents long-standing VA policy. An inconsistency existed in the language of § 3.353(d), however, which required a presumption in favor of competency in situations where doubt arises as to whether a beneficiary is capable of administering his or her funds (emphasis added).

Section 3.353(d) was designed to avoid appointing a fiduciary except in a situation where it is clearly in a beneficiary's best interest to do so because of mental incompetency. Since ratings of incompetency are based on the definition in § 3.353(a) and can result in appointment of a fiduciary, to limit consideration under § 3.353(d) only to the administration of funds would constitute internal inconsistency within the regulation and could lead to discrepancies in its application in individual cases. The regulatory history, in fact, shows that the language of § 3.353(d) predates the definition of § 3.353(a) and was never amended to conform with it. We, therefore, have amended § 3.353(d) to add a provision regarding a beneficiary's mental capacity to contract or to manage his or her own affairs, to change "administering" funds to "disbursement" of funds, and to add the phrase "without limitation" to the provision concerning disbursement of funds. We also have amended § 3.353(d) to clarify that by "doubt" whether a beneficiary is competent we mean "reasonable doubt." This change accords with VA's doctrine of reasonable doubt as defined in § 3.102 and represents in any event the intent of § 3.353(d) in this regard.

Section 3.353. Paragraph (d) has been amended to add a provision regarding a beneficiary's mental capacity to contract or manage his or her own affairs, to change "administering" funds to "disbursement" of funds, to add the phrase "without limitation" to the provision concerning disbursement of funds, and to clarify that by "doubt" whether a beneficiary is competent "reasonable doubt" is meant.

REGULATORY AMENDMENT

3-93-15

Regulations Affected: 38 CFR 3.203(c) and 3.205(a)(1).

EFFECTIVE DATE OF REGULATIONS: July 14, 1993

Date Secretary Approved Regulations: February 25, 1993

Federal Register Citation: 58 FR 37856-57 (July 14, 1993)

The purpose of the following comments on the changes included in these amendments of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Prior to October 28, 1980, VA accepted photo copies of discharge documents as proof of military service unless there was some reason to question the genuineness of the documents. However, 38 CFR 3.203 was amended to provide that VA may accept a copy of an original discharge document as proof of military service, but only if the copy was issued by the appropriate service department or by a public custodian of records who certifies that it is a true and exact copy of the document in his or her custody. If this type of evidence is not submitted, VA requests verification of military service from the appropriate service department.

No general review of previously allowed claims was conducted when § 3.203 was amended, so veterans who had previously been awarded compensation or pension based upon uncertified copies of discharge documents continue to receive those benefits. When one of those veterans dies, however, VA requests evidence of military service which satisfies the more stringent current requirements before authorizing payment of the one-time, nonservice-connected burial benefit. The maximum amount of the one-time burial benefit is $450 ($300 burial allowance plus $150 plot allowance), and it is payable only when the veteran was entitled to receive compensation or pension as of the date of death, or died in a VA hospital. It has been our experience that we are ultimately able to verify the service of virtually all of these veterans. We have therefore determined that the delay in authorizing payment which verification entails and the resulting distress to survivors are not warranted, and that evidence relied upon to authorize payment of compensation or pension is sufficient to authorize payment of the one-time, nonservice-connected burial benefit.

Prior to June 14, 1982, VA accepted the veteran's certified statement, under most circumstances, as proof of marriage; however, many claimants also submitted uncertified copies of the public record of marriage to support their claims. In 1982 VA began to require more than a certified statement as proof of marriage, with certified copies of the public or church record of marriage being the preferred type of evidence. No general review of claims in which the additional allowance for a spouse had been authorized was conducted, however. When a veteran who receives compensation or pension benefits dies, claims for death pension or dependency and indemnity compensation may be delayed while VA requests currently acceptable proof of marriage. This is true even though VA recognized the surviving spouse as a dependent while the veteran was alive and even though VA has on record an uncertified copy of the public record of marriage supporting a certified statement from the deceased veteran as well as the surviving spouse's certified statement on the application for death benefits. To require a certified marriage document under these circumstances results in unwarranted expense, inconvenience and loss of time to surviving spouses at a very difficult time.

Section 3.203. In § 3.203(c), a new second sentence has been added to provide that payment of nonservice-connected burial benefits may be authorized, if otherwise in order, based upon evidence of service which VA relied upon to authorize payment of compensation or pension during the veteran's

lifetime, provided that there is no evidence which would serve to create doubt as to the correctness of that service evidence.

Section 3.205. In § 3.205, paragraph (a)(1) has been amended to provide that payment of death benefits to a surviving spouse may be authorized, if otherwise in order, based upon an uncertified copy of the public record of marriage which was part of the VA record on the date of the veteran's death, and which substantiates the veteran's certified statement that VA relied upon to establish the claimant as the spouse for compensation or pension payments which the veteran was entitled to receive at the time of his or her death, provided that there is no evidence which would serve to create doubt as to the correctness of that copy.

REGULATORY AMENDMENT

3-93-16

Regulation affected: 38 CFR 3.357(a)

EFFECTIVE DATE OF REGULATION: October 6, 1993

Date Secretary Approved Regulation: August 26, 1993

Federal Register Citation: 58 FR 52017-18 (October 6, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

A majority of the disabilities addressed in the VA's Schedule for Rating Disabilities (38 CFR part 4) do not specify criteria for a zero percent level. Once it has been determined that a disability is service-connected, it has been VA's consistent practice to assign a zero percent evaluation whenever the condition does not meet the stated minimum requirements for compensable evaluation. In recent decisions, however, the U.S. Court of Veterans Appeals (COVA) pointed out that unless an individual diagnostic code requires residual disability for a compensable evaluation, a zero percent evaluation is not authorized under §§ 3.357(a) and 4.31. See Rabideu v. Derwinski, U.S. Vet. App. No. 90-1296 and Conley v. Derwinski, U.S. Vet. App. No. 91-527. From the Court's analysis it is apparent that VA regulations are seen as being inconsistent with VA's longstanding practice of assigning a zero percent evaluation for any disability which does not meet the minimum requirements for a compensable evaluation.

We have amended § 4.31 to eliminate this perceived discrepancy between VA practice and regulations. We have changed the heading of § 4.31 from "A no-percent rating" to "Zero percent evaluations" to more accurately represent the issue addressed in the regulation.

Section 3.357. Paragraph (a) is deleted because it is duplicative of § 4.31 and the issue is more appropriately addressed in the rating schedule.

REGULATORY AMENDMENT

3-93-17

Regulations Affected: 38 CFR 3.103(f)

EFFECTIVE DATE OF REGULATIONS: July 14, 1993

Date Secretary Approved Regulations: September 22, 1993

Federal Register Citation: 58 FR 59365-66 (November 9, 1993)

The purpose of the following comments on the changes included in these amendments of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

38 U.S.C. 5104(b) provides that when the Secretary of Veterans Affairs denies a benefit sought, the notification to the claimant (and to the claimant's representative) of that decision must include a statement of the reasons for the denial of benefits and a summary of the evidence considered in reaching that decision. This requirement is not clearly reflected in the regulations at 38 CFR 3.103 concerning procedural due process and appellate rights. 38 CFR 3.103(f) stipulates that a claimant or beneficiary and his or her representative will be notified in writing concerning decisions that affect the payment of benefits or granting of relief and describes the content of such a notification, but does not specify the content of the notification when benefits sought are denied. We have amended § 3.103(f) accordingly.

Section 3.103. 38 CFR 3.103(f) has been amended to provide that any notice that VA has denied a benefit sought will include a summary of the evidence considered.

REGULATORY AMENDMENT

3-94-1

Regulations Affected: 38 CFR 3.307(a), 3.309(e), 3.311a, and 3.311b

EFFECTIVE DATE OF REGULATIONS: February 3, 1994

Date Secretary Approved Regulations: January 4, 1994

Federal Register Citation: 59 FR 5106-07 (February 3, 1994)

The purpose of the following comments on the changes included in these amendments of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 2(a)(1) of the Agent Orange Act of 1991, Pub. L. 102-4, 105 Stat. 11 (1991), added 38 U.S.C. 1116 to establish presumptive service connection for veterans with service in the Republic of Vietnam during the Vietnam era who subsequently develop, to a degree of 10 percent or more, non-Hodgkin's lymphoma, soft-tissue sarcoma (subject to specified statutory exceptions), and chloracne or other acneform disease consistent with chloracne, even though there is no record of that disease during military service. Final regulations implementing this statutory provision were published in the Federal Register of May 19, 1993 (See 58 FR 29107-09).

Section 3 of Pub. L. 102-4 directed the Secretary to enter into an agreement with the National Academy of Sciences (NAS) to review the scientific evidence concerning the association between exposure to herbicides used in support of military operations in the Republic of Vietnam during the Vietnam era and each disease suspected to be associated with such exposure. Congress mandated that NAS determine, to the extent possible, (1) whether there is a statistical association between the suspect diseases and herbicide exposure, taking into account the strength of the scientific evidence and the appropriateness of the methods used to detect the association; (2) the increased risk of disease among individuals exposed to herbicides during service in the Republic of Vietnam during the Vietnam era; and (3) whether there is a plausible biological mechanism or other evidence of a causal relationship between herbicide exposure and the suspect disease.

Section 1116(b) of 38 U.S.C. provides that whenever the Secretary determines, based on sound medical and scientific evidence, that a positive association exists between exposure to an herbicide agent (i.e., a chemical in an herbicide used in support of the United States and allied military operations in the Republic of Vietnam during the Vietnam era) and a disease, the Secretary will publish regulations establishing presumptive service connection for that disease. In making that determination, the Secretary is to consider reports received from NAS as well as other available sound medical and scientific evidence and analyses.

After reviewing 6,420 scientific or medical articles, consulting with outside experts, and conducting public hearings, NAS issued a report, entitled "Veterans and Agent Orange: Health Effects of Herbicides Used in Vietnam", on July 27, 1993. NAS concluded that there is an association between exposure to herbicides used in the Republic of Vietnam and the subsequent development of chloracne, non-Hodgkin's lymphoma, and soft-tissue sarcoma, conditions for which VA is already paying compensation based upon the statutory presumptions established by Pub. L. 102-4.

The Secretary has determined that a positive association exists between exposure to herbicides used in the Republic of Vietnam and the subsequent development of chloracne, non-Hodgkin's lymphoma, and soft-tissue sarcoma. Chloracne has been linked to herbicide exposure in numerous epidemiological studies of occupationally and environmentally exposed individuals. The NAS report

considered a number of epidemiological studies, including studies involving occupational, environmental, and Vietnam exposures, and concluded that there was sufficient evidence for a positive association between exposure to herbicides used in the Republic of Vietnam and the development of non-Hodgkin's lymphoma. The NAS analysis gave great weight to the Swedish studies which demonstrated a relationship between herbicide exposure and the development of soft-tissue sarcoma.

NAS also concluded that there is an association between exposure to herbicides used in the Republic of Vietnam and the subsequent development of PCT (a disease in which porphyrins are abnormally metabolized and which is characterized by thinning and blistering of the skin in sun-exposed areas) in genetically susceptible individuals. The last time VA had considered this issue, it had determined, after receiving the advice of the Veterans' Advisory Committee on Environmental Hazards (VACEH), that PCT does not result from exposure to dioxin (See 56 FR 52473-74). A majority of the VACEH members felt that while the literature, particularly that dealing with an industrial accident in Seveso, Italy, left open the possibility of an association, it was insufficient to meet the requirements for a "significant statistical association," the standard in effect at that time.

The NAS report found that case studies and animal studies are sufficient to conclude that there is a positive association between herbicide exposure and PCT in genetically predisposed individuals. After reviewing the NAS report, which found an association based on case and animal studies, and reconsidering the analysis of VACEH focusing on the issue of whether there is an association between herbicide -- rather than dioxin -- exposure and PCT, the Secretary has found that the credible evidence for an association outweighs the credible evidence against an association and that there is, therefore, a positive association between exposure to herbicides used in the Republic of Vietnam and the subsequent development of PCT.

The clinical evidence provides that for both PCT and chloracne onset occurs soon after exposure, and that the conditions subside after exposure ceases. Pub. L. 102-4 established service connection for chloracne which occurred within one year of the veteran's last exposure to herbicide agents. A study of the onset of chloracne subsequent to an industrial accident involving herbicide production found that chloracne occurred within a few weeks of exposure, with one case occurring eleven months after the accident. We also propose to establish a one-year manifestation period for PCT. In our judgment, this is reasonable and consistent with manifestation periods established for other conditions for which presumptive service connection has been established (See 38 CFR 3.307(a)(3) and (4)). We have amended 38 CFR 3.307(a) and 3.309(e) to implement the Secretary's decision.

NAS also concluded that there is an association between herbicide exposure and the subsequent development of Hodgkin's disease, a neoplastic disease characterized by progressive anemia and enlargement of lymph nodes, spleen, and liver. Nearly all of the case-control and agricultural worker studies show increased risk for Hodgkin's disease. Although only a few of these results are statistically significant, those that are show a positive association. Those that are not statistically significant generally indicate increased risk of Hodgkin's disease and the pattern of the results is notably consistent.

Hodgkin's disease is a form of lymphoma with characteristic histopathologic findings, especially the presence of Reed-Sternberg cells. It also has a number of clinical features that typically differ from other lymphomas. While there were fewer studies for Hodgkin's disease than for non-Hodgkin's lymphoma, the NAS report noted that the pattern of results was consistent with the findings for non-Hodgkin's lymphoma and concluded that there was sufficient evidence for a positive association between exposure to the herbicides used in Vietnam and the development of Hodgkin's disease.

After reviewing the NAS report and noting (1) the difficulty which may occur in trying to distinguish between Hodgkin's disease and non-Hodgkin's lymphoma pathologically, (2) the occasional development of both diseases in the same patient, and (3) the biologic relationship between the two diseases in terms of tissue of origin, the Secretary has determined that there is an association between exposure to herbicides used in the Republic of Vietnam and the subsequent development of Hodgkin's

disease which manifests itself to a degree of 10 percent at any time after exposure. We have amended 38 CFR 3.309(e) to implement the Secretary's decision.

Currently, VA regulations address the issue of diseases resulting from exposure to herbicides used in Vietnam under two distinct sets of criteria: §§ 3.307 and 3.309 implement the statutory presumptions established by Congress in the Agent Orange Act of 1991, Pub. L. 102-4, while § 3.311a establishes service connection on the basis of exposure to herbicides containing dioxin, as previously authorized under the provisions of the Veterans' Dioxin and Radiation Exposure Compensation Standards Act, Pub. L. 98-542. However, Section 10 of Pub. L. 102-4 amended Pub. L. 98-542 by removing the provisions concerning dioxin exposure and there is therefore no need for VA to maintain separate regulations on this issue. Since the regulations implementing the other statutory presumptions for service connection created by Congress appear at §§ 3.307 and 3.309, and because the Secretary of Veterans Affairs is specifically authorized to add to the list of presumptive conditions established by Pub. L. 102-4, we have deleted § 3.311a and will address the issue of diseases resulting from exposure to herbicides used in Vietnam exclusively at §§ 3.307(a)(6) and 3.309(e).

VA has also amended § 3.307(a)(6) so that it (1) bases the presumption of service connection on exposure to certain herbicide agents rather than on service in the Republic of Vietnam during the Vietnam era as it currently does, (2) incorporates the definition of the term "herbicide agent" from Pub. L. 102-4, (3) incorporates the definition of the term "service in the Republic of Vietnam" from 38 CFR 3.311a, and (4) provides that for those who served in the Republic of Vietnam the last day of exposure to an herbicide agent will be presumed to be the last date of service in the Republic of Vietnam during the Vietnam era. In addition, we have amended § 3.307(a)(6) to specify the chemicals in the herbicides used in the Republic of Vietnam. We also have amended § 3.309(e) by revising the title to reflect the fact that the basis of entitlement is exposure to certain herbicide agents, and to incorporate the complete list of soft-tissue sarcomas VA has established by prior rulemakings (See 56 FR 51651-53 and 58 FR 29107-09). Since the complete list of soft-tissue sarcomas will now appear at § 3.309(e), the note that currently follows § 3.309(e) is no longer necessary and we have removed it.

Section 3.307. The heading and § 3.307(a)(6) have been revised as described above. In § 3.307(a), the first sentence of the introductory text, remove the words "a disease associated with service in the Republic of Vietnam" and insert, in their place, the words "a disease associated with exposure to certain herbicide agents".

Section 3.309. 38 CFR 3.309(e) has been revised as described above.

Section 3.311a. 38 CFR 3.311a is removed.

Section 3.311b. 38 CFR 3.311b is redesignated as § 3.311.

REGULATORY AMENDMENT

3-94-2

Regulations Affected: 38 CFR 3.103(c)

EFFECTIVE DATE OF REGULATIONS: February 10, 1994

Date Secretary Approved Regulations: January 12, 1994

Federal Register Citation: 59 FR 6218 (February 10, 1994)

The purpose of the following comments on the changes included in these amendments of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

It has been the long-standing policy of VA to offer claimants personal hearings as an integral part of the claims adjudication process. Hearings are held so that claimants may introduce into the record, in person, any available evidence which the claimant may consider material and any arguments and contentions which he or she may consider pertinent. They are held only at the request of the claimant, however, since VA does not require that evidence be submitted in person. Any evidence which the claimant presents, whether documentary, testimonial, or any other form, becomes part of the permanent VA record.

In keeping with the purpose of claimant hearings, VA expects that the claimant and witnesses, if any, will be present at the hearing. A hearing will not normally be scheduled solely for the purpose of receiving argument by a claimant's representative, since the adjudication process affords adequate alternative opportunities for the representative to present argument in support of a claim. Although current regulations at 38 CFR 3.103(c)(2) do indicate that the purpose of a hearing is for a claimant to present evidence "in person," they do not clearly state that a claimant hearing will not normally be scheduled solely for the purpose of receiving argument by a claimant's representative.

38 CFR 3.103(c)(1) currently states that VA will furnish personnel who have original determinative authority for the conduct of claimant hearings at Veterans Benefits Administration (VBA) regional offices without specifying any requisite number. Because the regulation does not specify the number, we believe the term "personnel" might reasonably be construed as encompassing one, two, or several persons. Even though it is well established that unless the context indicates otherwise terms which are plural in form may include the singular as well, some might argue that the term "personnel" signifies that VA must furnish more than one person to conduct hearings.

We have eliminated any possible confusion the current wording may create by amending 38 CFR 3.103(c)(1) to state that VA will provide one or more VA employees who have original determinative authority to conduct claimant hearings. Congress, through enactment of what is now 38 U.S.C. 7102(b), has indicated its consent to single members holding hearings before the Board of Veterans Appeals. There is nothing in the statutes to suggest that Congress intended a different procedure with respect to VBA hearings. We have also made a conforming amendment to the language of 38 CFR 3.103(c)(2), which refers to the responsibility of VA personnel conducting hearings.

Section 3.103. In § 3.103(c)(1), in the third sentence, remove the word "personnel" and insert, in its place, the words "one or more employees"; in the fourth sentence, remove the words "VA personnel" and insert, in their place, the words "one or more VA employees". In § 3.103(c)(2), remove the first two sentences and add, in their place, the words "The purpose of a hearing is to permit the claimant to introduce into the record, in person, any available evidence which he or she considers material and any arguments or contentions with respect to the facts and applicable law which he or she may consider

pertinent. All testimony will be under oath or affirmation. The claimant is entitled to produce witnesses, but the claimant and witnesses are expected to be present. The Veterans Benefits Administration will not normally schedule a hearing for the sole purpose of receiving argument from a representative." In § 3.103(c)(2), in what is now the fifth sentence, remove the word "personnel" and insert, in its place, the words "employee or employees".

REGULATORY AMENDMENT

3-94-3

Regulation Affected: 38 CFR 3.103(b)

EFFECTIVE DATE OF REGULATION: March 16, 1994

Date Secretary Approved Regulation: January 12, 1994

Federal Register Citation: 59 FR 6901 (February 14, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 3.103(b)(2) of title 38, Code of Federal Regulations, provides that if a VA decision involves discontinuance or reduction of benefit payments, VA generally is required to provide a pretermination/reduction notice providing 60 days within which a beneficiary may offer evidence to show why the action should not be taken. Final action must be deferred until expiration of the 60-day period. Section 3.103(b)(3) provides for exceptions to this requirement. The rationale behind the exceptions is to prevent issuance of benefit payments where it is reasonable to conclude that the beneficiary either would not receive them or would not be entitled to them, and that an attempt to give advance notice would be unsuccessful or of little or no value in protecting the beneficiary's rights. To the original three exceptions we have added the following:

(1) A written and signed statement from the beneficiary renouncing VA benefits. Delaying for pretermination notice would only serve to ensure continued payment of benefits which the beneficiary no longer wants and is no longer entitled to receive and would thereby create an overpayment.

(2) A written and signed statement from the beneficiary indicating that he or she has returned to active service. Since veterans reentering active service often are aware of the prohibition against concurrent receipt, in instances where these veterans notify VA specifically of the nature of their service and date of reentry, it is proper to terminate benefits as quickly as possible.

(3) A garnishment order issued under 42 U.S.C. 659(a). In these instances, VA would not need to provide a pretermination/reduction notice because an opportunity for a hearing and presentation of evidence has already been given by the court issuing the order.

Section 3.103: 38 CFR 3.103(b)(3)(i) has been amended to insert the words "to VA" after the word "provided" to remove any potential ambiguity. New paragraphs (b)(3)(iv), (b)(3)(v), and (b)(3)(vi) have been added to include the three new exceptions (renouncement, reentry into active service, and garnishment under 42 U.S.C. 659(a)) to the general requirement for pretermination/reduction notice.

REGULATORY AMENDMENT

3-94-4

Regulation Affected: 38 CFR 3.1003

EFFECTIVE DATE OF THE REGULATION: June 15, 1994

Date Secretary Approved Regulation: January 31, 1994

Federal Register Citation: 59 FR 25329-30 (May 16, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 5121(a) of title 38, United States Code, authorizes VA to pay an accrued amount of periodic monetary benefits which are due and unpaid at the time of a beneficiary's or claimant's death. Payment must be made in a specific order of precedence as designated in the statute. The amount of accrued payable is limited to a period not exceeding one year prior to the date of last entitlement. A claim for accrued benefits must be filed within one year after the date of death.

Section 5122 of title 38, United States Code, provides that the amount represented by a benefit check received but unnegotiated prior to a beneficiary's death shall be payable in the same order of precedence as listed in § 5121(a). Any amount not paid as provided in § 5122 will be paid upon settlement by the General Accounting Office to the estate of the deceased provided that the estate will not escheat. There is no time limit for filing a claim for the proceeds of such a check, but the amount payable may not include payment for the month of the beneficiary's death.

A precedent opinion of the General Counsel (O.G.C. Prec. 22-92) has held that the statutes intend a distinction between payment of accrued benefits under § 5121 and payment of the proceeds of an unnegotiated check under § 5122. After reviewing O.G.C. 22-92, we have amended 38 CFR 3.1003 to ensure that the regulation clearly and correctly expresses the requirements of 38 U.S.C. 5122.

Section 3.1003: We have amended 38 CFR 3.1003 to accomplish the following:

(1) restate for clarity much of the current text of the regulation;

(2) add introductory text concerning the return and cancellation of unnegotiated checks.

(3) add a paragraph concerning settlement by GAO and payment to the deceased beneficiary's estate; and

(4) remove unnecessary references to 38 CFR 3.1000 and 3.1008.

REGULATORY AMENDMENT

3-94-5

Regulation affected: 38 CFR 3.309.

EFFECTIVE DATE OF REGULATION: October 1, 1992

Date Secretary Approved Regulation: January 31, 1994

Federal Register Citation: 59 FR 25328-29, May 16, 1994

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 2 of the Veterans' Radiation Exposure Amendments of 1992, Public Law 102-578, amended 38 U.S.C. 1112(c) by adding cancer of the urinary tract to the list of conditions for which presumptive service connection is authorized for veterans who participated in a radiation-risk activity. In the Federal Register of April 27, 1993 (58 FR 25563), VA published adjudication regulations to reflect this change.

Clarification of what structures are included in the urinary tract is needed, since this has been subject to various interpretations, and Congress did not indicate what they considered to be included.

We have defined urinary tract according to standard medical dictionaries (Dorland's Medical Dictionary, 27th Edition, p. 1740; Gould's Medical Dictionary, 4th Edition, p. 1432) and commonly used medical textbooks.

We have amended Section 3.309 by adding a note at the end of paragraph (d)(2)(xv) stating that for purposes of this section, the term "urinary tract" means the kidneys, renal pelves, ureters, urinary bladder, and urethra.

REGULATORY AMENDMENT

3-94-6

Regulations Affected: 38 CFR 3.307(a) and 3.309(e)

EFFECTIVE DATE OF THE REGULATION: June 9, 1994

Date Secretary Approved Regulation: April 28, 1994

Federal Register Citation: 59 FR 29723-24 (June 9, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 2(a)(1) of the Agent Orange Act of 1991, Pub. L. 102-4, 105 Stat. 11 (1991), added 38 U.S.C. 1116 which established presumptive service connection for veterans with service in the Republic of Vietnam during the Vietnam era who subsequently develop, to a degree of 10 percent or more, non-Hodgkin's lymphoma, soft-tissue sarcoma (subject to specified statutory exceptions), and chloracne or other acneform disease consistent with chloracne (within one year of the last date of active service in the Republic of Vietnam during the Vietnam era), even though there is no record of that disease during military service. Final regulations implementing this statutory provision were published in the Federal Register of May 19, 1993 (58 FR 29107-09).

Section 3 of Pub. L. 102-4 directed the Secretary to enter into an agreement with the National Academy of Sciences (NAS) to review the scientific evidence concerning the association between exposure to herbicides used in support of military operations in the Republic of Vietnam during the Vietnam era and each disease suspected to be associated with such exposure. Congress mandated that NAS determine, to the extent possible: (1) whether there is a statistical association between the suspect diseases and herbicide exposure, taking into account the strength of the scientific evidence and the appropriateness of the methods used to detect the association; (2) the increased risk of disease among individuals exposed to herbicides during service in the Republic of Vietnam during the Vietnam era; and (3) whether there is a plausible biological mechanism or other evidence of a causal relationship between herbicide exposure and the suspect disease.

Section 1116(b) of 38 U.S.C. provides that whenever the Secretary determines, based on sound medical and scientific evidence, that a positive association exists between exposure of humans to an herbicide agent (i.e., a chemical in an herbicide used in support of the United States and allied military operations in the Republic of Vietnam during the Vietnam era) and a disease, the Secretary will publish regulations establishing presumptive service connection for that disease. An association is considered "positive" if the credible evidence for the association is equal to or outweighs the credible evidence against the association. In making that determination, the Secretary is to consider reports received from NAS as well as other available sound medical and scientific evidence and analyses.

After reviewing approximately 6,420 abstracts of scientific or medical articles and approximately 230 epidemiological studies, consulting with outside experts, and conducting public hearings, NAS issued a report, entitled "Veterans and Agent Orange: Health Effects of Herbicides Used in Vietnam", on July 27, 1993. NAS concluded that there is sufficient evidence of an association between exposure to herbicides used in the Republic of Vietnam and the subsequent development of chloracne, non-Hodgkin's lymphoma, soft-tissue sarcoma, Hodgkin's disease and porphyria cutanea tarda. VA was already paying compensation for the first three conditions based upon the statutory presumptions established by Pub. L. 102-4, and the Secretary announced that same day that he had concluded that a positive association exists between exposure to herbicides used in the Republic of Vietnam and the subsequent development of Hodgkin's disease and porphyria cutanea tarda. Final regulations for these two conditions were published in the Federal Register on February 3, 1994 (59 FR 5106-07).

The Secretary also announced that VA would review the remaining findings in the NAS report to determine whether a positive association exists between herbicide exposure and any other conditions. That review has been completed and the Secretary has concluded that a positive association exists for multiple myeloma and respiratory cancers.

The NAS report found "limited/suggestive evidence" -- a category it defined as meaning that evidence suggests an association between herbicide exposure and a specific disease, but that chance, bias, and confounding factors cannot be ruled out with confidence -- of an association between herbicide exposure and the subsequent development of multiple myeloma. VA, however, found the evidence concerning multiple myeloma, a malignant proliferation of plasma cells which are derived from B lymphocytes, to be convincing. Most of the studies reviewed by NAS showed an increased risk, although in most cases it was not a statistically significant increase. One occupational study found a relationship between herbicide exposure and multiple myeloma. Another study showed a clear association between herbicide exposure and multiple myeloma in both males and females. Moreover, multiple myeloma is closely related biologically to B-cell non-Hodgkin's lymphoma; consequently, the epidemiological evidence concerning non-Hodgkin's lymphoma gives added weight to the association between herbicide exposure and multiple myeloma. Based on this clinical consideration and the weight of the epidemiological evidence, the Secretary has determined that there is a positive association between herbicide exposure and multiple myeloma that manifests itself to a degree of 10 percent at any time after exposure. We are amending 38 CFR 3.309(e) to implement the Secretary's decision. This amendment is effective June 9, 1994, the date of publication of the final rule, as provided by Pub. L. 102-4.

The NAS report also found limited/suggestive evidence of an association between herbicide exposure and the subsequent development of respiratory cancers, specifically cancers of the lung, larynx, or trachea. For study purposes, NAS included cancer of the bronchus when it considered cancer of the lung; therefore, we are including cancer of the bronchus within the scope of the presumption.

In reviewing the NAS report, which noted that not all studies had fully controlled for or evaluated smoking as a confounding factor, VA gave weight to the fact that the studies found high relative risks for respiratory cancers in production workers. One study showed an increased risk with the duration of exposure. VA also noted that despite the failure of some studies to control for smoking, it is unlikely that there were major differences in smoking patterns between the study and control groups. Considering all of the evidence, the Secretary has determined that the credible evidence for an association outweighs the credible evidence against an association and that there is, therefore, a positive association between exposure to herbicides used in the Republic of Vietnam and the subsequent development of respiratory cancers.

VA also found that the weight of the available evidence indicates that chemically-induced respiratory cancers manifest within a definite period following exposure, after which there is little effect from the exposure. In our judgment, it is reasonable to assume that respiratory cancers due to herbicide exposure will show a risk pattern similar to other chemically-induced respiratory cancers, and we are providing in our rule that respiratory cancer will be presumed service connected only if it is manifest within 30 years after exposure. The longest manifestation period noted for a respiratory cancer following herbicide exposure is about 30 years. If future studies indicate that this manifestation period is inappropriate, VA will amend it accordingly. We are amending 38 CFR 3.307(a)(6)(ii) and 3.309(e) to implement the Secretary's decision. This amendment is effective June 9, 1994, the date of publication of the final rule, as provided by Pub. L. 102-4.

38 U.S.C. 1113 provides that where there is affirmative evidence to the contrary, or evidence to establish that an intercurrent injury or disease which is a recognized cause of any of the diseases for which presumptive service connection may be allowed under the provisions of 38 U.S.C. 1112 (i.e., chronic diseases, tropical diseases, prisoner-of-war related diseases, or diseases specific to radiation-exposed veterans), has been suffered between the date of separation from service and the onset of any such diseases, or the disability is due to the veteran's own willful misconduct, presumptive service connection will not be in order. Section 2(b) of Pub. L. 102-4 amends 38 U.S.C. 1113 so that its provisions also apply to the presumptive conditions associated with herbicide exposure under 38 U.S.C. 1116. Consequently, service connection for multiple myeloma or respiratory cancers based on herbicide

exposure is precluded if there is affirmative evidence that establishes a non-service related supervening condition or event as the cause of the multiple myeloma or respiratory cancers, or the disability is due to the veteran's own willful misconduct (See 38 U.S.C. 1113).

Section 3.307. 38 CFR 3.307(a)(6)(ii) has been amended as described above.

Section 3.309. 38 CFR 3.309(e) has been amended as described above.

REGULATORY AMENDMENT

3-94-7

Regulation Affected: 38 CFR 3.53

EFFECTIVE DATE OF THE REGULATION: May, 13, 1993

Date Secretary Approved Regulation: January 13, 1994

Federal Register Citation: 59 FR 32658-59 (June 24, 1994)

The purpose of the following comments on the change included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

38 U.S.C. 101(3) requires that in order to establish entitlement to death benefits as a "surviving spouse" of a veteran, the spouse must have lived with the veteran continuously from the date of marriage to the date of the veteran's death, except where there was a separation which was due to the misconduct of, or procured by, the veteran without the fault of the spouse. VA implemented this statutory provision at 38 CFR 3.50(b)(1) utilizing language identical to that of the statute. In addition, 38 CFR 3.53(a) provides that the requirement of 38 U.S.C. 101(3) concerning continuous cohabitation from the date of marriage to the date of death of the veteran will be considered as having been met when the evidence shows there was "no separation due to the fault of the surviving spouse." In Gregory v. Brown, U.S. Vet. App. No. 91-912, the Court noted the inconsistency between 38 U.S.C. 101(3) and § 3.53(a) and invalidated that portion of § 3.53(a) that it found inconsistent with the governing statute. The Court found that 38 U.S.C. 101(3) establishes a two-part test to determine whether a spouse will be deemed to have continuously cohabited with the veteran when there has been a separation: (1) the spouse must be free of fault at the time of the separation, and (2) the separation must be due to the misconduct of, or procured by, the veteran. The Court held that given the plain meaning of the statute, the language in the first sentence of § 3.53(a) which requires that the separation not be due to the fault of the surviving spouse, in essence eliminates the second part of the test and is therefore unlawful because it exceeds the authority of the Secretary provided by 38 U.S.C. 501(a). We have amended § 3.53(a) to remove that inconsistency effective May 13, 1993, the date of the Court's decision.

Section 3.53: We have amended paragraph (a) to state that a separation must be due to the misconduct of, or procured by, the veteran.

REGULATORY AMENDMENT

3-94-8

Regulation Affected: 38 CFR 3.7(x)

EFFECTIVE DATE OF THE REGULATION: December 13, 1993

Date Secretary Approved Regulation: June 10, 1994

Federal Register Citation: 59 FR 34382-83 (July 5, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

The Secretary of the Air Force held under Pub. L. 95-202 that the service of members of the following groups is active duty for VA benefit purposes: "U.S. Civilian Flight Crew and Aviation Ground Support Employees of Northwest Airlines, Who Served Overseas as a Result of Northwest Airline's Contract with the Air Transport Command during the Period December 14, 1941 through August 14, 1945," and the group known as "U.S. Civilian Female Employees of the U.S. Army Nurse Corps While Serving in the Defense of Bataan and Corregidor During the Period January 2, 1942 to February 3, 1945."

Section 3.7 38 CFR 3.7(x)(27) and (28) have been added to include service performed by members of U.S. Civilian Flight Crew and Aviation Ground Support Employees of Northwest Airlines, Who Served Overseas as a Result of Northwest Airline's Contract with the Air Transport Command during the Period December 14, 1941 through August 14, 1945, and U.S. Civilian Female Employees of the U.S. Army Nurse Corps While Serving in the Defense of Bataan and Corregidor During the Period January 2, 1942 to February 3, 1945.

REGULATORY AMENDMENT

3-94-9

Regulations Affected: 38 CFR 3.262(m), 3.262(o), and 3.272(h)

EFFECTIVE DATE OF THE REGULATION: August 5, 1993

Date Secretary Approved Regulation: February 25, 1994

Federal Register Citation: 59 FR 35265-66 (July 11, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Rates payable under VA's income-based benefit programs, pension and parents' dependency and indemnity compensation, are affected by the claimant's income. As countable income goes up, the rate payable goes down. The law does, however, provide certain exclusions from countable income.

38 U.S.C. 1503(a)(3) excludes amounts paid by a surviving spouse or child of a deceased veteran for the veteran's just debts from countable income; 38 U.S.C. 1315(f)(1)(H) provides a similar exclusion for a dependent parent of a deceased veteran who pays a deceased spouse's just debts. The term "just debts," however, is not currently defined by statute or regulation.

In a precedent opinion dated August 5, 1993 (OGC Prec 5-93), VA's General Counsel held that amounts paid by a surviving spouse on secured obligations incurred for the purchase of real or personal property could not be excluded as "just debts" under 38 U.S.C. 1503(a)(3)(A). Based on the principles in OGC Prec 5-93, we have amended 38 CFR Sections 3.262(m), 3.262(o), and 3.272(h) to state that the term "just debts" does not include secured debts.

Section 262. Paragraphs (m)(2) and (o)(2) have been amended to show that for purposes of Section 306 pension and Parents' Dependency and Indemnity Compensation secured debts cannot be considered "just debts."

Section 272. Paragraph (h) has been amended to show that secured debts cannot be considered "just debts" for Improved Pension purposes.

REGULATORY AMENDMENT

3-94-10

Regulation Affected: 38 CFR 3.309

EFFECTIVE DATE OF THE REGULATION: August 24, 1993

Date Secretary Approved Regulation: June 27, 1994

Federal Register Citation: 59 FR 35464-65 (July 12, 1994)

The purpose of the following comments on the change included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Public Law 91-376 established a presumption of service connection for seven categories of diseases and conditions, including "beriberi (including beriberi heart disease)," developing to a ten-percent degree of disability at any time after active service in the case of a veteran held as a prisoner of war in World War II, the Korean Conflict, or the Vietnam War who suffered from dietary deficiencies, forced labor or inhumane treatment in violation of the Geneva Conventions.

The Medical Follow-up Agency of the Institute of Medicine, National Academy of Sciences, issued a study in 1992 which reported the results of a medical examination survey of former World War II and Korean Conflict POWs and comparable control groups. That study found what it termed a noteworthy association between ischemic heart disease and earlier reporting of localized edema of feet, ankles and legs-presumably due to beriberi heart disease (wet beriberi)-while in captivity. After reviewing this study the Secretary has determined, in keeping with the intent of Congress to provide a presumption of service connection for former prisoners of war, that the term beriberi heart disease found in 38 U.S.C. 1112(b)(2) includes ischemic heart disease if the former prisoner of war suffered localized edema during captivity. We have amended 38 CFR 3.309(c) accordingly.

Section 3.309(c): We have added a note at the end of the paragraph to state that the term beriberi heart disease includes ischemic heart disease in a former prisoner of war who had experienced localized edema during captivity.

REGULATORY AMENDMENT

3-94-11

Regulation Affected: 38 CFR 3.326

EFFECTIVE DATE OF THE REGULATION: August 15, 1994

Date Secretary Approved Regulation: July 1, 1994

Federal Register Citation: 59 FR 35851 (July 14, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 3.326 of title 38, Code of Federal Regulations, requires VA to authorize a medical examination where a reasonable probability of a valid claim for disability compensation or pension benefits is indicated, including either an original or reopened claim or a claim for increased benefits. In specified cases, alternative types of medical evidence may be deemed a "Department of Veterans Affairs examination" and accepted for rating purposes. A statement from a private physician which includes clinical manifestations and substantiation of a diagnosis through medically acceptable diagnostic techniques may be accepted to rate pension and certain other claims. It may not, however, be accepted as the sole basis for a rating decision in compensation claims.

This amendment will permit acceptance of a private physician's statement for rating purposes in claims for increased compensation due to the increased severity of service-connected disabilities. Since the basic issue of service connection has already been resolved, a private physician's statement meeting the requirements mentioned above contains medical evidence acceptable for rating purposes with no need for verification through a VA examination. Furthermore, acceptance of this type of evidence will permit earlier decisions by removing the need for VA to schedule, conduct, and review the results of an additional examination.

Section 3.326: We have amended paragraph (b) to remove a statement that evidence of permanent and total disability will not be required in pension claims for veterans who have attained age 65. The Omnibus Budget Reconciliation Act of 1990, eliminated the presumption of total disability for these veterans with respect to claims filed after October 31, 1990.

We also have amended paragraph (d) to permit acceptance of certain private physicians' statements in rating claims for increased compensation, as explained above, and to clarify the other types of claims in which such statements may be accepted.

Section 3.351: In this section we have revised the authority citation following paragraph (a)(2).

REGULATORY AMENDMENT

3-94-12

Regulations Affected: 38 CFR 3.261(a)(37), 3.262(v), and 3.272(r)

EFFECTIVE DATE OF THE REGULATION: January 1, 1994

Date Secretary Approved Regulation: July 12, 1994

Federal Register Citation: 59 FR 37695-96 (July 25, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 13736 of Public Law 103-66 amended 25 U.S.C. 1408 to provide that up to $2,000 per year of income received from trust or restricted lands shall be excluded from the income of individual Indians when determining eligibility for assistance from any Federal program.

25 CFR 151.2(d) defines "trust land" as land the title to which is held in trust by the United States for an individual Indian or a tribe. 25 CFR 151.2(e) defines "restricted land" as land the title to which is held by an individual Indian or a tribe and which can only be alienated or encumbered by the owner with the approval of the Secretary of the Interior.

We have amended 38 CFR 3.261, 3.262, and 3.272 to show that up to $2,000 per year of income from trust or restricted lands is excludable from the countable income of an individual Indian. The purpose is to make the regulations consistent with the provisions of Section 13736 of Public Law 103-66.

Section 261. A new paragraph (a)(37) has been added to show that for purposes of protected pension programs and Parents' Dependency and Indemnity Compensation up to $2,000 per year of income from trust or restricted lands is excludable from the countable income of an individual Indian beneficiary.

Section 3.262. A new paragraph (v) has been added to show that for purposes of protected pension programs and Parents' Dependency and Indemnity Compensation up to $2,000 per year of income from trust or restricted lands is excludable from the countable income of an individual Indian beneficiary.

Section 3.272. A new paragraph (r) has been added to show that for purposes of Improved Pension up to $2,000 per year of income from trust or restricted lands is excludable from the countable income of an individual Indian beneficiary.

REGULATORY AMENDMENT

3-94-13

Regulation Affected: 38 CFR 3.316

EFFECTIVE DATE OF THE REGULATION: January 6, 1993

Date Secretary Approved Regulation: July 15, 1994

Federal Register Citation: 59 FR 42497-500 (August 18, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

On July 31, 1992, VA published 38 CFR 3.316 authorizing service connection in claims from veterans who underwent full-body exposure to mustard gas during field or chamber experiments to test protective clothing or equipment during World War II, and who subsequently develop chronic forms of laryngitis, bronchitis, emphysema, asthma, conjunctivitis, keratitis, or corneal opacities. The regulation was based on a Veterans Health Administration (VHA) review of the available English language medical literature dealing with the effects of exposure to mustard gas. VA also contracted with the National Academy of Sciences (NAS) to conduct a review of the world medical and scientific literature, including that published in languages other than English, to determine the long-term health effects of exposure to mustard agents and Lewisite. After reviewing almost 2,000 medical and scientific papers, consulting with outside experts, and conducting public hearings, NAS issued a report, entitled "Veterans at Risk: The Health Effects of Mustard Gas and Lewisite", on January 6, 1993. We have amended 38 CFR 3.316 based upon our review of that report.

NAS findings confirmed VA's prior determination that there is a relationship between exposure to mustard gas and the subsequent development of the seven conditions mentioned above. NAS also found that the evidence indicated a causal relationship between exposure to mustard gas and the subsequent development of nasopharyngeal, laryngeal, lung, and skin cancers, pigmentation abnormalities of the skin, and chronic skin ulceration and scar formation. We have added nasopharyngeal, laryngeal and lung cancer (except mesothelioma) to the list of conditions for which presumptive service connection may be granted based on exposure to mustard gas. We excluded mesothelioma because the only known cause of that condition is asbestos exposure.

Although NAS used the term "skin cancer" in the summary of its findings, in our judgment the body of the report, which refers to squamous cell and basal cell carcinomas of the skin but not malignant melanomas, does not support so broad a presumption of service connection. Although basal cell skin cancers were noted in some animal studies, these studies constitute evidence of carcinogenicity rather than evidence of skin cancer because there is no good animal model for human skin response to mustard agents. Likewise, the one occupational study that described basal cell carcinomas, Bowen's disease, and other hyperkeratotic skin lesions was too seriously flawed to establish a causal relationship with exposure to mustard agents. As the report notes, the workers in that study were exposed to all types of gases, not just mustard gas and Lewisite. Also, those individuals who participated in chamber and field testing suffered acute rather than chronic exposure like the chemical plant workers in the occupational study, which occurred for many hours each week over many years. The report states that "cutaneous cancers following acute sulfur mustard exposure usually localize in scars," and scar cancers are squamous cell carcinomas, not basal cell carcinomas. Finally, since the study cited in the NAS report in reference to the occurrence of basal cell carcinoma is not an epidemiological study, it is difficult to draw conclusions as to whether the findings represent an unusual rate for basal cell carcinoma. For these reasons, we have included only squamous cell carcinomas of the skin.

In our judgment, there is no reason to establish presumptive service connection for "pigmentation abnormalities of the skin" because these abnormalities would be obvious from the time of the exposure to vesicant agents rather than occurring many years after exposure, and most pigmentation abnormalities resulting from these burns would not be considered disabling, unless they interfered with the veteran's ability to function. There is no mention in the NAS report of vitiligo-type lesions, which are usually considered to be disabling because they are disfiguring. Since compensation is only payable for disability resulting from an injury or disease incurred or aggravated in the line of duty, and since exposure to vesicant agents does not cause a type of pigmentation abnormality which is disabling, we have not included pigmentation abnormalities of the skin in the regulation. However, we have included scar formation.

In addition to the respiratory conditions VA had previously recognized, NAS found that the evidence indicated a causal relationship between exposure to mustard gas and chronic obstructive pulmonary disease. NAS further found that all these respiratory conditions could also result from exposure to Lewisite, another vesicant agent. We have provided service connection for a chronic form of laryngitis, bronchitis, emphysema, asthma or chronic obstructive pulmonary disease, as a result of exposure to mustard gas or Lewisite.

NAS also determined that the evidence indicated a causal relationship exists between exposure to nitrogen mustard and the subsequent development of acute nonlymphocytic leukemia. Based on that information, we have provided service connection for acute nonlymphocytic leukemia as a result of exposure to nitrogen mustard only.

Since the revised regulation addresses the effects of Lewisite as well as mustard agents, we have revised the heading of 38 CFR 3.316 to indicate that the regulation addresses claims based on chronic effects of exposure to vesicant agents rather than mustard gas only. The prior regulation applied only to those veterans exposed while participating in secret tests of protective equipment during World War II; we have expanded it to cover any verified full-body exposure during military service, which will allow veterans exposed to mustard gas under battlefield conditions in World War I, those present at the German air raid on the harbor of Bari, Italy, in World War II, and those engaged in manufacturing and handling vesicant agents during their military service to be eligible for consideration under this regulation.

We also have amended 38 CFR 3.316 by adding a requirement that service connection will not be established if there is affirmative evidence that establishes a nonservice-related supervening condition or event as the cause of the claimed condition. The prior regulation was based upon a literature search of the immediate and short-term effects of mustard gas exposure by the Veterans Health Administration, which revealed that nonfatal exposures to mustard gas result in an immediate acute injury. It was also reported that any chronic disability related to mustard gas exposure should appear shortly after the exposure and continue to the present. The NAS report, however, found that delayed effects of mustard gas exposure may appear even though no acute effects were noted. Because of this delay in manifestation of effects of mustard gas exposure reported by the NAS, during which time the veteran may have been exposed to other nonservice-related causative conditions or events, we have determined that it is reasonable to consider evidence of intervening cause which may exist, just as we do for other presumptive conditions (See 38 CFR 3.307(b)).

The proposed rule stated that the amendment would be effective on the date of publication of the final rule. In a letter of May 12, 1994, the Chairman of the Senate Committee on Veterans' Affairs, expressed his concern over the delay in publishing the final regulation as well as his belief that VA could establish an earlier effective date for the amendments. We share Senator Rockefeller's concern over the delay in the rulemaking process, and have therefore determined that it would be both appropriate and more equitable for this amendment to be effective January 6, 1993, the date of the decision to modify 38 CFR 3.316.

Section 3.316: We have amended 38 CFR 3.316 as discussed above.

REGULATORY AMENDMENT

3-94-14

Regulation Affected: 38 CFR 3.272

EFFECTIVE DATE OF THE REGULATION: October 6, 1994

Date Secretary Approved Regulation: July 12, 1994

Federal Register Citation: 59 FR 45975-76 (September 6, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

In O.G.C. Prec. 1-93, VA's General Counsel found that maintenance of a life insurance policy involved two transactions: (1) purchase of coverage during the period for which premiums are paid and (2) accumulation of savings or investment. Upon surrender of the policy, the policy owner receives a refund of the accumulated investment (the premiums paid) plus interest that has accrued on the investment. The General Counsel determined that it would be consistent with VA's policy regarding exclusions from income to exclude from income computation under the improved pension program that portion of the proceeds which represents a return of the owner's investment. We therefore have amended § 3.272 to exclude that portion of life insurance proceeds which represents a return of premiums. Interest that has accumulated on the investment will be considered income when paid, since that is an amount which is paid over and above the owner's investment.

Section 3.272: We have amended 38 CFR 3.272 by adding new paragraph (q) to exclude from countable income under improved pension that portion of proceeds from the cash surrender of a life insurance policy which represents a return of insurance premiums.

REGULATORY AMENDMENT

3-94-15

Regulation Affected: 38 CFR 3.311(b)(2)

EFFECTIVE DATE OF REGULATION: September 6, 1994

Date Secretary Approved Regulation: August 17, 1994

Federal Register Citation: 59 FR 45975 (September 6, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Under 38 CFR 1.17(c), when VA determines that a significant statistical association exists between exposure to ionizing radiation and any disease, 38 CFR 3.311 is amended to provide guidelines for the establishment of service connection for that disease. Such a determination is made after receiving the advice of the Veterans Advisory Committee on Environmental Hazards (VACEH) based on its evaluation of scientific or medical studies.

In a public meeting on April 22-23, 1993, the VACEH met in Washington, DC. At that meeting, the VACEH reviewed studies by Modan, et al., "Radiation-induced Head and Neck Tumors," Lancet, February 23, 1974, pp. 277-279, and Ron, et al., "Tumors of the Brain and Nervous System After Radiotherapy in Childhood," New England Journal of Medicine 319: 1033-1039 (1988). Based on this review, the VACEH recommended that tumors of the brain and central nervous system, including, but not limited to, gliomas, astrocytomas, and meningiomas, be added to the list of diseases VA will recognize as being radiogenic. The Secretary accepted that recommendation and 38 CFR 3.311 (b)(2) is amended to include these conditions on the list of radiogenic diseases for purposes of service-connected disability compensation.

REGULATORY AMENDMENT

3-94-16

Regulations Affected: 38 CFR 3.202(c), 3.204(b) and (c), 3.205(a), 3.207(b), 3.209(a) and (b), 3.210(b) and (c), and 3.211(a) and (d). Also amended are 38 CFR 3.205 (a)(4) and 3.210(b)(3)(i).

EFFECTIVE DATE OF REGULATION: September 8, 1994

Date Secretary Approved Regulation: July 14, 1994

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

A number of recent developments, including military downsizing, judicial review of VA decisions concerning benefit claims, and changes in due process procedures, have had a major impact on the volume of claims filed with the VA. The growing backlog of pending claims has created additional delays for claimants, and in June 1993 VA established a Blue Ribbon Panel on Claims Processing (the Panel) to develop recommendations on eliminating this backlog and improving the timeliness of claims processing.

One recommendation by the Panel was to revise the regulations to allow the acceptance of photocopies of documents necessary to establish birth, death, marriage or relationship. Current VA regulations provide, in general, that, in order to establish birth, death, marriage or relationship for VA purposes, a claimant must submit a copy of the required document certified over the signature and official seal of the person having custody of the record.

It has been our experience that many claimants are not certain of the definition of a "certified copy" and often submit photocopies or notarized copies, or fail to respond to a request for evidence because of difficulty in obtaining certified copies. Such actions by claimants result either in additional requests from VA for certified copies -- further delaying the authorization of benefits -- or in benefits to which a claimant may be entitled being denied.

Accepting photocopies would reduce not only delays but also the frustrations experienced by claimants who have difficulty obtaining certified copies. The Panel was of the opinion that 38 CFR 3.216, which requires claimants to furnish VA with the social security numbers for all dependents on whose behalf benefits are claimed or received, and 38 U.S.C. 5317, which authorizes data exchanges between VA and other federal agencies, are adequate safeguards against the possibility that VA would erroneously award benefits based upon acceptance of altered photocopies. Additionally, VA would retain the option of requesting certified documentation if not satisfied that the photocopies are genuine or free from alteration.

The Secretary of Veterans Affairs has accepted this recommendation of the Panel, and we have amended 38 CFR 3.202(c), 3.204(b) and (c), 3.205(a), 3.207(b), 3.209(a) and (b), 3.210(b) and (c), and 3.211(a) and (d) to implement the Secretary's decision. We have also amended § 3.205(a)(4) to remove the restrictions to the submission of an original certificate of marriage, which are unnecessary in view of the determination to accept a photocopy. Additionally, we have amended § 3.210(b)(3)(i) to reflect gender-neutral terminology in accordance with 38 CFR 1.13. In light of the Secretary's commitment to reduce the backlog of pending claims and provide timely claims adjudication to all claimants, and since this action cannot work to the detriment of any claimant and is an agency rule of practice or procedure, we have elected to publish this rule as an interim rule with request for comments rather than a proposed rule.

This amendment is effective the date of publication of the interim rule. The Secretary finds good cause for doing so since this amendment will work to the advantage of those who will be affected without working to the detriment of any other claimant. This decision is fully consistent with VA's longstanding policy to administer the law under a broad interpretation for the benefit of veterans and their dependents (38 CFR 3.102). Although this amendment is effective immediately, any comments received will be carefully considered and another rule document will be published, if indicated.

REGULATORY AMENDMENT

3-94-17

Regulation Affected: 38 CFR 3.385

EFFECTIVE DATE OF THE REGULATION: December 27, 1994

Date Secretary Approved Regulation: November 18, 1994

Federal Register Citation: 59 FR 60560 (November 25, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

In a recent decision the U.S. Court of Veterans Appeals noted that 38 CFR 3.385 is negative in both tone and application in that it states when service-connection will not be established (See Hensley v. Derwinski, U.S. Vet. App. No. 90-1179). The Court also noted that the regulation "mixes apples and oranges" by using criteria for hearing loss to determine service-connection rather than degree of disability.

We have corrected these shortcomings by amending 38 CFR 3.385 to establish a standard for determining whether, for VA purposes, a disability due to impaired hearing exists. If such a disability does exist, whether or not it is service-connected is a separate determination governed by the provisions of 38 CFR 3.303-3.344. These changes will clearly limit the regulation to a definition of disability due to impaired hearing, and no longer suggest that the rule governs service-connection once the disability has been established. There is no substantive change in the actual criteria.

The effective date of this amendment is December 27, 1994.

Section 3.385: We have amended this section to state that impaired hearing will be considered to be a disability for VA purposes when the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, 4000 Hertz is 40 decibels or greater; or when the auditory thresholds for at least three of the frequencies 500, 1000, 2000, 3000 or 4000 Hertz are 26 decibels or greater; or when speech recognition scores using the Maryland CNC Test are less than 94 percent.

REGULATORY AMENDMENT

3-94-18

Regulation Affected: 38 CFR 3.551(i)

EFFECTIVE DATE OF THE REGULATION: August 10, 1993

Date Secretary Approved Regulation: November 23, 1994

Federal Register Citation: 59 FR 62584 (December 6, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 8003 of Pub. L. 101-508 required VA to reduce the pension benefits of any veteran having neither spouse nor child who receives Medicaid-covered nursing home care to $90 per month. The statutory provisions expired September 30, 1992. Section 601 of Pub. L. 102-568 reestablished this requirement effective until September 30, 1997, and required an identical reduction in death pension payments to surviving spouses having no children who receive Medicaid-covered nursing home care. Section 12005 of the Omnibus Budget Reconciliation Act of 1993, Pub. L.103-66, further extends these statutory provisions with respect to both veterans and their surviving spouses until September 30, 1998. VA accordingly amends 38 CFR 3.551(i) to reflect this statutory change.

The effective date of this amendment is August 10, 1993.

REGULATORY AMENDMENT

3-94-19

Regulation Affected: 38 CFR 3.807(c)

EFFECTIVE DATE OF THE REGULATION: December 6, 1994

Date Secretary Approved Regulation: November 25, 1994

Federal Register Citation: 59 FR 62584-85 (December 6, 1994)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

The Survivors' and Dependents' Educational Assistance (DEA) Program, established under 38 U.S.C. Chapter 35, authorizes monetary educational benefits to a qualifying spouse or child, or surviving spouse or child, of a veteran whose death or permanent and total disability was due to military service.

38 CFR 3.807 provides that a spouse or child of a veteran has basic eligibility for Chapter 35 benefits if the veteran has a permanent total service-connected disability. The surviving spouse or child of a deceased veteran has basic eligibility for Chapter 35 benefits if a permanent total service-connected disability was in existence at the date of the veteran's death or the veteran died of a service-connected disability.

38 U.S.C. 1160 provides that where a veteran has suffered service-connected loss of use of an eye, kidney, ear, hand, foot, or lung and nonservice-connected loss of use of the paired eye, kidney, ear, hand, foot, or lung, the veteran shall be paid compensation as if the combination of disabilities were the result of service-connected disability. 38 CFR 3.383 is the corresponding regulation.

In Precedent Opinion 75-90 dated July 18, 1990, the VA General Counsel held that Chapter 35 eligibility is not established where a disability of paired organs treated as if service-connected under 38 U.S.C. 1160 for purposes of disability compensation is evaluated as permanently and totally disabling. The General Counsel reasoned that the threshold criterion for DEA eligibility is total service-connected disability and stated that this criterion is not satisfied where permanent and total disability is based on the "as if service-connected" status established under 38 U.S.C. 1160.

In a recent decision (Kimberlin v. Brown, No. 91-1972), however, the United States Court of Veterans Appeals held that Chapter 35 entitlement was established where the veteran was entitled to compensation for a total disability, permanent in nature, regardless of whether entitlement was based on loss of use of paired organs treated as if service-connected under 38 U.S.C. 1160. The Court's opinion overrules General Counsel Precedent Opinion 75-90 insofar as it relates to Chapter 35 eligibility.

Currently the regulation does not specifically address whether Chapter 35 eligibility may be established based on a combination of disabilities treated as if service-connected under 38 CFR 3.383(a). We are amending 38 CFR 3.807 to reflect the Court's determination that such an evaluation may be the basis for Chapter 35 eligibility.

Section 3.807: Paragraph (c) has been amended to include combinations of disabilities of paired organs or extremities treated as if service-connected under 38 U.S.C. 1160 in the definition of "service-connected disability" in 38 CFR 3.807(a).

REGULATORY AMENDMENT

3-95-1

Regulations Affected: 38 CFR 3.261(a)(38), 3.262(w), 3.272(s), and 3.275(h)

EFFECTIVE DATE OF THE REGULATION: October 15, 1990

Date Secretary Approved Regulation: December 22, 1994

Federal Register Citation: 60 FR 2522-23 (January 10, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Public Law 101-426, the Radiation Exposure Compensation Act (RECA), was enacted by Congress to compensate individuals who may have suffered adverse health effects from working in uranium mines or living downwind of above-ground nuclear tests. Section 6(h) of that law provides that RECA payments shall not be included as income or resources for purposes of determining eligibility for benefits described in section 3803(c)(2)(C) of Title 31, United States Code. Title 31 U.S.C. 3803(c)(2)(C)(viii) lists benefits under chapters 11, 13 and 15 of Title 38, United States Code, which governs payment of VA benefits.

VA administers several income-based benefit programs under which a claimant's countable income determines the rate of VA benefits payable. Net worth may also affect eligibility. Those affected by RECA are death compensation (38 U.S.C. chapter 11), Parents' Dependency and Indemnity Compensation (38 U.S.C. chapter 13) and the Improved Pension program (38 U.S.C. chapter 15). Other VA benefits which are income-based, notably the prior pension programs known as the Section 306 and Old Law pension programs, are no longer authorized under those chapters of 38 U.S.C. listed in Public Law 101-426.

VA regulations at 38 CFR 3.271 state that payments of any kind from any source shall be counted as income for purposes of the Improved Pension program unless specifically excluded under 38 CFR 3.272. 38 CFR 3.261(a) indicates whether various categories of income are included or excluded when determining eligibility for Parents Dependency and Indemnity Compensation or pension programs which were in effect prior to January 1, 1979. It also indicates whether various categories of income are included or excluded when determining whether a parent qualifies as a dependent parent for purposes of 38 U.S.C. chapter 11. 38 CFR 3.274 states that Improved Pension shall be denied or discontinued when the corpus of a claimant's estate is such that it is reasonable that some of the estate be used for the claimant's maintenance.

We are amending 38 CFR 3.261, 3.262, and 3.272 to show that RECA payments are excludable from countable income for Parents' Dependency and Indemnity Compensation, the Improved Pension program, and in determining whether a parent is dependent for purposes of 38 U.S.C. chapter 11. We are amending 38 CFR 3.275 to show that RECA payments are not to be included in computing an Improved Pension claimant's net worth. Net worth is not a factor for Parents' Dependency and Indemnity Compensation. The purpose of this rule is to amend the regulations to be consistent with the provisions of section 6 of Public Law 101-426.

Section 3.261. Paragraph (a)(38) has been added to show that RECA payments are countable income for Section 306 and Old Law pension but not countable for purposes of Parents' Dependency and Indemnity Compensation and parents' dependency determinations.

Section 3.262. A new paragraph (w) has been added to show that RECA payments are excluded as income for purposes of Parents' Dependency and Indemnity Compensation

Section 3.272. A new paragraph (s) has been added to show that RECA payments are excluded as income for purposes of Improved Pension.

Section 3.275. A new paragraph (h) has been added to show that RECA payments are excluded from Improved Pension net worth determinations.

REGULATORY AMENDMENT

3-95-2

Regulations Affected: 38 CFR 3.317; 3.500

EFFECTIVE DATE OF THE REGULATION: November 2, 1994

Date Secretary Approved Regulation: January 25, 1995

Federal Register Citation: 60 FR 6660-66 (February 3, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

On November 2, 1994, the President signed the "Veterans Benefits Improvements Act of 1994," Public Law 103-446. Title I of the statute, the "Persian Gulf War Veterans' Benefits Act," authorizes the Secretary of Veterans Affairs to compensate any Persian Gulf veteran suffering from a chronic disability resulting from an undiagnosed illness or combination of undiagnosed illnesses that became manifest either during active duty in the Southwest Asia theater of operations during the Persian Gulf war or to a degree of 10 percent or more within a presumptive period thereafter, as determined by the Secretary. We have added 38 CFR 3.317 to implement the authority granted by the statute.

Section 3.317 provides that VA shall pay compensation to Persian Gulf veterans who exhibit objective indications of chronic disabilities which result from an undiagnosed illness or combination of undiagnosed illnesses, and which first became manifest either during active service in the Southwest Asia theater of operations during the Persian Gulf War or to a degree of 10 percent or more within 2 years after the date on which a veteran last performed such service. A disability for which service connection is established under § 3.317 will be considered service connected for the purposes of all laws of the United States.

"Objective indications of chronic disabilities" include both "signs" in the medical sense of objective evidence perceptible to an examining physician and other, non-medical indicators that are capable of independent verification. Non-medical indicators include, but are not limited to such circumstance or events as time lost from work, evidence that a veteran has sought medical treatment for his or her symptoms, evidence affirming changes in the veteran's appearance, physical abilities, or mental or emotional attitude, etc. Lay statements from individuals who establish that they are able from personal experience to make their observations or statements will be considered as evidence if they support the conclusion that a disability exists. Objective indications will assist in determining both the actual presence of a disability and the extent of impairment caused by the disability.

Possible manifestations of undiagnosed illness are represented by the presence of one or more signs or symptoms, 13 categories of which are specified at § 3.317(b). These categories represent the wide range of signs and symptoms that have been encountered in over 17,000 completed and analyzed examinations of participants in VA's Persian Gulf Health Registry, including those for whom a known clinical diagnosis has not been established. The 13 categories, however, are not exclusive; other signs and symptoms could legitimately qualify for consideration under § 3.317.

Payment under § 3.317 is prohibited for disabilities that through medical history, physical examination, and laboratory tests are determined to have resulted from any known clinical diagnosis. Once a diagnosis is established, the condition falls outside the scope of § 3.317 but would receive consideration under other provisions of statute or regulation governing service connection through direct incurrence, aggravation, or presumption.

A disability is considered chronic if it has existed for 6 months. Disabilities that are subject to intermittent periods of improvement and worsening during a 6-month period are also considered chronic for the purposes of this regulation. The 6-month period of chronicity is measured from the first date on

which the pertinent evidence establishes that the signs and symptoms of the disability first became manifest. Rating Boards will evaluate disabilities resulting from undiagnosed illnesses using criteria from the Rating Schedule for a disease or injury in which the functions affected, the anatomical localization, or the symptomatology are similar.

In claims alleging incurrence during active service in the Southwest Asia theater of operations, compensation under § 3.317 may not be paid where there is affirmative evidence that the undiagnosed illness was not incurred during that service. In claims alleging either incurrence of the illness during active service in the Southwest Asia theater of operations or manifestation during the 2-year presumptive period, compensation under § 3.317 may not be paid where there is affirmative evidence that the undiagnosed illness was caused by a supervening condition or event that occurred between the veteran's latest departure from the Persian Gulf and the onset of the illness. Compensation also may not be paid where there is affirmative evidence that the illness is the result of the veteran's own willful misconduct or the abuse of alcohol or drugs.

For the purposes of this regulation a Persian Gulf veteran means a veteran who served in the active military, naval, or air service in the Southwest Asia theater of operations during the Persian Gulf War, which by law runs from August 2, 1990, through a date yet to be determined by law or Presidential proclamation (38 U.S.C. 101(33)). The Southwest Asia theater of operations is defined according to Executive Order 12744 of January 21, 1991, in which President Bush designated the combat zone of the Persian Gulf War, and includes Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, the Red Sea, and the airspace above these locations.

Situations may arise that will require termination or reduction of benefits previously awarded under § 3.317. We, therefore, have amended § 3.500 to add paragraph (y) providing that reduction or termination of benefits would be effective the last day of the month in which the 60-day period following notice of the final rating action expires. Final rating action will not be taken prior to expiration of a 60-day predetermination period, during which a payee will have an opportunity to present evidence showing why benefits should not be reduced or terminated. These procedures are consistent with the requirements of 38 CFR 3.103(b) regarding predetermination notice of adverse determinations, and 38 CFR 3.105(d) and (e) governing severance and reduction of compensation. Termination or reduction under § 3.500(y) would not preclude continuation of payments if entitlement is established under other sections of the statute or regulations governing service connection for diseases or injuries incurred or aggravated during active duty or that first appeared following service but within a statutory or regulatory presumptive period.

Section 3.317:

Paragraph (a) authorizes payments of compensation to any Persian Gulf veteran who exhibits indications of chronic disability resulting from an undiagnosed illness or combination of undiagnosed illnesses that became manifest either during active duty in the Southwest Asia theater of operations or to a degree of 10 percent or more within a two-year presumptive period thereafter, and that by history, physical examination, or laboratory tests cannot be attributed to any known clinical diagnosis. The paragraph also defines "objective indications of chronic disability"; defines the term "chronic disability"; provides that a chronic disability will be rated using criteria from the Rating Schedule for a disease or injury in which the functions affected, the anatomical localization, or the symptomatology are similar; and provides that a disability for which compensation is payable under § 3.317 is considered service connected for the purposes of all laws of the United States.

Paragraph (b) lists 13 categories of signs and symptoms that may be manifestations of undiagnosed illness but cautions that the list is not exclusive.

Paragraph (c) provides that compensation under § 3.317 shall not be paid where there is affirmative evidence that the undiagnosed illness was not incurred during service in the Southwest Asia theater of operations during the Persian Gulf War; or where there is affirmative evidence that the undiagnosed illness was caused by a supervening condition or event that occurred between the veteran's latest

departure from the Persian Gulf and the onset of the illness; or where there is affirmative evidence that the illness is the result of the veteran's own willful misconduct or the abuse of alcohol or drugs.

Paragraph (d) defines the terms "Persian Gulf veteran" and "Southwest Asia theater of operations."

Section 3.500: We have added paragraph (y) to provide for termination of benefits paid under § 3.317 as of the last day of the month in which 60 days following notice of the final rating action expires.

REGULATORY AMENDMENT

3-95-3

Regulation Affected: 38 CFR 3.311

EFFECTIVE DATE OF THE REGULATION: September 1, 1994

Date Secretary Approved Regulation: February 10, 1995

Federal Register Citation: 60 FR 9627-28 (February 21, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

The Veterans' Dioxin and Radiation Exposure Compensation Standards Act (Public Law 98-542) required VA to develop regulations establishing standards and criteria for adjudicating veterans' claims for service-connected compensation for diseases arising from exposure to ionizing radiation during service. The law also required that the Secretary, after receiving the advice of the Veterans Advisory Committee on Environmental Hazards, determine which conditions could be considered service-connected on the basis of exposure to ionizing radiation and include those conditions in VA's regulations.

In September 1985 VA published 38 CFR 3.311b, since redesignated as 3.311, to implement the radiation provisions of Pub. L. 98-542. As threshold requirements for entitlement to compensation under this regulation, a veteran must have been exposed to ionizing radiation during atmospheric testing of nuclear weapons, the occupation of Hiroshima and Nagasaki during World War II, or through other activities as claimed, and must have subsequently developed a radiogenic disease within a specified time period. Conditions not specifically listed in the regulation at 3.311(b)(2) as radiogenic diseases were excluded from consideration.

On September 1, 1994, the United States Court of Appeals for the Federal Circuit reversed the decision of the United States Court of Veterans Appeals in Combee v. Brown, No. 93-7107. The Federal Circuit held that Public Law 98-542 did not authorize VA to establish an exclusive list of radiogenic conditions for which a claimant might establish entitlement to direct service connection under § 3.311. On November 2, 1994, Public Law 103-446, the "Veterans' Benefits Improvements Act of 1994, was signed into law. Section 501(b) of that law amended 38 U.S.C. § 1113(b) to clarify that nothing contained in Public Law 98-542 precludes a claimant from attempting to establish direct service connection for a disability or disease based upon exposure to ionizing radiation in service.

This amendment provides that if a claimant cites or submits competent scientific or medical evidence that the claimed condition is a radiogenic disease, the claim will be considered under the provisions of § 3.311. This is consistent with a decision by the U.S. Court of Veterans Appeals that, where a determinative issue involves medical causation, competent medical evidence indicating that the claim is plausible or possible is required to establish that the claim is well grounded. (See Grottveit v. Brown 5 Vet. App. 91 (1993)) The amendment also deletes 3.311(h), which set out VA's previous policy that the list of radiogenic diseases is an exclusive list. That policy has been superseded by the Court of Appeals' decision in Combee and section 501(b) of Public Law 103-446.

We have made technical changes throughout § 3.311 to conform with the Court of Appeals' decision and Public Law 103-446, including a revision in § 3.311(b)(2) to define the term "radiogenic disease" for the purposes of this regulation as a disease which may be induced by ionizing radiation.

We have also replaced all references to "Chief Medical Director" and "Chief Benefits Director" with "Under Secretary for Health" and "Under Secretary for Benefits" respectively, which are the correct statutory titles.

Section 3.311: We have amended § 3.311(b) to define "radiogenic disease" and to provide that VA shall consider a claim involving a disease not on the regulatory list of radiogenic diseases where the claimant has cited or submitted competent medical or scientific evidence showing that the claimed condition is a radiogenic disease. We have made necessary technical changes and have deleted § 3.311(h). We also have changed the words "Chief Medical Director" and "Chief Benefits Director" to "Under Secretary for Health" and "Under Secretary for Benefits," respectively.

REGULATORY AMENDMENT

3-95-4

Regulation Affected: 38 CFR 3.500

EFFECTIVE DATE OF THE REGULATION: February 21, 1995

Date Secretary Approved Regulation: February 10, 1995

Federal Register Citation: 60 FR 9626-9627 (February 21, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

5 U.S.C. 8116(a) prohibits a federal employee who is receiving benefits for a work-related injury or death under FECA from receiving benefits from VA for the same injury or death.

Currently the adjudication regulations at 38 CFR 3.500(e) specify that the effective date for reduction of VA benefits based on an election of FECA benefits will be the end of the month following the month in which notice is received from the Department of Labor's Office of Workers' Compensation Programs that a VA payee has elected FECA benefits. The regulations do not prohibit concurrent payment of VA and FECA benefits. Thus, in those cases where FECA payment is authorized prior to a proper election and discontinuance of VA benefits, a potential for duplicate payment exists.

Section 3.500: VA has amended 38 CFR 3.500(e) to provide that the effective date for reduction or discontinuance of VA benefits in cases where FECA benefits are elected for an injury or death which is the basis of VA payment will be the day preceding the date on which the FECA award became effective.

REGULATORY AMENDMENT

3-95-5

Regulations Affected: 38 CFR 3.350(i)

EFFECTIVE DATE OF THE REGULATION: March 9, 1995

Date Secretary Approved Regulation: November 23, 1994

Federal Register Citation: 60 FR 12886 (March 9, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Special monthly compensation is a benefit established by Congress to be paid for specified disabilities independent of any other compensation authorized by Title 38 U.S.C. 1114(a) - (j). 38 U.S.C. 1114(s) provides for payment of special monthly compensation for a veteran who has a service-connected disability rated as total and (1) has additional service-connected disability or disabilities independently ratable at 60 percent or more, or, (2) is permanently housebound by reason of a service-connected disability or disabilities. 38 CFR 3.350(i), the implementing regulation, provided that the special monthly compensation rate under 38 U.S.C. 1114(s) is payable where the veteran has a single service-connected disability rated as 100 percent "without resort to individual unemployability" and meets the other criteria.

In a precedent opinion dated February 2, 1994 (OGC Prec 2-94), VA's General Counsel held that the plain and unambiguous language of 38 U.S.C. 1114(s) does not restrict the nature of total ratings that may serve as a basis for entitlement to the rate of special monthly compensation which section 1114(s) authorizes. Based on that holding, the General Counsel found that the portion of 38 CFR 3.350(i) which precludes eligibility if the service-connected disability rated as total is so rated due to individual unemployability is an unauthorized restriction.

The General Counsel has recommended that the regulation be revised. We are, therefore, revising the text of 38 CFR 3.350(i) to remove the unauthorized restriction.

Section 3.350: The introductory text of paragraph (i) is amended by removing the phrase "without resort to individual unemployability."

REGULATORY AMENDMENT

3-95-6

Regulations Affected: 38 CFR 3.358

EFFECTIVE DATE OF THE REGULATION: November 25, 1991

Date Secretary Approved Regulation: February 23, 1995

Federal Register Citation: 60 FR 14222-3 (March 16, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

38 U.S.C. 1151 provides for the payment of disability or dependency and indemnity compensation for additional disability or death resulting from an injury or aggravation of an injury suffered as the result of VA hospitalization, medical or surgical treatment, examination, or pursuit of a course of vocational rehabilitation under 38 U.S.C. ch. 31. VA had long interpreted the statute to require a showing of fault on the part of VA or the occurrence of an accident to establish entitlement to § 1151 compensation for adverse consequences of VA medical treatment. See 38 CFR 3.358(c)(3) (1994). The Supreme Court, however, recently affirmed a lower court ruling that invalidated VA's fault-or-accident interpretation.

In deciding Brown v. Gardner, U.S. Sup. Ct. No. 93-1128 (Dec. 12, 1994), the Court held that the fault-or-accident requirement in 38 CFR 3.358(c)(3) was inconsistent with the plain language of the statute and that no fault requirement was implicit in the statute.

Although the Supreme Court found that the statutory language simply requires a causal connection between an injury or aggravation of an injury and VA hospitalization, medical or surgical treatment, examination, or vocational rehabilitation, it also indicated that not every additional disability resulting from an injury or aggravation so connected was compensable under § 1151. The Court noted that it did not intend to exclude application of the doctrine volenti non fit injuria (which is sometimes loosely translated as "assumption of the risk" but more precisely refers to the doctrine of consent). Moreover, the Court provided an example of disabilities that, although causally connected to VA treatment, are not compensable under § 1151. In this regard, the Court stated, "[i]t would be unreasonable, for example, to believe that Congress intended to compensate veterans for the necessary consequences of treatment to which they consented (i.e., compensating a veteran who consents to the amputation of a gangrenous limb for the loss of the limb)."

Under the authority granted in 38 U.S.C. 505, the Secretary of Veterans Affairs requested an opinion from the U.S. Attorney General on precisely what the Supreme Court meant by its statement regarding application of the doctrine volenti non fit injuria. The response, from the Department of Justice's Office of Legal Counsel, was that the Court construed § 1151 to exclude from coverage only those injuries that are the certain, or perhaps the very nearly certain, result of proper medical treatment.

In this document VA is revising 38 CFR 3.358(c)(3) to reflect the Supreme Court's holding that 38 U.S.C. 1151 permits compensation for all but the necessary consequences of properly administered VA medical or surgical treatment or examination to which a veteran consented. "Necessary consequences" is the term the Supreme Court used in its example of what Congress could not reasonably have intended to cover with § 1151. We define "necessary consequences" as those consequences certain or intended to result from treatment or examination. We consider this interpretation of the statute to be consistent with the Supreme Court's opinion.

Consistent with our interpretation of the Supreme Court's opinion, this rule also provides that whether results were either certain or intended is to be determined in relation to the examination or

treatment actually administered. Consequences otherwise certain or intended to result from a treatment will not be considered uncertain or unintended solely because it had not been determined at the time consent was given whether that treatment would in fact be administered. For example, consider a case in which a veteran is about to undergo exploratory surgery and, depending on the findings, would undergo one of two possible additional procedures, each of which has distinct consequences that are certain or intended to result. Under these circumstances it is not known before the exploratory surgery which additional procedure will actually be performed. However, if the veteran consents both to the exploratory surgery and whichever procedure ultimately is determined to be required, the certainty of consequences is to be determined in relation to the consented-to procedure or procedures actually performed.

Also, as reflected in the text of the rule, we have concluded that when the Supreme Court stated that compensation should not be payable for the necessary consequences of treatment to which the veteran "consented," the Court meant both express and implied consent. This is consistent with the common meaning of the term "consent" and the Court did not indicate that any other meaning should be applied.

This interim final rule, unlike the regulatory provision it replaces, expressly includes the consequences of VA examinations. The statute covers injuries or aggravation of injuries resulting from examination, as well as from medical or surgical treatment. Thus, the rule's inclusion of examination consequences is necessary to reflect completely the provisions of the statute.

We also are deleting other references in the section to the invalidated fault requirement. We are eliminating paragraph (c)(4), which requires that VA be at fault to establish entitlement for claims based on being transported while in hospitalized status. Such claims will now be adjudicated under the standard applicable to hospitalization, treatment, or examination. We are also making corresponding changes to paragraph (c)(7) to remove the fault requirement for claims based on nursing home care.

Section 3.358: Paragraph (c)(3) has been amended as described above. Paragraph (c)(4) has been eliminated as described above. Paragraphs (c)(5), (c)(6), and (c)(7) have been redesignated as paragraphs (c)(4), (c)(5), and (c)(6). Redesignated paragraph (c)(6) has been amended as described above.

REGULATORY AMENDMENT

3-95-7

Regulations Affected: 38 CFR 2.67a, 38 CFR 3.5(c), 38 CFR 3.8, 38 CFR 3.100, 38 CFR 3.106, 38 CFR 3.251(a)(3), 38 CFR 3.261(a)(39), 38 CFR 3.262(x), 38 CFR 3.272(t), 38 CFR 3.400(s), 38 CFR 3.702(d), 38 CFR 3.1600

EFFECTIVE DATE OF THE REGULATION: November 2, 1994, except for the provisions removing the requirement to pay certain benefits in Philippine pesos (38 CFR §§ 2.67a, 3.8, 3.100(b), 3.251(a)(3), and 3.1600) which are effective January 1, 1995.

Date Secretary Approved Regulation: March 31, 1995

Federal Register Citation: 60 FR 18354-56 (April 11, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

On November 2, 1994, the Veterans' Benefits Improvements Act of 1994 was signed into law. Formerly, no person in receipt of DIC could elect to receive any other benefit based on the same death. Section 111 of the Veterans' Benefits Improvements Act of 1994, Public Law 103-446, amended 38 U.S.C. 1317 to allow a surviving spouse in receipt of DIC to elect death pension instead of such compensation. VA is amending 38 CFR 3.5(c) and 3.702(d) to conform with this new statutory provision. We have also made a nonsubstantive change in § 3.702(d) to clarify when an election of DIC is final.

Under the provisions of 38 U.S.C. 5306 any person can renounce a benefit to which he or she is entitled. Until recently any new application filed thereafter was treated as an original application. Section 503 of Public Law 103-446 amended 38 U.S.C. 5306 by adding a new subsection which provides that a new application for pension or parents' DIC filed within one year after renouncement of that benefit shall not be treated as an original application but rather that any benefits due will be payable as if the renouncement has not occurred. VA is amending 38 CFR §§ 3.106 and 3.400(s) to conform to this new statutory requirement.

All income is countable when VA determines entitlement to income-based benefits unless specifically excluded by law. Section 506 of Public Law 103-446 provides a new exception to countable income if cash, stock, land, or other interests are received by an individual from a Native Corporation under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.). VA is amending 38 CFR §§ 3.261, 3.262 and 3.272 to conform to this new statutory requirement.

Section 507 of Public Law 103-446 amended 38 U.S.C. 107 to eliminate the requirement that compensation, DIC, or burial allowance based on certain Philippine service deemed not to be active service for other purposes be paid in Philippine pesos. VA is amending 38 CFR §§ 3.8, 3.251(a)(3), and 3.1600 to conform to this statutory revision and removing §§ 2.67a and 3.100(b).

Section 2.67a. This section is removed. Calculation of the annual income limitation in Philippine pesos is no longer required so a delegation for that purpose is unnecessary.

Section 3.5. Paragraph (c) has been amended to provide that a surviving spouse who is receiving dependency and indemnity compensation may elect to receive death pension.

Section 3.8. This section has been amended to provide that benefits based on certain Philippine service deemed not to be active service for other purposes be payable at the rate of $.50 for each dollar authorized. Previously, these benefits were payable only in Philippine pesos.

Section 3.100. Paragraph (b) is removed. Calculation of the annual income limitation in Philippine pesos is no longer required so a delegation for that purpose is unnecessary. Paragraph 3.100(c) is redesignated as 3.100(b).

Section 3.106. Paragraphs (c) and (d) are redesignated as paragraphs (d) and (e) respectively. A new paragraph (c) is added to provide that an application for pension or parents' dependency and indemnity compensation filed within one year after VA receives a renouncement of that benefit shall not be treated as an original application and benefits will be payable as if the renouncement had not occurred.

Section 3.251. Paragraph (a)(3) is amended to provide that the income limitation will be $.50 on the dollar for claims based on service in the Commonwealth Army of the Philippines, or as a guerrilla or as a Philippine Scout under section 14, Public Law 190, 79th Congress.

Section 3.261. Paragraph (a)(39) is added to provide an income exclusion for certain income from a Native Corporation under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).

Section 3.262. Paragraph (x) is added to provide an income exclusion for certain income from a Native Corporation under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).

Section 3.272. Paragraph (t) is added to provide an income exclusion for certain income from a Native Corporation under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).

Section 3.400. Paragraph (s) is amended to show that an application for pension or parents' dependency and indemnity compensation filed within one year after VA receives a renouncement of that benefit shall not be treated as an original application

Section 3.702. Paragraph (d) is revised to permit a surviving spouse in receipt of dependency and indemnity compensation to elect death pension.

Section 3.1600. Paragraphs (a), (b), and (f), are amended to delete references to payment in Philippine pesos. Effective January 1, 1995, benefits formerly payable in Philippine pesos are payable in U.S. dollars at the rate of $.50 on the dollar.

REGULATORY AMENDMENT

3-95-8

Regulation Affected: 38 CFR 3.812(f)

EFFECTIVE DATE OF THE REGULATION: April 27, 1995

Date Secretary Approved Regulation: April 7, 1995

Federal Register Citation: 60 FR 20642-43 (April 27, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

The Omnibus Budget Reconciliation Act of 1981 amended title 42, United States Code, to terminate or reduce payment of the Social Security child's insurance benefit and to terminate the mother's benefit at the point at which the youngest child reached age 16. Previously, the mother's benefit had terminated when the youngest child reached age 18. Section 156 of Pub. L. 97-377, which established a program known as the Restored Entitlement Program for Survivors or REPS, in effect, restored such terminated or reduced benefits for surviving spouses and children of veterans who died on active duty prior to August 13, 1981, or who died as a result of service-connected disability incurred or aggravated prior to that date.

Under the authority granted in section 156, VA issued regulations, codified at 38 CFR 3.812, which implemented the statute. Paragraph (f) of section 3.812 provided that benefits could be paid from the first day of the month during which the claimant first became eligible, if application was filed within 11 months following that month. This paragraph was amended on June 28, 1993, to require that the application be filed within 6 months of the month during which the claimant first became eligible in order for benefits to be payable from the first day of the month in which eligibility arose.

The United States Court of Veterans Appeals struck down subsections (2) and (3) of 38 CFR 3.812(f), which specified the time limits for filing an application for REPS benefits, in the case of Cole v. Derwinski, 2 Vet. App. 400 (1992), aff'd, 35 F.3d 551 (Fed. Cir. 1994), involving a claim for the REPS mother's benefit. The court relied on its Cole decision in Skinner v. Brown, 4 Vet. App. 141 (1993), aff'd, 27 F.3d 1571 (Fed. Cir. 1994), a case involving a claim for the REPS child's benefit.

In affirming the Court of Veterans Appeals decision, the United States Court of Appeals for the Federal Circuit held that the VA regulation denying retroactive payment to claimants who failed to file a REPS claim within 6 months of the month entitlement arose was contrary to the plain meaning of the REPS statute, which imposes no time restrictions on filing, and was therefore invalid. Paragraph (f) of 38 CFR 3.812 is therefore amended to show that there is no time limit for filing a claim for REPS benefits. The only restriction on payment to an otherwise eligible claimant is that no payment can be made for any period prior to January 1, 1983, the effective date set by the REPS statute.

Section 3.812. Paragraph (f) is amended to show that there is no time limit for filing a REPS claim.

REGULATORY AMENDMENT

3-95-9

Regulations Affected: 38 CFR 3.1 and 38 CFR 3.301

EFFECTIVE DATE OF THE REGULATION: November 1, 1990

Date Secretary Approved Regulation: May 12, 1995

Federal Register Citation: 60 FR 27407-27408.

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 8052 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Pub. L. 101-508, amended 38 U.S.C. 105(a), section 110 (recodified as 1110) and section 331 (recodified as 1131) to provide that injuries or diseases resulting from the abuse of alcohol or drugs by the person on whose service benefits are claimed will not be considered incurred in line of duty and thus are not compensable by VA as service-connected disabilities.

VA has amended its adjudication regulations at 38 CFR 3.1(m) and 3.301 to provide that injuries or diseases incurred or aggravated during service as a result of the abuse of alcohol or drugs will not be considered incurred or aggravated in line of duty for purposes of service connection. We have also defined drug and alcohol abuse for purposes of this implementing rule and have specified that the provisions concerning abuse of alcohol or drugs pertain only to those claims filed after October 31, 1990, the effective date of OBRA 1990.

Section 3.1(m): We have amended 38 CFR, section 3.1(m) to show that "in line of duty" excludes injury or disease that is a result of a veteran's own willful misconduct or due to abuse of alcohol or drugs.

Section 3.301(a): We have similarly amended this section to state that direct service connection may be granted only when disability or cause of death was incurred in line of duty and not a result of a veteran's own willful misconduct or abuse of alcohol or drugs.

Section 3.301(c): We have amended the title of this section to read as follows: "Specific applications; willful misconduct." Paragraph (3) has been amended to add a specific reference to claims for service connection where disability is a result of abuse of alcohol or drugs, specifying that this reference is found in the new paragraph 3.301(d).

Section 3.301(d): This paragraph has been added to specify that an injury or disease incurred during active service shall not be considered to have been incurred in line of duty if such disease or injury was a result of abuse of alcohol or drugs by the person on whose service such benefits are claimed. It also defines alcohol and drug abuse.

REGULATORY AMENDMENT

3-95-10

Regulations Affected: 38 CFR 3.157(b)(2), 3.326(d), 3.327(b)(1), 3.352(b)(1)

EFFECTIVE DATE OF THE REGULATION: November 2, 1994

Date Secretary Approved Regulation: May 17, 1995

Federal Register Citation: 60 FR 27409 (May 24, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

On November 2, 1994, the Veterans' Benefits Improvements Act of 1994 was signed into law. Section 301 of that statute created 38 U.S.C. 5125, which authorizes the Secretary of Veterans Affairs to accept the report of a private physician's examination that is otherwise adequate for rating purposes to establish entitlement to compensation or pension benefits. This document amends 38 CFR 3.157, 3.326, 3.327, and 3.352 in order to reflect that statutory authority.

Section 3.157: Paragraph (b)(2) is amended to remove the requirement that a private physician's statement be confirmed by a VA examination prior to granting service connection for a disability.

Section 3.326: Paragraph (d) is amended to show that a private physician's statement may be accepted for rating any compensation or pension claim as long as it is adequate for rating purposes.

Section 3.327: Paragraph (b)(1) is amended to remove the requirement that at least one VA examination be made in every case in which compensation benefits are awarded.

Section 3.352: Paragraph (b)(1) is amended to remove the requirement that a veteran's need for the special aid and attendance benefit under 38 U.S.C. 1114(r) must be determined by a Department of Veterans Affairs physician.

REGULATORY AMENDMENT
3-95-11

Regulation Affected: 38 CFR 3.309

EFFECTIVE DATE OF THE REGULATION: November 2, 1994

Date Secretary Approved Regulation: March 27, 1995

Federal Register Citation: 60 FR 31250-31252.

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

The Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. 100-321, which was enacted May 20, 1988, established a presumption of service connection for specific radiogenic diseases arising in veterans who had been present at the occupation of Hiroshima or Nagasaki, who had potentially been exposed to ionizing radiation as prisoners of war in Japan during World War II, or who had participated onsite in a test involving the atmospheric detonation of a nuclear device.

On June 21, 1989, VA published regulations at 38 CFR 3.309 to implement the provisions of Pub. L. 100-321. The introductory language of the statute had indicated that it was to apply to veterans "who participated in atmospheric or underwater nuclear tests as part of the United States nuclear weapons testing program." In formulating the regulations, therefore, VA defined radiation risk activity as including onsite participation in a test involving the atmospheric detonation of a nuclear device by the United States. The effect of that rulemaking was to exclude those veterans exposed to ionizing radiation during atmospheric nuclear testing by governments other than the United States from the presumption of service connection.

The Secretary determined that this rule should be revised to allow consideration of service connection on the same presumptive basis for these veterans as for veterans exposed to ionizing radiation due to atmospheric nuclear detonations conducted as a part of the U.S. testing program. Accordingly, on September 8, 1994, VA published a proposal in the Federal Register (59 FR 46379-46380) to amend its adjudication regulations at 38 CFR 3.309(d)(3) to extend the presumption that specified diseases are the result of in-service exposure to ionizing radiation to veterans who were present at atmospheric nuclear tests conducted by any government allied with the United States during World War II.

On November 2, 1994, the President signed Pub. L. 103-446, the Veterans' Benefits Improvements Act. Section 501(a) of that law clarified Congressional intent on this issue by amending 38 U. S. C. 1112(c)(3)(B) to define the term "radiation-risk activity" to include onsite participation in a test involving the atmospheric detonation of a nuclear device "without regard to whether the nation conducting the test was the United States or another nation."

The current regulatory amendment incorporates the legislation enacted after the proposed rule was published and deletes the reference to allied governments.

Section 3.309(d)(3)(ii)(A) is revised to define "radiation risk activity" as including onsite participation in a test involving the atmospheric detonation of a nuclear device without regard to the nation conducting the test by removing the restriction that such tests must have been detonated by the United States.

Section 3.309(d)(3)(v) is revised to show that the specific operational periods shown apply to U. S. tests only.

REGULATORY AMENDMENT

3-95-12

Regulations Affected: 38 CFR 3.256 and 3.277

EFFECTIVE DATE OF THE REGULATION: October 4, 1995

Date Secretary Approved Regulation: September 7, 1995

Federal Register Citation: 60 FR 51921-22 (October 4, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Public Law 103-271, the Board of Veterans' Appeals Administrative Procedures Improvement Act of 1994, amended 38 U.S.C. 1315 and 1506 to give the Secretary of Veterans Affairs discretionary authority to require submission of income and resource reports by recipients of income-based benefits. This amendment outlines the manner in which the Secretary will exercise this discretionary authority to determine which claimants and beneficiaries must complete an EVR.

The rule requires an EVR in three instances. First, VA will require submission of an EVR by any beneficiary whose Social Security number, or whose spouse's Social Security number, has not been verified by the Social Security Administration (SSA). A Social Security number is considered to be verified when the identifying information associated with that number in VA records (e.g., name, date of birth, sex) matches identifying information associated with the number in SSA records.

VA will also require beneficiaries who receive income other than Social Security to submit an EVR. These beneficiaries must submit an EVR because VA is unable to verify the receipt and amount of other types of income with the same accuracy that it can verify Social Security income.

Even if all relevant Social Security numbers have been verified and neither the beneficiary nor the beneficiary's spouse received income other than Social Security, VA will still require completion of an EVR if it determines that submission of an EVR is necessary to preserve program integrity. The phrase "necessary to preserve program integrity" applies when it is necessary for VA, or an agency with oversight authority over VA, to verify that EVR-exempt beneficiaries are accurately reporting changes in entitlement factors.

Although beneficiaries will be required to file an EVR only if requested to do so by VA, they have an affirmative obligation to advise VA promptly of changes in factors such as income, marital status, etc. which affect entitlement. This affirmative obligation appears at §§ 3.256(a) and 3.277(b) of the amendments.

These amendments do not change any substantive rules concerning eligibility for VA benefits, alter the recipient's obligation to report changes that may affect the rate of VA benefits payable, or limit VA's authority to require evidence of entitlement factors in an individual case. The amendments merely set out VA's policy on requiring completion of an EVR.

Section 3.256 is revised to set out eligibility reporting requirements for parents' DIC, section 306, and old law pension recipients and claimants.

Section 3.277 is revised to set out eligibility reporting requirements for improved pension recipients and claimants.

REGULATORY AMENDMENT

3-95-13

Regulations Affected: 38 CFR 3.326

EFFECTIVE DATE OF THE REGULATION: October 11, 1995

Date Secretary Approved Regulation: July 31, 1995

Federal Register Citation: 60 FR 52863-64 (October 11, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

For many years VA regulations provided that a compensation claim could not be rated without a current VA examination, or a report deemed to be the equivalent of a VA examination. In general, hospital reports (government or private) were deemed to be VA examinations if otherwise adequate for rating purposes, but private physicians' reports were not.

On July 14, 1994, VA published a final rule in the Federal Register (59 FR 35851) amending 38 CFR 3.326 to permit acceptance of a private physician's statement for the purpose of rating claims for increased compensation due to the increased severity of service-connected disabilities. A private physician's statement, however, was still not acceptable for rating an original compensation claim.

On November 2, 1994, the Veterans' Benefits Improvements Act of 1994, Public Law 103-446, was signed into law. Section 301 of Public Law 103-446 granted the Secretary of Veterans Affairs discretionary authority to accept the report of a private physician's examination that is otherwise adequate for rating purposes to establish entitlement to any compensation or pension benefit. A final rule enabling the Secretary to exercise that discretionary authority was published on May 24, 1995 in the Federal Register (60 FR 27409). That final rule amended 38 CFR 3.326(d) as well as 3.157, 3.327, and 3.352.

Previously, paragraph (a) of § 3.326 indicated that a VA examination would be authorized where the reasonable probability of a valid claim was indicated in any compensation or pension claim filed by a veteran, surviving spouse, or parent, whether an original or reopened claim or a claim for increase. This document revises paragraph (a) to state that a VA examination will be authorized where there is a "well-grounded claim" for disability compensation or pension but where the medical evidence accompanying the claim is not adequate for rating purposes. We believe this will not cause a substantial change in the criteria for authorizing VA examinations; however, this change is made to more accurately reflect statutory language and caselaw requirements concerning such VA examinations.

The Court of Veterans Appeals has held that scheduling a VA examination may be required as part of VA's duty to assist the claimant under 38 U.S.C. 5107(a), and that the duty to assist attaches when a claim is well-grounded, i.e., when the claim is plausible, meritorious on its own, or capable of substantiation. See, e.g., Betties v. Brown, 6 Vet. App. 333, 336 (1993).

The amendments made by this document do not affect the provisions already in place that require former prisoners of war to be offered a complete examination at a VA hospital or outpatient clinic prior to any rating action denying monetary benefits.

Also, nonsubstantive changes are made to delete provisions that no longer apply and to simplify and clarify other provisions.

Section 3.326 is revised to provide that a VA examination will be authorized where there is a well-grounded claim for disability compensation or pension but the medical evidence accompanying the claim is not adequate for rating purposes.

REGULATORY AMENDMENT

3-95-14

Regulations Affected: 38 CFR 3.55(a)(2) and 3.400

EFFECTIVE DATE OF THE REGULATION: October 11, 1995

Date Secretary Approved Regulation: September 11, 1995

Federal Register Citation: 60 FR 52862-63 (October 11, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

A surviving spouse of a veteran must be unmarried to receive VA benefits. The law regarding the eligibility for benefits of a surviving spouse of a veteran who remarries after the veteran's death and whose remarriage later terminates has changed several times in recent years.

Before November 1, 1990, 38 U.S.C. 103(d)(2) provided that the remarriage of a surviving spouse of a veteran would not bar benefits if the remarriage was terminated by death or dissolved by a court with basic authority to render divorce decrees, unless VA determined that the divorce was secured through fraud by the surviving spouse or collusion.

The Omnibus Budget Reconciliation Act of 1990 (OBRA), Public Law 101-508, deleted 38 U.S.C. 103(d)(2). The effect of this change was to deny benefits to those filing claims on or after November 1, 1990, who had remarried at any time after the death of the veteran.

The Veterans' Benefits Programs Improvement Act of 1991, Public Law 102-86, provided that the 1990 OBRA amendments would not apply to any person who met the statutory definition of a surviving spouse on October 31, 1990, unless after that date the individual married or lived with another person and held himself or herself out openly to the public as that person's spouse.

The Veteran's Benefits Act of 1992, Public Law 102-568, provided in section 103 that the 1990 OBRA amendment would not apply to any case in which a legal proceeding that terminated an existing marital relationship was commenced before November 1, 1990, by an individual who, but for that marital relationship, would be considered the surviving spouse of a veteran.

VA regulations pertaining to reinstatement of benefits eligibility of a surviving spouse based upon terminated marital relationships appear at 38 U.S.C. 3.55(a). Previously, subsection (a) included the following provisions:

> (2) On or after January 1, 1971, remarriage of a surviving spouse terminated prior to November 1, 1990, or terminated by legal proceedings commenced prior to November 1, 1990, shall not bar the furnishing of benefits to such surviving spouse provided that the marriage:

* * *

(ii) Has been dissolved by a court with basic authority to render divorce decrees unless the Department of Veterans Affairs determines that the divorce was secured through fraud by the surviving spouse or through collusion.

* * *

Since 38 CFR 3.55(a)(2) previously did not provide that the legal proceedings which result in termination of the remarriage must have been commenced by the individual seeking benefits as a veteran's surviving spouse, it is now amended to conform with section 103 of Public Law 102-568. We are also making nonsubstantive amendments to 38 CFR 3.400 in order to update cross-references and authority citations.

Section 3.55(a)(2) is amended to make it clear that where a surviving spouse claimant seeks reinstatement of benefits on the basis of legal proceedings terminating a remarriage, the legal proceedings must have been initiated by the surviving spouse claimant

Section 3.400 is amended to update various cross references and authority citations.

REGULATORY AMENDMENT

3-95-15

REGULATION AFFECTED: 38 CFR 3.311(b)(2)

EFFECTIVE DATE OF REGULATION: October 13, 1995

Date Secretary Approved Regulation: May 17, 1995

Federal Register Citation: 59 FR 53276-77, (October 13, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Under 38 CFR 1.17(c), when VA determines that a significant statistical association exists between exposure to ionizing radiation and any disease, 38 CFR 3.311 is amended to provide guidelines for the establishment of service connection for that disease. This determination is made by the Secretary of Veterans Affairs after receiving the advice of the Veterans' Advisory Committee on Environmental Hazards (VACEH) based on its evaluation of scientific and medical studies.

In a public meeting on October 28-29, 1993, the VACEH met in Washington, DC and reviewed 53 medical and scientific studies having to do with health effects of radiation exposure. Based on that review, VACEH recommended that VA add lymphomas other than Hodgkin's disease and rectal cancer to the list of diseases recognized by VA as being radiogenic. The Secretary accepted that recommendation and the proposed amendment was published in the Federal Register on November 25, 1994. The appropriate comment period was observed and 38 CFR 3.311(b)(2) is now amended to add lymphomas other than Hodgkin's disease and rectal cancer to the list of radiogenic diseases This amendment relieves claimants suffering from these conditions from having to establish that they may be induced by ionizing radiation.

Section 3.311(b)(2) is amended to add cancer of the rectum and lymphomas other than Hodgkin's disease to the list of diseases VA will recognize as radiogenic for purposes of service connection based on exposure to ionizing radiation.

REGULATORY AMENDMENT

3-95-16

Regulation Affected: 38 CFR 3.353

EFFECTIVE DATE OF THE REGULATION: November 3, 1995

Date Secretary Approved Regulation: October 26, 1995

Federal Register Citation: 60 FR 55791-55792 (November 3, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Regulations at 38 CFR 3.353 govern VA determinations of competency and incompetency. 38 CFR 3.353(a) defines a mentally incompetent person as one who lacks the mental capacity to manage his or her own affairs, including disbursement of funds without limitation. 38 CFR 3.353(b) was intended to authorize rating boards to make determinations of competency and incompetency for VA purposes without involvement of a Veterans Services Officer (VSO).

In a Coleman v. Brown, No. 90-966, the United States Court of Veterans Appeals interpreted § 3.353(b) as requiring VSO participation prior to determination of the issue of incompetency. Although the VSO was meant to play an integral role in developing evidence relating to the veteran's ability to handle his or her affairs, the intent of the regulation was to give rating boards sole responsibility for incompetency determinations without the VSO participating in the decision. See 38 CFR 3.104(a). Although it was intended that evidence produced by the VSO could lead to later reconsideration of the incompetency determination, it was not intended that the VSO's concurrence be a condition precedent to rating a beneficiary incompetent. The VSO's investigation was meant merely to provide an additional safeguard which could lead to later review.

The amendment provides that the rating board has sole authority to determine the competency of beneficiaries for VA benefit purposes, but that if the VSO develops new information bearing on the issue of the beneficiary's competency, the rating board will consider that evidence together with all other evidence of record to determine whether the prior determination of incompetency should remain in effect. Paragraph (b)(2) provides that the Adjudication Officer will authorize disbursement to an incompetent beneficiary as directed by the VSO (e.g., supervised direct payment, payment to a fiduciary, or payment to the beneficiary's spouse). Additional nonsubstantive changes are made in the wording and format of § 3.353(b) for the sake of clarity.

Section 3.353(b) is amended to make it clear that only rating boards are authorized to make determinations of incompetency for purposes of insurance and payment of VA benefits.

REGULATORY AMENDMENT

3-95-17

Regulation Affected: 38 CFR 3.6

EFFECTIVE DATE OF THE REGULATION: October 3, 1994

Date Secretary Approved Regulation: November 3, 1995

Federal Register Citation: 60 FR 57178-57179 (November 14, 1995)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Under 38 U.S.C. 101(21)(D), service as a cadet at the United States Military, Air Force, or Coast Guard Academy, or as a midshipman at the United States Naval Academy is considered "active duty." A precedent opinion of the VA General Counsel (VAOPGCPREC 18-94) dated October 3, 1994, addressed the question of whether attendance at the United States Air Force Academy Preparatory School constituted "active duty." The General Counsel noted that attendance at a service academy preparatory school does not constitute service as a cadet or midshipman at a service academy.

In VAOPGCPREC 18-94 the General Counsel held that an enlisted servicemember who is reassigned to the United States Air Force Academy Preparatory School without a release from active duty continues on "active duty" but that persons enlisted directly from civilian life, a reserve component, or the Air National Guard for the sole purpose of attending the Air Force Academy Preparatory School are on "active duty for training." The General Counsel found it significant that an enlisted servicemember who is disenrolled from a preparatory school prior to completion of the school program still has a military obligation to complete while an individual attending a preparatory school from the Reserves, National Guard, or civilian life is generally discharged from the service in the event of premature disenrollment.

In VAOPGCPREC 6-95 dated February 10, 1995, the VA General Counsel held that the analysis in VAOPGCPREC 18-94 for determining whether service at the United States Air Force Academy Preparatory School constitutes "active duty" is generally applicable to service consisting of attendance at the United States Military Academy Preparatory School and the United States Naval Academy Preparatory School. However, the opinion stated that in individual cases it would be advisable to determine whether a student had made a commitment to active duty service which would be binding upon disenrollment because such a student, even though not transferring directly from enlisted active duty status, would be considered to be on active duty while attending a preparatory school. Paragraphs (b) and (c) of 38 CFR 3.6 are amended to reflect the holdings in VAOPGCPREC 18-94 and VAOPGCPREC 6-95.

In the second sentence of § 3.6(a) the phrase "any period of active duty for training" is substituted for "and period of active duty for training." This corrects a typographical error. No substantive rule change is involved.

Section 3.6(a) is amended to correct a typographical error.

Sections 3.6(b)(5) and (c)(5) are amended to show the criteria for determining whether a person attending a military academy preparatory school is on active duty or active duty for training status.

REGULATORY AMENDMENT

3-96-1

Regulation Affected: 38 CFR 3.811

Effective Date of the Regulation: March 20, 1996

Date Secretary Approved Regulation: March 11, 1996

Federal Register Citation: 61 FR 11309-10 (March 20, 1996)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

The "Brownsville Incident" occurred on August 13, 1906, when an estimated 5 to 20 persons shot up the town of Brownsville, Texas. One civilian was killed and one wounded. It was charged that soldiers from the 25th Infantry Regiment, which was stationed adjacent to the town at Fort Brown, were responsible for the shootings, but it proved impossible to establish the guilt of individual soldiers. On November 5, 1906, President Theodore Roosevelt ordered that all 167 enlisted men in the three companies stationed at Fort Brown be dishonorably discharged.

On April 6, 1910, 14 of the 167 soldiers were exonerated by a special Army Tribunal and permitted to reenlist. On September 22, 1972, the Secretary of the Army ordered the discharges of all the dishonorably discharged soldiers changed to honorable.

On December 6, 1973, Congress enacted Public Law 93-177. Section 7 of Public Law 93-177 provided for payment of $25,000 to surviving veterans who were dishonorably discharged as a result of the "Brownsville Incident" and were not thereafter eligible for reenlistment. It also provided for payment of $10,000 to the unremarried surviving spouses of such veterans. The law provided that applications for these payments must be filed within 5 years after December 6, 1973.

Section 3.811 of 38 CFR was promulgated in 1974. Since more than 15 years have passed since anyone could file for payments under Public Law 93-177, we are removing 38 CFR 3.811 as obsolete.

Section 3.811: Removed and reserved.

REGULATORY AMENDMENT

3-96-2

Regulation Affected: 38 CFR 3.6(b)(7)

Effective Date of the Regulation: March 22, 1996

Federal Register Citation: 61 FR 11731 (March 22, 1996)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

38 CFR 3.6(b) sets out what constitutes "active duty" for purposes of VA benefit eligibility. Paragraph (b)(7) states that a discharged servicemember shall be deemed to have continued on active duty during the period required to travel from the point of separation to his or her home of record. The authority for the travel time provision of 38 CFR 3.6(b)(7) is 38 U.S.C. 106(c).

A review of historical materials indicates that paragraphs (i), (ii), and (iii) of 38 CFR 3.6(b)(7) reflect effective dates for the travel time provision of 38 U.S.C. 106(c). On June 23, 1976 (41 FR 26681) VA published a final rule that removed the effective dates from the regulation because they were historical only and no longer served any purpose for claims processing. The deletions were never reflected in the Code of Federal Regulations. This document corrects that erroneous action.

Section 3.6(b)(7): Paragraphs (i), (ii), and (iii) are removed.

REGULATORY AMENDMENT

3-96-3

Regulations Affected: 38 CFR 3.314(b)(2) and 3.323(b)

Effective Date of the Regulation: May 7, 1996

Date Secretary Approved Regulation: April 19, 1996

Federal Register Citation: 61 FR 20438 (May 7, 1996)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Before 1978, the statute governing entitlement to pension for nonservice-connected disability (now 38 U.S.C. 1521(a)) provided that VA pension was potentially payable to a veteran who was permanently and totally disabled from non-service-connected disability not the result of the veteran's willful misconduct or vicious habits. In 1978 the Veterans' and Survivors' Pension Improvement Act of 1978, Public Law 95-588, deleted the words "vicious habits" from the pension statute.

In 1990 VA amended 38 CFR 3.301(b) to delete the reference to "vicious habits" (55 FR 13529). 38 CFR 3.301(b) now states simply that "disability pension is not payable for any condition due to the veteran's own willful misconduct."

There are additional references to "vicious habits" in 38 CFR sections 3.314(b)(2), and 3.323(b) which apparently were overlooked when 38 CFR 3.301(b) was amended in 1990. This rule deletes those references and conforms the rules to the current language of 38 U.S.C. 1521(a).

Section 3.314: Paragraph (b)(2) is amended by removing the words "or vicious habits".

Section 3.323: Paragraphs (b)(1) and (b)(2) are amended by removing the words "or vicious habits".

REGULATORY AMENDMENT

3-96-4

Regulations Affected: 38 CFR 3.23(d)(5), 3.24(c)(1), 3.25(c), 3.100(a), 3.250(d), 3.252(a), 3.321(b)(1), 3.458(f)(2), 3.460(b), 3.461(b)(1), 3.559(c), 3.702, 3.852, 3.901, 3.902(d), 3.1612(e)(3)

Effective Date of the Regulation: May 8, 1996

Date Secretary Approved Regulation: April 30, 1996

Federal Register Citation: 61 FR 20726-27 (May 8, 1996)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

38 CFR 3.23(d)(5) concerns annual income for improved pension surviving spouses. The authority citation for 38 CFR 3.23(d)(5) is shown incorrectly as "38 U.S.C. 1541(c),(h)". The authority citation is corrected to "38 U.S.C. 1541(c),(g)".

38 CFR 3.24(c)(1) states that in certain situations pension shall be paid to a child in the custody of a person legally responsible for the child's support at an annual rate equal to the difference between the rate for a surviving spouse and one child, and "the sum of the annual income of such person." This paragraph is based on 38 U.S.C. 1542 which states that the child's rate is reduced by the child's income or, if the child is residing with a person legally responsible for the child's support, by "the sum of the annual income of <u>such child and</u> such person." 38 CFR 3.24(c)(1) is amended to restore the words "the annual income of such child and" before "the annual income of such person". These words appear in the *Federal Register* of September 16, 1987, but were omitted from the July 1, 1988, *Federal Register* codification of 38 CFR and all subsequent versions. This change will conform the regulation to 38 U.S.C. 1542.

The most recent change to 38 CFR 3.25 appeared in the *Federal Register* of September 16, 1987. The version of 38 CFR 3.25(c)(2) in the *Federal Register* of September 16, 1987, contained the following statement: "* * * no payment of DIC to a parent under this paragraph may be less than $5 monthly. Each time there is a rate increase under 38 U.S.C. 3112, the amount of the reduction under this paragraph shall be recomputed to provide, as nearly as possible, for an equitable distribution of the rate increase." However, the July 1, 1988, codified version of 38 CFR 3.25(c)(2) omitted the following words: "may be less than $5 monthly. Each time there is a rate increase under 38 U.S.C. 3112, the amount of the reduction under this paragraph." This change restores the words that were inadvertently omitted from 38 CFR 3.25(c)(2).

38 CFR 3.250(d) on remarriage of a parent receiving Dependency and Indemnity Compensation (DIC) contains an incorrect reference to "38 U.S.C. 102(a)(2)." The reference is corrected to read "38 U.S.C. 102(b)(1)".

38 CFR 3.252(a), which concerns annual income limitations in old-law pension cases, contains an incorrect reference to "§3.26(b)". 38 CFR 3.252(a) is changed to show the correct reference for old-law pension, which is 38 CFR 3.26(c).

In 1991 §14(d)(8)(b) of Public Law 102-54 eliminated subsection (e) from 38 U.S.C. 6103. The language that was previously in subsection (e) was included under subsection (b). The authority citation for 38 CFR 3.458(f)(2) is changed from "38 U.S.C. 6103(e)" to "38 U.S.C 6103(b)".

38 CFR 3.100(a), 38 CFR 3.321(b)(1), 3.460(b), 38 CFR 3.461(b)(1), and 38 CFR 3.559(c) are amended to show the current title of the chief officer of the Veterans Benefits Administration. Previously the Under Secretary for Benefits was called the "Chief Benefits Director."

A regulatory change published in the *Federal Register* of June 24, 1985, moved effective date rules for Dependency and Indemnity Compensation (DIC) from 38 CFR 3.400(c)(3) to 38 CFR 3.400(c)(4). 38 CFR 3.702 on DIC is amended to reflect that change in two references to 38 CFR 3.400.

We are amending 38 CFR 3.852 on institutional awards to add authority citations for subparagraphs (a), (c), (d), and (e).

In 1991 §14(d)(8)(b) of Public Law 102-54 eliminated subsection (e) from 38 U.S.C. 6103. The authority citation for 38 CFR 3.901(c) is changed from "38 U.S.C. 6103(e)" to "38 U.S.C 6103". The authority citation for 38 CFR 3.901(d)(3) is changed from "38 U.S.C. 6103(a), (d), (e)" to "38 U.S.C. 6103". The authority citation for 38 CFR 3.902(d)(3) is changed from "38 U.S.C. 6103(d), (e), 6104" to "38 U.S.C. 6104".

38 CFR 3.1612(e)(3) is amended to show the current name of the element within VA which is responsible for furnishing Government headstones and markers. Previously the Office of Memorial Programs was called the "Monument Service."

Section 3.23: Paragraph (d)(5) is amended by revising the authority citation.

Section 3.24: Paragraph (c)(1) is amended by adding words which were inadvertently omitted.

Section 3.25: Paragraph (c) is amended by adding words which were inadvertently omitted.

Section 3.100: Paragraph (a) is amended by substituting "Under Secretary for Benefits" for "Chief Benefits Director."

Section 3.250: Paragraph (d) is amended by correcting a cross-reference.

Section 3.252: Paragraph (a) is amended by correcting a cross-reference.

Section 3.321: Paragraph (b)(1) is amended by substituting "Under Secretary for Benefits" for "Chief Benefits Director."

Section 3.458: Paragraph (f)(2) is amended by revising the authority citation.

Section 3.460: Paragraph (b) is amended by substituting "Under Secretary for Benefits" for "Chief Benefits Director."

Section 3.461: Paragraph (b)(1) is amended by substituting "Under Secretary for Benefits" for "Chief Benefits Director."

Section 3.559: Paragraph (c) is amended by substituting "Under Secretary for Benefits" for "Chief Benefits Director."

Section 3.702: Paragraphs (a) and (b) are amended by correcting cross-references.

Section 3.852: Paragraphs (a), (c), (d), and (e) are amended by revising the authority citations.

Section 3.901: Paragraphs (c) and (d) are amended by revising the authority citations.

Section 3.902: Paragraph (d) is amended by revising the authority citation.

Section 3.1612: Paragraph (e)(3) is amended by substituting "Office of Memorial Programs" for "Monument Service".

REGULATORY AMENDMENT
3-96-5

Regulations Affected: 38 CFR 3.307(a) and 3.309(e)

Effective Date of the Regulation: November 7, 1996

Date Secretary Approved Regulation: October 29, 1996

Federal Register Citation: 61 FR 57586-89 (November 7, 1996)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 3 of the Agent Orange Act of 1991, Pub. L. 102-4, 105 Stat. 11, directed the Secretary to seek to enter into an agreement with the National Academy of Sciences (NAS) to review and summarize the scientific evidence concerning the association between exposure to herbicides used in support of military operations in the Republic of Vietnam during the Vietnam era and each disease suspected to be associated with such exposure. Congress mandated that NAS determine, to the extent possible: (1) whether there is a statistical association between the suspect diseases and herbicide exposure, taking into account the strength of the scientific evidence and the appropriateness of the methods used to detect the association; (2) the increased risk of disease among individuals exposed to herbicides during service in the Republic of Vietnam during the Vietnam era; and (3) whether there is a plausible biological mechanism or other evidence of a causal relationship between herbicide exposure and the suspect disease. Section 3 of Pub. L. 102-4 also required that NAS submit reports on its activities every two years (as measured from the date of the first report) for a ten-year period.

Section 1116(b) of 38 U.S.C., which was added by Pub. L. 102-4, provides that whenever the Secretary determines, based on sound medical and scientific evidence, that a positive association exists between exposure of humans to an herbicide agent (i.e., a chemical in an herbicide used in support of the United States and allied military operations in the Republic of Vietnam during the Vietnam era) and a disease, the Secretary will publish regulations establishing presumptive service connection for that disease. An association is considered "positive" if the credible evidence for the association is equal to or outweighs the credible evidence against the association. In making that determination, the Secretary is to consider the reports received from NAS as well as all other available sound medical and scientific information and analyses.

NAS issued its initial report, entitled "Veterans and Agent Orange: Health Effects of Herbicides Used in Vietnam" (VAO), on July 27, 1993. The Secretary subsequently determined that positive associations exist between exposure to herbicides used in the Republic of Vietnam and the subsequent development of Hodgkin's disease, porphyria cutanea tarda, multiple myeloma and certain respiratory cancers. Final regulations were published in the *Federal Register* on February 3, 1994 (See 59 FR 5106-07) and June 9, 1994 (See 59 FR 29723-24) creating presumptions of service connection for these conditions based on herbicide exposure. Presumptions already existed for chloracne, non-Hodgkin's lymphoma and soft tissue sarcomas.

After reviewing the latest scientific studies and conducting a public meeting, NAS issued a second report, entitled "Veterans and Agent Orange: Update 1996," on March 14, 1996. On the same day, the Secretary announced that VA would review the findings in that second NAS report and pertinent studies to determine whether a positive association exists between herbicide exposure and any condition for which the Secretary has not specifically determined a presumption of service connection is warranted. After that review the Secretary concluded that positive associations exist for prostate cancer and acute and subacute peripheral neuropathy.

Prostate cancer is a very common male cancer which shows marked increased prevalence with age. The 1993 NAS report assigned prostate cancer to a category labeled limited/suggestive evidence of an association. This is defined as meaning there is evidence suggestive of an association between herbicide exposure and a particular health outcome, but that evidence is limited because chance, bias, and

confounding could not be ruled out with confidence. There were statistically significant occupational studies which showed no association between prostate cancer and herbicide exposure. Some occupational studies showed a slight, elevated risk for prostate cancer among farm and forestry workers; a large cohort study of farmers found the risk of prostate cancer among farmers increased with the magnitude of potential herbicide exposure. Upon a review of the evidence then available, the Secretary determined that the credible evidence against an association between prostate cancer and herbicide exposure outweighed the credible evidence for such an association, and he determined that a positive association did not exist.

In its 1996 report NAS, after a thorough review of previously and newly available scientific literature, also assigned prostate cancer to the category labeled limited/suggestive evidence of an association with herbicide exposure, which it defined in the same manner as in the 1993 NAS report (See above). The 1996 NAS report noted several new occupational studies and veteran studies. One study found a statistically significant, slightly increased proportionate cancer mortality ratio (PCMR) for prostate cancer among farmers in 22 of 23 states. Another cancer mortality study evaluated employees of two Dutch companies which produced chlorophenoxy herbicides. Mortality rates from prostate cancer were increased among the exposed men in this study (standardized mortality rate (SMR) = 2.6, confidence interval (CI) 0.5-7.7), although the results were not statistically significant. A mortality study of chemical workers exposed to an accidental release of TCDD in 1949 found an increased risk of prostate cancer death in the exposed workers when compared to the rates in the local population, although, again, the results were not statistically significant. One recent study of Finnish herbicide workers with a median total duration of exposure of six weeks showed no increased risk of death from prostate cancer. Cancer incidence rates after TCDD exposure in the Seveso, Italy, cohort were re-evaluated. The cancer risk in the more highly exposed zones was previously reported to be slightly increased (relative risk (RR) = 1.4, CI 0.5-3.9), although not to a statistically significant degree, but an updated study of the less exposed areas failed to show an increased risk. A proportionate mortality study of Michigan Vietnam veterans showed a nonsignificant, slightly increased rate of death due to genital cancers. Prostate cancer rates were not reported separately in this study.

The large cohort study of Canadian farmers had been previously reviewed by the 1993 NAS report. Although this study found a decreased risk of prostate cancer for the entire cohort, when the cohort was divided into subsets based on suspected herbicide exposure, the study found an increased risk of prostate cancer among those considered most likely to have been exposed (based on amount of herbicides used on the subjects' farms and the lack of hired help or customary expenses for assisting in work). In addition, the study reported an increasing risk with increasing numbers of acres sprayed. Subsequent to the 1993 report, the authors published a letter to the editor containing a reanalysis of their data which supported the findings of an increased risk of prostate cancer and the previously reported dose-response relationship with herbicide exposure. Most of the other occupational and environmental studies indicate some elevation in risk of prostate cancer. Considering all of the evidence, the Secretary has determined that the credible evidence for an association is equal to or outweighs the credible evidence against an association and, therefore, there is a positive association between herbicide exposure and prostate cancer. Accordingly, we are amending 38 CFR 3.309(e) to establish a presumption of service connection based on herbicide exposure for prostate cancer that manifests itself to a degree of 10 percent at any time after exposure. This amendment is effective the date of publication of the final rule, in accordance with 38 U.S.C. 1116(c)(2).

Peripheral neuropathy can be induced by many common medical and environmental disorders unrelated to herbicide exposure, such as alcoholism, diabetes, and exposure to other toxic chemicals. The 1993 NAS report assigned peripheral neuropathy to a category labeled inadequate/insufficient evidence to determine whether an association exists, which was defined as meaning that the available studies were of insufficient quality, consistency, or statistical strength to permit a conclusion regarding the presence or absence of an association with herbicide exposure. NAS stated that many case reports suggested that acute or subacute peripheral neuropathy can develop with exposure to dioxin, but that the most rigorously conducted studies argued against a relationship between dioxin or herbicides and chronic peripheral neuropathy. VAO stated that, as a group, the studies on peripheral neuropathy suffered from various methodologic defects, such as not applying consistent methods to define a comparison group, determine exposure, evaluate clinical deficits, use standard definitions of peripheral neuropathy, or eliminate confounding variables. Occupational studies that did not have those methodological problems

showed no difference in the incidence of peripheral neuropathy for workers exposed to herbicides and workers not so exposed. Accordingly, the Secretary determined that the credible evidence against an association between peripheral neuropathy and herbicide exposure outweighed the credible evidence for such an association, and he determined that a positive association did not exist. The Secretary asked, however, that NAS reconsider in detail the relationship between exposure to herbicides and the development of acute and subacute effects of peripheral neuropathy in the next report.

The 1996 NAS report assigned acute and subacute peripheral neuropathy to the category labeled limited/suggestive evidence of an association with herbicide exposure. However, the 1996 NAS report continued to assign chronic peripheral neuropathy to the category labeled inadequate/insufficient evidence to determine whether an association exists. In response to VA's request to conduct a detailed reconsideration of the relationship between herbicide exposure and the subsequent development of acute and subacute peripheral neuropathy, the 1996 NAS report noted that the methodology used to establish associations between suspected causal agents and persistent chronic peripheral neuropathy relies on epidemiological studies with adequate controls. Such studies can rarely be set in motion with sufficient speed to assess relationships between unexpected chemical exposure and the development of acute or subacute peripheral neuropathy. Because of the transient nature of the conditions, documenting signs and symptoms in association with documented exposures can be difficult to accomplish in a systematic manner. Consequently, greater reliance must be placed on case and less well controlled studies.

Two case studies reported development of peripheral neuropathies within days of exposure to 2,4-D followed by gradual recovery over a period of months. Studies of the Seveso, Italy accident suggested that peripheral nerve problems were more prevalent in the exposed group. One study demonstrated that those individuals with clinical signs of significant exposure (chloracne or elevated liver enzymes) showed a risk ratio of 2.8. Two subsequent follow-up studies showed no increased frequency of peripheral neuropathy several years after the accident among the highly exposed group. Environmental studies and case reports suggest that the development of peripheral neuropathy can follow high levels of exposure to herbicides, and that peripheral neuropathy associated with herbicide exposure will manifest very soon after exposure. The trend to recovery in the individual cases reported and the negative findings of many long-term follow up studies of peripheral neuropathy suggest that, if a neuropathy develops, it resolves with time. Considering all of the evidence, the Secretary has determined that the credible evidence for an association is equal to or outweighs the credible evidence against an association and, therefore, there is a positive association between herbicide exposure and acute and subacute peripheral neuropathy that manifests within one year of exposure.

Since the available evidence indicates that herbicide-related acute and subacute peripheral neuropathy develops shortly after exposure, we have established a manifestation period of one year following exposure to identify all peripheral neuropathies that are associated with herbicide exposure. We have also defined the term "acute and subacute peripheral neuropathy" to mean transient peripheral neuropathy that appears within weeks or months of exposure to an herbicide agent and resolves within two years of the date of onset. The definition differentiates transient peripheral neuropathies, for which the Secretary has found a positive association with herbicide exposure, from chronic peripheral neuropathies, for which he has found no such association.

REGULATORY AMENDMENT
3-96-6

Regulations Affected: 38 CFR 3.204 and 3.213

Effective Date of the Regulation: November 4, 1996

Date Secretary Approved Regulation: October 22, 1996

Federal Register Citation: 61 FR 56626 (November 4, 1996)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 301 of the Veterans' Benefits Improvements Act of 1994, Pub. L. 103-446, authorizes the Secretary of Veterans Affairs to accept the written statement of a claimant as proof of the existence of following relationships between the claimant and another person: marriage, dissolution of a marriage, birth of a child, and death of any family member. The statute further authorizes the Secretary to require documentation in support of the claimant's statement if: (1) The claimant does not reside within a State; (2) the claimant's statement on its face raises a question of its validity; (3) there is conflicting information of record; or (4) there is reasonable indication, in the claimant's statement or otherwise, of fraud or misrepresentation. The Secretary has determined to exercise this discretionary authority.

Accordingly, we have amended 38 CFR 3.204 to require that a claimant's written statement contain the date (month and year) and place of the event, the full name and relationship of the other person to the claimant, and, where the claimant's dependent child does not reside with the claimant, the name and address of the person who has custody of the child. We need this information, which currently must be supplied by an individual claiming additional dependency allowance, not only to make a proper determination of dependency, but also to determine whether or not the claimant's statement is valid or in conflict with other information of record. We are also requiring that a claimant seeking benefits on behalf of a dependent provide the social security number of the dependent in accordance with the provisions of 38 CFR 3.216. We have revised the heading of § 3.204 to reflect its contents more accurately. Finally, in §§ 3.204 and 3.213(a), we have made technical amendments to conform to the substantive changes made, and we have made technical changes in the "Cross References" following §§ 3.205 through 3.214 to conform to the heading revision of § 3.204.

Previously, we promulgated an amendment to the adjudication regulations to allow claimants to submit uncertified photocopies of documents to establish birth, death, marriage, or relationship (59 FR 46337 and 60 FR 46531). That amendment implemented a recommendation of VA's Blue Ribbon Panel on Claims Processing and was intended to reduce delays and improve efficiency in claims processing. This regulation revision will, we believe, further improve timeliness and efficiency.

REGULATORY AMENDMENT
3-96-7

Regulation affected: 38 CFR 3.1(n) and 3.1(y)(4)

EFFECTIVE DATE OF REGULATION: November 4, 1996

Date Secretary approved regulation: September 12, 1996

Federal Register Citation: 61 FR 214 (November 4, 1996)

The purpose of the following comment on the changes included in this amendment of VA regulations is state why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the CFR, the Department of Veterans Affairs amended sections 3.1(n) and 3.1(y)(4) 38 CFR, Part 3, dealing with the definition of "willful misconduct."

We have deleted the Latin terms "malum in se" and "malum prohibitum." Although they are standard legal terms, they serve no purpose here because the definition in §3.1(n) is clear without them.

Also, a note following §3.1(n)(3) previously directed users to §3.1(y)(2)(iii) for a definition of the term "willful misconduct" to determine whether certain veterans met the requirements to be considered former prisoners of war. The correct citation was §3.1(y)(4); however, the definition at §3.1(y)(4) merely duplicated the first sentence of §3.1(n) (without the Latin terms) and all of §3.1(n)(1). It was therefore redundant and we have deleted the last two sentences in §3.1(y)(4) as well as the note following §3.1(n)(3).

REGULATORY AMENDMENT
3-96-8

Regulations Affected: 38 CFR 3.107, 3.315(c), 3.400(d), 3.709, 3.712, 3.961, 3.962 and 3.1000(g)

Effective Date of the Regulation: December 26, 1996

Date Secretary Approved Regulation: November 21, 1996

Federal Register Citation: 61 FR 67949-50 (December 26, 1996)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

38 CFR 3.107 contains requirements for processing benefit awards where claims have not been filed by or on behalf of all dependents who may be entitled to monetary benefits. The heading of § 3.107, "Awards where all dependents do not apply", does not accurately reflect its content and we are revising it to read "Awards where not all dependents apply".

38 CFR 3.315(c)(1)(i) and (ii) require basic eligibility determinations under certain circumstances when veterans apply for education benefits under 38 U.S.C. Chapter 34 and Chapter 32, respectively. Since 38 U.S.C. Chapter 34 expired on December 31, 1989, § 3.315(c)(1)(i) is obsolete and we have removed it. The last date that a veteran seeking benefits under 38 U.S.C. Chapter 32 could have entered active duty and not have the two-year service requirement found in 38 U.S.C. 5303A apply was October 16, 1981. If such a veteran also did not meet the 181-day service requirement, that veteran would have been released from active duty before April 16, 1982, and, if found eligible for benefits under 38 U.S.C. Chapter 32, would have had the period of eligibility expire ten years from the date of release from active duty, or no later than April 16, 1992. If such a veteran made a current application for chapter 32 educational benefits, there would be no need for rating board referral in order to adjudicate that claim. Section 3.315(c)(1)(ii) is therefore obsolete and we have removed it.

The references in § 3.315(c)(4) to Post-Korean and Vietnam era service were needed to administer § 3.315(c)(1)(i). Since § 3.315(c)(1)(i) has been removed, there is no longer any need in § 3.315(c)(4) to refer to service between January 31, 1955, and August 5, 1964, and during the Vietnam era. We have revised § 3.315(c)(4) accordingly. As there is no longer any need to refer to 38 U.S.C. 3452(a) in the authority citation following § 3.315(c), we have removed that reference. Also, that authority citation contains an incorrect reference to "10 U.S.C. 2133(b)". The correct reference is "10 U.S.C. 16133(b)", and we have revised the reference accordingly. Sections 3.315(c)(3)(i) and 3.1000(g) contain incorrect references to "10 U.S.C. Chapter 106". The correct reference is "10 U.S.C. Chapter 1606", and we have revised the references accordingly.

38 CFR 3.400(d) is being deleted because it merely restates a statute and its provisions have become obsolete.

When the Social Security Administration (SSA) has notified the Department of Veterans Affairs (VA) that payments to any individual have been authorized pursuant to section 217(b)(2) of the Social Security Act (42 U.S.C. 417(b)(2)), 38 CFR 3.709 requires VA to notify SSA of any determination that death pension, compensation, or dependency and indemnity compensation is payable to any dependent of the veteran. Section 5117 of Pub. L. 101-508 revised 42 U.S.C. 417(b)(2) so that it applied only to individuals applying for SSA benefits before the end of the 18-month period after the month in which Pub. L. 101-508 was enacted. Since that 18-month period expired on June 1, 1992, 38 CFR 3.709 is obsolete and we have removed it.

38 CFR 3.712(a) concerns the election of improved pension by Spanish-American War veterans. However, there are no Spanish-American War veterans currently receiving monetary benefits from VA. Consequently, § 3.712(a) is no longer required and is removed. Since the remainder of § 3.712 concerns surviving spouses only, we have revised the heading to read "Improved pension elections; surviving

spouses of Spanish-American War veterans", and redesignated paragraphs (b)(1) and (b)(2) as paragraphs (a) and (b), respectively.

Pub. L. 95-588 completely revised the statutory framework for VA pension benefits effective January 1, 1979. 38 CFR 3.961 states that pension claims pending on December 31, 1978, will be adjudicated under title 38 U.S.C. as in effect on December 31, 1978, and that pension claims filed after December 31, 1978, will be adjudicated under title 38 U.S.C. as in effect on January 1, 1979 or thereafter. 38 CFR 3.962 states that claims filed after December 31, 1978, will generally be adjudicated under title 38 U.S.C. as in effect on December 31, 1978, if entitlement is based on permanent and total disability that existed or death that occurred prior to January 1, 1979. Since such claims have long since been adjudicated, §§ 3.961 and 3.962 are obsolete and we have removed them.

REGULATORY AMENDMENT
3-96-9

Regulations affected: 38 CFR 3.101, 3.352 and 14.597

EFFECTIVE DATE OF REGULATION: December 30, 1996

Date Secretary approved regulation: December 9, 1996

Federal Register Citation: 61 FR 68665-6 (December 30, 1996)

The purpose of the following comments on the changes included in this amendment of VA regulations is to state why this change is being made. These comments are not regulatory.

38 CFR 3.101 states that all decisions of the Department of Veterans Affairs will conform to the statutes and regulations of the Department of Veterans Affairs and to the precedent opinions of the General Counsel. That an agency must comply with its governing statutes and its own regulations, which have the force and effect of law, is such a fundamental legal concept that a regulation specifically requiring such compliance is unnecessary.

38 CFR 14.507 indicates that General Counsel opinions designated as precedential will be considered binding on VA officials as legal interpretations of general applicability. This document revises 38 CFR 14.507(b) to more clearly state that precedent opinions are binding on VA officials and employees in subsequent matters involving a legal issue decided by the precedent opinion. Accordingly, there is no need to state separately in part 3 that VA decisions must conform to VA precedent opinions. For the foregoing reasons, this document amends VA adjudication regulations by removing section 3.101.

This document revises 38 CFR 14.507(b) by adding at the end thereof a sentence stating that an opinion designated as a precedent is binding on VA officials and employees in subsequent matters involving a legal issue decided in the precedent opinion, unless there has been a material change in a controlling statute or regulation or the opinion has been overruled or modified by a subsequent precedent opinion or judicial decision. Also, a minor conforming change is made to 38 CFR 14.507(a). These changes merely clarify the provisions of the current regulation.

Currently, 38 CFR 14.507(b) authorizes the VA General Counsel to designate as a ``precedent opinion'' any General Counsel opinion having significance beyond the particular case or matter at issue in the opinion. The term ``precedent'' has a well-established legal meaning indicating an interpretation of law by a competent authority which is considered binding or persuasive in subsequent cases involving the same issue of law. Further, section 14.507(b) currently provides that General Counsel precedent opinions are subject to the provisions of 5 U.S.C. 552(a)(1), which requires Federal agencies to publish in the Federal Register, among other things, ``interpretations of general applicability formulated and adopted by the agency.'' Although section 14.507(b) presently indicates that General Counsel precedent opinions will be generally applicable and binding on VA employees and officials with respect to matters involving the same question of law, we believe it would be helpful to state the binding effect of precedent opinions in clearer terms.

This document also revises the heading of section 3.352 of the adjudication regulations. Currently the heading reads ``Criteria for permanent need for aid and attendance and `permanently bedridden.' '' The heading is revised to read ``Criteria for determining need for aid and attendance and `permanently bedridden.' '' The revised heading more accurately indicates that section 3.352 concerns entitlement to increased pension, compensation, or dependency and indemnity compensation based on an individual's need for the regular aid and attendance of another person without regard to whether or not such need is permanent.

REGULATORY AMENDMENT
3-97-1

Regulation Affected: 38 CFR 3.272(c)

EFFECTIVE DATE OF THE REGULATION: November 29, 1994

Date Secretary Approved Regulation: January 23, 1997

Federal Register Citation: 62 FR 5528 (February 6, 1997)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Under Title 38 United States Code, Chapter 15, eligible veterans may be entitled to nonservice-connected disability pension benefits and eligible surviving spouses and/or children may be entitled to payment of nonservice-connected death pension benefits subject to statutory annual income limitations. In determining annual income under Chapter 15, all payments of any kind or from any source are countable unless specifically excluded by statute. 38 U.S.C. 1503(a)(2) specifically excludes "payments under this chapter," i.e., Chapter 15, from countable income.

Under the provisions of 38 U.S.C. 5121, certain periodic monetary benefits to which an individual was entitled at death under existing ratings or decisions or based on evidence in file at date of death, that are due and unpaid for a period not to exceed two years shall, upon the death of such individual, be paid to certain individuals as set forth in 5121(a).

The United States Court of Veterans Appeals (the Court) has held that, since accrued benefits paid to a veteran's surviving spouse and/or child based on pension benefits owed to a veteran at the time of his or her death are derivative in nature, they are no more than payments of pension under 38 U.S.C. Chapter 15 that VA owed a veteran at the time of death and are, therefore, excludable from countable annual income for VA improved death pension purposes. See *Martin v. Brown*, 7 Vet. App. 196, 199-200 (1994). We have amended 38 CFR 3.272(c) to incorporate this holding of the Court.

REGULATORY AMENDMENT
3-97-2

Regulations Affected: 38 CFR 3.50, 3.51, 3.106, 3.205, 3.214, 3.252, 3.257, 3.262, 3.400, 3.401, 3.666, 3.702, 3.805, 3.857, and 3.1000.

EFFECTIVE DATE OF THE REGULATION: February 6, 1997

Date Secretary Approved Regulation: January 27, 1997

Federal Register Citation: 62 FR 5528 (February 6, 1997)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

This document amends Department of Veterans Affairs (VA) adjudication regulations to replace gender specific language with gender neutral language. The amendments are necessary to conform the adjudication regulations with the VA policy that all of its publications will be stated in a manner that does not seem to preclude benefits for female veterans, dependents or beneficiaries.

This document deletes references throughout 38 CFR Part 3 to "wife," "husband," "widow," or "widower," and replaces them with the terms "spouse" and "surviving spouse." In 38 CFR 3.205(a)(6) "held themselves out as married" has been substituted for "held themselves out as husband and wife." 38 CFR 3.50 is revised to provide a new definition of "spouse" and "surviving spouse" to reflect statutory requirements. Because of this change, it is no longer necessary to define "wife" and "widow." These terms are therefore removed. 38 CFR 3.51 previously provided that the term "wife" includes the husband of a female veteran and the term "widow" includes the widower of a female veteran. Because we have substituted gender neutral terms such as "spouse" and "surviving spouse" for terms such as "wife," "husband," "widow," or "widower" throughout the adjudication regulations, 38 CFR 3.51 is no longer necessary and we have removed it.

REGULATORY AMENDMENT
3-97-3

Regulations affected: 38 CFR 3.12

EFFECTIVE DATE OF REGULATION: March 28, 1997

Date Secretary approved regulation: March 14, 1997

Federal Register Citation: 62 FR 14822-3 (March 28, 1997)

The purpose of the following comments on the changes included in this amendment of VA regulations is to state why this change is being made. These comments are not regulatory.

38 U.S.C. 1110 authorizes the Secretary of Veterans Affairs to compensate veterans for disability resulting from injury or disease incurred or aggravated during active military service provided that the veteran was discharged or released under conditions other than dishonorable from the period of service in which the injury or disease was incurred. 38 U.S.C. 1521(a) authorizes the Secretary to pay non-service-connected disability pension to certain veterans who are permanently and totally disabled from non-service-connected disability.

Regulations at 38 CFR 3.12 implement two distinct statutory provisions governing entitlement to most benefits administered by VA. One provision, 38 U.S.C. 101(2), defines the term "veteran" for purposes of establishing entitlement to benefits as a person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable. The other, 38 U.S.C. 5303, bars the payment of VA benefits to individuals discharged under certain listed circumstances regardless of how they fare under the statutory definition of veteran.

Paragraphs 3.12(g) and (h) implement provisions of Pub. L. 95-126, enacted on October 8, 1977, concerning the effect of certain discharge upgrades and discharge review programs on the definition of veteran and the statutory bars to benefits. This document reorganizes the material in paragraphs (g) and (h) into a format that is simpler to read and understand. The changes are not substantive.

Since these amendments merely reorganize and simplify the current regulation and are not substantive in nature, this change is being promulgated without regard to notice and comment and effective date provisions of 5 U.S.C. 553.

REGULATORY AMENDMENT
3-97-4

Regulations affected: 38 CFR 3.114

EFFECTIVE DATE OF REGULATION: June 12, 1996

Date Secretary approved regulation: February 12, 1997

Federal Register Citation: 62 FR 17706 (April 11, 1997)

The purpose of the following comments on the changes included in this amendment of VA regulations is to state why this change is being made. These comments are not regulatory.

Under the provisions of 38 U.S.C. 5110(a) and 38 CFR 3.400, awards of compensation, pension and dependency and indemnity compensation benefits are generally effective on the date VA receives the claim or the date entitlement arose, whichever is later. However, 38 U.S.C. 5110(g) provides an exception: Where benefits are awarded or increased based on a change in law or an administrative issue, benefits are awarded based on facts found but not earlier than the effective date of the law or issue and not more than one year prior to the earlier of the date of application or administrative determination of entitlement. The purpose of section 5110(g) was to provide a one-year grace period, such as that allowed after service discharge or death, for potential beneficiaries who would otherwise be penalized by not filing promptly.

The implementing regulation for section 5110(g) is 38 CFR 3.114. Section 3.114(a) states that the effective date of an award or increase made pursuant to a liberalizing law or VA issue will be made in accordance with facts found but not earlier than the effective date of the law or administrative issue. It goes on to state that, in order for a claimant to be eligible for a retroactive award, the evidence must show that he or she met all eligibility criteria for the liberalized benefit on the effective date of the liberalizing law or issue and that the eligibility existed continuously from that date to the date of claim or administrative determination of entitlement.

In McCay v. Brown, 9 Vet. App. 183 (1996), the U.S. Court of Veterans Appeals (the Court) noted that both section 5110(g) and Sec. 3.114(a) are silent as to a liberalizing law or issue with a retroactive effective date. The Court stated that the requirement that the claimant must have met all eligibility criteria on the effective date of the law or issue fulfills the intent of section 5110(g) when the liberalizing law is prospective. However, the Court held that, where the liberalizing law has a retroactive effective date, it is not a permissible construction of section 5110(g) and would result in unequal treatment of claimants. This document amends Sec. 3.114(a) to make it clear that that requirement applies only when liberalizing laws or issues take effect on or after the date of enactment or issuance.

REGULATORY AMENDMENT
3-97-5

Regulations Affected: 38 CFR 3.2(f), 3.20, 3.307(a)(6)(i) and (iii), 3.810, 3.1000, and 3.1600(c)

EFFECTIVE DATE OF THE REGULATION: October 9, 1996, except for the amendments to §§ 3.2(f) and 3.307(a)(6), which are effective January 1, 1997. The amendment to 38 CFR 3.20 apply to the deaths of compensation and pension recipients that occur after December 31, 1996. The amendment to 38 CFR 3.1000 applies to claims for accrued benefits based on deaths that occurred before October 9, 1996, and that were not finally decided before then, as well as to claims based on deaths that occurred after then.

Date Secretary Approved Regulation: April 28, 1997

Federal Register Citation: 62 FR 35421-23 (July 1, 1997)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Under the provisions of 38 U.S.C. 1162, VA pays a clothing allowance to each veteran who, because of a service-connected disability, either wears or uses a prosthetic or orthopedic appliance which tends to wear out or tear the veteran's clothing or uses a medication prescribed for a skin condition due to a service-connected disability and which causes irreparable damage to the veteran's outer clothing. Although 38 U.S.C. 5313 limits the amount of compensation or dependency and indemnity compensation that is payable to any person who is incarcerated in a Federal, State, or local penal institution for a period in excess of 60 days for conviction of a felony, there was no such restriction on payment of the clothing allowance.

Section 502 of the Veterans' Benefits Improvements Act of 1996, Pub. L. 104-275, amended 38 U.S.C. Chap. 53 to reduce the amount of the clothing allowance payable under 38 U.S.C. 1162 to veterans who are incarcerated in a Federal, State, or local penal institution for a period in excess of 60 days and who are furnished clothing without charge by the institution. Under this amendment, VA is required to reduce the amount of the clothing allowance by an amount equal to 1/365 of the amount of the allowance otherwise payable for each day on which the veteran was incarcerated during the 12-month period preceding the date on which payment of the clothing allowance would be due. VA has amended 38 CFR 3.810 to reflect this statutory change.

The Vietnam era was defined as the period August 5, 1964, through May 7, 1975, inclusive (See 38 CFR 3.2(f)). Section 505 of Pub. L. 104-275 amended 38 U.S.C. 101(29) to expand the Vietnam era to the period beginning on February 28, 1961, and ending on May 7, 1975, but only for veterans who served in the Republic of Vietnam during that period. Pub. L. 104-275 also amended 38 U.S.C. 1116(a) to expand the period during which veterans must have served in Vietnam to be entitled to the application of certain presumptions relating to exposure to certain herbicide agents and the service connection of associated diseases to the period beginning January 9, 1962, and ending on May 7, 1975. VA has amended 38 CFR 3.2(f) and 3.307(a)(6) to reflect these statutory changes, which are effective January 1, 1997.

Under the provisions of 38 U.S.C. 5310, a veteran's surviving spouse who is entitled to death benefits for the month of the veteran's death gets an amount not less than the amount which the veteran would have received for that month but for his or her death. Section 506 of Pub. L. 104-275 revised 38 U.S.C. 5310 to allow a surviving spouse who is not entitled to death benefits for the month of the veteran's death to receive a benefit in an amount equal to the amount which the veteran would have received for that month but for his or her death. It further provided that a compensation or pension payment issued to a veteran for the month of death shall be treated as being payable to a surviving spouse who is entitled to this new benefit and that if the payment is negotiated or deposited it will be considered as the benefit due the surviving spouse. However, if the payment is less than the amount the veteran would have received for the month of death, the statute requires that the unpaid amount be treated as an accrued benefit (See 38 U.S.C. 5121 and 38 CFR 3.1000). The changes made by section 506 of Pub. L. 104-275

apply to deaths occurring after December 31, 1996. VA has amended 38 CFR 3.20 to reflect these statutory changes.

Under the provisions of 38 U.S.C. 5121, when an individual eligible for VA periodic monetary benefits dies, the amount of benefits due but unpaid at death may be paid either to certain survivors or as a reimbursement to the person who bore the expense of the individual's last illness and burial. The amount of accrued benefits payable was limited to the amount due for a period not to exceed one year prior to the date of death. Section 507 of Pub. L. 104-275 revised this to the amount due for a period not to exceed two years prior to the date of death. VA has amended 38 CFR 3.1000(a) to reflect this statutory change.

Under the provisions of 38 U.S.C. 2303, VA pays burial benefits on behalf of a veteran who dies in a VA facility to which he or she was admitted for hospital, nursing home, or domiciliary care, or who dies in an institution at which he or she was receiving hospital or nursing home care at the expense of the United States at the time of death. Section 212 of Pub. L. 104-275 amended 38 U.S.C. 2303 to provide burial benefits for certain veterans who die in State nursing homes. VA has amended 38 CFR 3.1600(c) to reflect this statutory change, to correct an obsolete reference to 38 U.S.C. 1701(4), and to include within the scope of the term "hospitalized by VA" contract hospital care under 38 U.S.C. 1703. These amendments merely conform the regulations to the governing statutory provisions.

REGULATORY AMENDMENT
3-97-6

Regulations Affected: 38 CFR 3.27(c) and (d), 3.105, 3.158, 3.261, 3.262, 3.263, 3.272, 3.275, 3.403, 3.503, and 3.814

EFFECTIVE DATE OF THE REGULATION: October 1, 1997

Date Secretary Approved Regulation: September 11, 1997

Federal Register Citation: 62 FR 51274-281 (September 30, 1997)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 3 of the Agent Orange Act of 1991, Pub. L. 102-4, 105 Stat. 11, directed the Secretary of Veterans Affairs to seek to enter into an agreement with the National Academy of Sciences (NAS) for a series of reports to review and summarize the scientific evidence concerning the association between exposure to herbicides used in support of military operations in the Republic of Vietnam during the Vietnam era, and each disease suspected to be associated with such exposure. In its most recent report, entitled "Veterans and Agent Orange: Update 1996," which was released on March 14, 1996, NAS noted what it considered "limited/suggestive evidence of an association" between herbicide exposure and spina bifida in the offspring of Vietnam veterans.

Since VA did not have the statutory authority to provide benefits to children of veterans based on birth defects, the Secretary announced on May 28, 1996, that he would seek legislation to provide an appropriate remedy and submitted proposed legislation to Congress in July of that year. Section 421 of Pub. L. 104-204 added a new chapter 18 to title 38, United States Code, authorizing VA to provide certain benefits, including a monthly monetary allowance, to children born with spina bifida who are the natural children of veterans who served in the Republic of Vietnam during the Vietnam era. This document amends existing VA adjudication regulations and adds a new section to title 38, Code of Federal Regulations, to implement this new authority.

Section 1805(c) of title 38, United States Code, specifies that receipt of this allowance shall not affect the right of the child, or the right of any individual, based on the child's relationship to that individual, to receive any other benefit to which the child, or that individual, may be entitled under any law administered by VA, nor will the allowance be considered income or resources in determining eligibility for, or the amount of, benefits under any Federal or federally assisted program. We are amending 38 CFR 3.261, 3.262, 3.263, 3.272, and 3.275 to reflect this statutory provision as it applies to VA's income-based benefit programs.

Section 1806 of title 38, United States Code, provides that the effective date of the monetary allowance to a child under new chapter 18 will be fixed in accordance with the facts found, but will not be earlier than the date of receipt of application. Additionally, 38 U.S.C. 5110(n), which applies to all benefits, provides that the award of benefits by reason of the birth of a child will be effective on the date of birth if VA receives sufficient proof of the event within one year. The effective date of section 421 of Pub. L. 104-204 is October 1, 1997. VA is amending 38 CFR 3.403 to reflect these statutory provisions.

VA is also amending 38 CFR 3.503 to specify that this monetary allowance will terminate the last day of the month before the month in which the death of a child occurs. This date is consistent with the termination provisions of 38 U.S.C. 5112(b) applicable to compensation, pension, and dependency and indemnity compensation benefits administered by VA, and there is no indication in the statute that Congress intended that VA administer this benefit in any different manner. Due to the amendments to 38 CFR 3.403 and 3.503 we are making technical amendments to each cross reference following 38 CFR 3.57, 3.659, 3.703, 3.707, and 3.807.

VA is also amending 38 CFR 3.105 to specify that, where there is a change in disability status warranting a reduction of the monetary allowance, such reduction in evaluation will be effective the last day of the month following sixty days from the date of notice to the recipient (at the recipient's last address of record) of the contemplated reduction. This is the date stipulated by 38 U.S.C. 5112(b)(6) for reduction of disability compensation benefits under the same circumstances. We are not, however, incorporating an additional sixty-day notice such as that provided before reductions of compensation awards under the provisions of 38 CFR 3.105(e). Since reduction of this monetary allowance would generally be based on private medical evidence that the claimant had authorized to be released to VA, and since the rating criteria for this benefit are generally less complex than those for rating compensation claims, in our judgment, 60 days is enough time for claimants to submit evidence showing that the monthly allowance should not be reduced. We are applying the provisions of 38 CFR 3.105(h) concerning the opportunity for a predetermination hearing to reductions of this monetary allowance.

Section 3.158 of title 38, Code of Federal Regulations, describes the circumstances under which VA will consider a claim abandoned. Where evidence requested in connection with a claim is not furnished within one year after the date of request, the claim will be considered abandoned and further action will not be taken unless a new claim is received. Should entitlement be established on the basis of this new claim, benefits are awarded effective not earlier than the date of the filing of the new claim. Where benefit payments have been discontinued because a payee's present whereabouts are unknown, payments will be resumed effective the day following the date of last payment if entitlement is otherwise established, upon receipt of a valid current address. In view of the similarity between this benefit and other monetary benefits which VA administers, and, in order to maintain consistency with respect to the administration of these benefits, we believe it is appropriate to apply these provisions to the monetary monthly allowance for children with spina bifida, and we are amending 38 CFR 3.158 accordingly.

Pursuant to 38 U.S.C. 1805(b)(3), the amount of the monthly monetary allowance payable to a child with spina bifida will be $200, $700, or $1,200, based on the individual's degree of disability. Section 1805(b)(3) also specifies that these amounts are subject to adjustment under the provisions of 38 U.S.C. 5312, which provides for the adjustment of certain VA benefit rates whenever there is an increase in benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.). We amending 38 CFR 3.27 to reflect that statutory provision.

We are adding a new section 3.814 to title 38, Code of Federal Regulations, to implement additional provisions of 38 U.S.C. 1805. If a child with spina bifida is the natural child of two Vietnam veterans, new section 3.814 would make clear that that child may receive only one monthly allowance. This limitation is consistent with the provision of 38 U.S.C. 5304(a)(1) that limits a person to not more than one award of pension, compensation, emergency officers, regular or reserve retirement pay based on his or her own service. Such a limit is appropriate in this instance because a child establishes entitlement to this benefit in his or her own right due to being afflicted with spina bifida, and awarding more than one monthly allowance based on the existence of the same disability would constitute a duplication of benefits similar to that prohibited by 38 U.S.C. 5304(a)(1).

We are requiring an applicant for the monetary allowance to furnish certain information contained on a VA form entitled "Application for Spina Bifida Benefits" which is set forth in full in the text portion of proposed § 3.814(b). The information requested is necessary for making determinations regarding eligibility for monetary allowances. Furnishing the Social Security numbers of the natural parent(s) and the child on whose behalf benefits are sought is not mandatory, given the absence, under current law, of statutory authority that would authorize VA to require this information. Nevertheless, voluntary submission of such Social Security numbers would be helpful to VA in establishing an individual's eligibility for the monetary allowance authorized by law. VA would use the Social Security numbers to: (1) verify that the child's natural parent was a veteran who served in Vietnam during the specified period; (2) identify medical records; and (3) ensure that awards to deceased beneficiaries are terminated in a timely manner to avoid creation of overpayments.

The term "Vietnam veteran" is defined by the statute as a veteran who performed active military, naval, or air service in the Republic of Vietnam during the Vietnam era. We are adopting the statutory language for purposes of new section 3.814. We also are defining the term service in the Republic of Vietnam to include service in the waters offshore and service in other locations if the conditions of

service involved duty or visitation in the Republic of Vietnam. This is consistent with the definition of service in the Republic of Vietnam that appears at 38 CFR 3.307(a)(6)(iii), which sets forth the conditions under which VA presumes that Vietnam veterans were exposed to an herbicide agent during active military service. Since the purpose of this rulemaking is to provide for payment to the children of those same veterans if the children are born with spina bifida, it is appropriate to recognize the same area in which veterans are presumed to have been exposed to herbicides.

The statute defines the term "child" as meaning a natural child of a Vietnam veteran, regardless of age or marital status, who was conceived after the date on which the veteran first entered the Republic of Vietnam during the Vietnam era. In general, the statutes authorizing VA benefits recognize a legitimate child, a legally adopted child, a stepchild who is a member of the veteran's household, or an illegitimate child either acknowledged in writing by the veteran or judicially decreed to be the child of the veteran, as the child of the veteran (See 38 U.S.C. 101(4)(A)). 38 U.S.C. 1801, however, establishes a stricter requirement; in order to be eligible for this benefit a child must be the natural child of a Vietnam veteran. We therefore are requiring that, in order to establish entitlement to this benefit, a claimant must provide the types of evidence specified in 38 CFR 3.209 and 3.210 sufficient to demonstrate in the judgment of the Secretary, that the child on whose behalf benefits are sought is the natural child of a Vietnam veteran.

38 U.S.C. 1805 (b) authorizes VA to make monthly payments at one of three levels based on the degree of disability suffered by the child, as determined in accordance with a schedule for rating such disabilities to be prescribed by the Secretary. Spina bifida is a developmental anomaly characterized by defective closure of the bony encasement of the spinal cord, through which the cord (myelocele), meninges (meningocele), or both (meningomyelocele) may (spina bifida cystica) or may not (spina bifida occulta) protrude (Dorland's Illustrated Medical Dictionary, 27th ed. 1988, 1560 and The Merck Manual, 16th ed. 1992, 2077). Neurological deficit is the main determinant of disability for an individual with spina bifida (Long-term Outcome in Surgically Treated Spina Bifida Cystica, Isao Date, M.D., Yasunori Yagyu, M.D., Shoji Asari, M.D., and Takshi Ohmoto, M.D., Surg. Neurol. 1993, 40:471-5). In our judgment, the neurological manifestations that best define the severity of disability are impairment of: functioning of the extremities; bowel or bladder function; and intellectual functioning.

We are designating levels of disability identified as Level I, II, or III, based on an assessment of these neurologic manifestations in eligible individuals. Each of these neurologic manifestations exhibits three clearly identifiable levels of impairment that can be used in determining levels of payment. Functioning of the lower extremities can be assessed from least to most impaired based on (1) the ability to walk without braces or other external support; (2) the ability to walk only with braces or other external support; or (3) the inability to walk. Functioning of the upper extremities can be assessed from least to most impaired based on (1) absence of sensory or motor impairment; (2) existence of sensory or motor impairment not precluding the ability to grasp a pen, feed one's self, perform self care; and (3) existence of sensory or motor impairment severe enough to preclude the ability to grasp a pen, feed one's self, or perform self care. Bowel or bladder function can be assessed from least to most impaired based upon whether an individual is (1) continent of urine and feces; (2) requires drugs or mechanical means to maintain proper bladder or bowel function; or (3) is completely incontinent of urine or feces.

Intellectual function is ordinarily assessed through the use of any of several standardized tests that determine the intelligence quotient (I.Q.). The average or normal I.Q. range is generally considered to be 90 to 110 ("Comprehensive Textbook of Psychiatry" 497 (Harold I. Kaplan, M.D., and Benjamin J. Sadock, M.D., eds., 5th ed. 1989)). The American Association of Mental Deficiency considers an I.Q. of 69 or less to indicate mental retardation. Between these ranges falls an intermediate group with an I.Q. between 70 and 89, considered to be in the range of dull-normal to borderline mental retardation.

Section 1805(a) authorizes VA to pay a monetary allowance for any disability resulting from spina bifida. We have concluded that any person who has spina bifida, other than spina bifida occulta, suffers some degree of disability. Accordingly, we will rate individuals suffering from spina bifida at Level I (the lowest level of disability) if they are able to walk without braces or other external support (although gait may be impaired), have no motor or sensory impairment of the upper extremities, have an I.Q. of 90 or higher, and are continent of urine and feces. Provided that none of their disabilities due to spina bifida are severe enough to meet the requirements of Level III, we will rate individuals at Level II (the

intermediate level of disability) if they are ambulatory, but only with braces or other external support; or, if they have motor or sensory impairment of the upper extremities but are able to grasp a pen, feed themselves, and perform self care; or, if they have an I.Q. between 70 and 89; or, if they require drugs or intermittent catheterization to maintain proper urinary bladder function, or mechanisms for proper bowel function. We will rate individuals at Level III (the highest level of disability) if they are unable to ambulate; or, if they have motor or sensory impairment of the upper extremities severe enough to preclude grasping a pen, self-care or self-feeding; or, if they have an I.Q. of 69 or less; or, if they are completely incontinent of urine or feces. For a child with spina bifida to be evaluated at Level I, each of any existing neurological disabilities would have to fall into the least impaired range described above. If at least one of the claimant's neurological impairments falls into the middle range, the individual will be rated at Level II. Furthermore, if at least one of the disabilities falls into the highest level of impairment, the individual will be rated at Level III.

Children who are less than one year of age, regardless of whether they suffer from spina bifida, are essentially helpless, incontinent, unable to walk, and too young for I.Q. to be measured. Therefore, the above-noted criteria are not readily applicable as determinants of disability at that age. Therefore, children under the age of one will be rated at Level I, unless a pediatric neurologist or a pediatric neurosurgeon certifies that, in his or her medical judgment, there is a neurological deficit present that will prevent the child from ambulating, grasping a pen, performing self-care, or feeding him or herself because of sensory or motor impairment of the upper extremities, or that will make it impossible for the child to achieve urinary or fecal continence. In our judgment, pediatric neurologists or pediatric neurosurgeons are the only physicians with the expertise in this highly specialized area necessary to assess neurological deficits and their likely prognosis in children under the age of one. If such a deficit is present, the child will be rated at Level III. We also are requiring that VA reassess the level of disability in each child at the age of one year, at which time the effects of spina bifida can more readily be determined.

In some cases, symptoms due to spina bifida do not become manifest for several years. Even if the limbs initially appear totally paralyzed, early training and the use of appliances may allow ambulation in childhood (Brain's Diseases of the Nervous System, revised by John N. Walton, M.D., D.Sc., F.R.C.P., 8th ed., 1977, 777). However, children with lesions at the second lumbar level or higher, even if they become ambulatory in childhood, usually will require wheelchairs in the teenage period. Despite initial bowel or bladder incontinence, most older children, with training and the use of medication or appliances, are able to achieve continence (Diseases of the Nervous System, Arthur K. Asbury, M.D., Guy M. McKhann, M.D., and W. Ian McDonald, Ph.D., F.R.C.P., eds., 1986, 712).

VA will reassess the level of disability due to spina bifida whenever it receives medical evidence indicating that a change is warranted. Nevertheless, we are requiring that VA reassess the level of disability due to spina bifida at intervals of not more than five years until the child has reached the age of 21. Required reassessments will assure that the appropriate level of disability is assigned during the period of time when changes in the disabling effects of spina bifida are most likely to occur. Thereafter, we will reassess the level of disability only if we receive medical evidence indicating a material change in the level of disability or that the current rating may be incorrect. By the time a child is age 21, the condition has generally stabilized and, in our judgment, required reassessments beyond that age will no longer be necessary.

Because VA medical facilities generally provide examination and care only to veterans, VA lacks pediatric examiners, pediatric neurologists, and other pediatric specialists who might participate in the evaluation and care of children with spina bifida. We therefore will accept statements from private physicians, as well as examination reports from government or private institutions, for the purpose of rating spina bifida claims without further examination, provided they are adequate to permit the evaluation of the effects of spina bifida under the criteria proposed above. Because of the critical need to obtain this information in order to assure assignment of an appropriate rating level, we are requiring that individuals seeking or receiving benefits under this provision authorize the release of pertinent medical records to VA and that children for whom VA schedules an examination, whether at a VA facility or by a private health-care provider under contract, report for that examination. Individuals who fail to authorize the release of pertinent medical records or fail to report for examination would be rated at Level I.

For the reasons set forth in the preamble, 38 CFR Part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for Part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. In § 3.27, paragraph (c) is redesignated as paragraph (d), a new paragraph (c) is added, and newly redesignated paragraph (d) and its authority citation are revised to read as follows:

§ 3.27 Automatic adjustment of benefit rates.

* * * * *

(c) Monetary allowance under 38 U.S.C. 1805 for a child suffering from spina bifida who is a child of a Vietnam veteran. Whenever there is a cost-of-living increase in benefit amounts payable under section 215(i) of Title II of the Social Security Act, VA shall, effective on the dates such increases become effective, increase by the same percentage the monthly allowance under 38 U.S.C. 1805 for a child suffering from spina bifida who is a child of a Vietnam veteran.

(Authority: 38 U.S.C. 1805(b)(3))

(d) Publishing requirements. Increases in pension rates, parents' dependency and indemnity compensation rates and income limitation, and the monthly allowance under 38 U.S.C. 1805 for a child suffering from spina bifida made under this section shall be published in the FEDERAL REGISTER.

(Authority: 38 U.S.C. 5312(c)(1), 1805 (b)(3))

3. In § 3.105, paragraphs (g) and (h) are redesignated as paragraphs (h) and (i), respectively; in paragraphs (d), (e), (f) and newly redesignated paragraph (h) remove "paragraph (h)" each time it appears and add, in its place, "paragraph (i)"; in newly redesignated paragraph (i)(1) remove "paragraphs (d) through (g)" and add, in its place, "paragraphs (d) through (h)"; in newly redesignated paragraph (i)(2) introductory text remove "paragraph (d), (e), (f) or (g)" and add, in its place, "paragraph (d), (e), (f), (g) or (h)"; in newly redesignated paragraph (i)(2)(ii) remove "paragraph (f)" and add, in its place, "paragraphs (f) and (g)"; in new redesignated paragraph (i)(2)(iii) remove "paragraph (g)" and add, in its place, "paragraph (h)"; and add a new paragraph (g) to read as follows:

§ 3.105 Revision of decisions.

* * * * *

(g) Reduction in evaluation - monetary allowance to a child suffering from spina bifida under 38 U.S.C. 1805. Where a change in disability level warrants a reduction of the monthly allowance currently being paid, VA will notify the beneficiary at his or her latest address of record of the proposed reduction, furnish detailed reasons therefor, and allow the beneficiary 60 days to present additional evidence to show that the monthly allowance should be continued at the present level. Unless otherwise provided in paragraph (i) of this section, if VA does not receive additional evidence within that period, it will take final rating action and reduce the award effective the last day of the month following sixty days from the date of notice to the payee of the proposed reduction.

(Authority: 38 U.S.C. 501)

* * * * *

[§ 3.158 Amended]

4. In § 3.158, paragraphs (a) and (c) are amended by removing "or dependency and indemnity compensation" and adding, in its place, "dependency and indemnity compensation, or monetary allowance under the provisions of 38 U.S.C. 1805".

5. In § 3.261, paragraph (a)(40) is added to read as follows:

§ 3.261 Character of income; exclusions and estates.

* * * * *

(a) * * *

Income	Dependency (parents)	Dependency and Indemnity compensation (parents)	Pension; old-law (veterans, surviving spouses and children	Pension; section 306 (veterans, surviving spouses and children)	See
(40) Monetary allowance under 38 U.S.C. 1805 for children suffering from spina bifida who are children of Vietnam Veterans. (38 U.S.C. 1805(d))	Excluded	Excluded	Excluded	Excluded	§3.262(y)

* * * * *

6. In § 3.262, paragraph (y) is added immediately preceding the final authority citation at the end of the section to read as follows:

§ 3.262 Exclusions of income.

* * * * *

(y) Monetary allowance under 38 U.S.C. 1805 for a child suffering from spina bifida who is a child of a Vietnam veteran. There shall be excluded from income computation any allowance paid under the provisions of 38 U.S.C. 1805 to a child suffering from spina bifida who is the child of a Vietnam veteran.

(Authority: 38 U.S.C. 1805(d))

7. In § 3.263, paragraph (g) is added to read as follows:

§ 3.263 Corpus of estate; net worth.

* * * * *

(g) Monetary allowance under 38 U.S.C. 1805 for a child suffering from spina bifida who is a child of a Vietnam veteran. There shall be excluded from the corpus of estate or net worth of a claimant any allowance paid under the provisions of 38 U.S.C. 1805 to a child suffering from spina bifida who is the child of a Vietnam veteran.

(Authority: 38 U.S.C. 1805(d))

8. In § 3.272, paragraph (u) is added to read as follows:

§ 3.272 Exclusions from income.

* * * * *

(u) Monetary allowance under 38 U.S.C. 1805 for a child suffering from spina bifida who is a child of a Vietnam veteran. Any allowance paid under the provisions of 38 U.S.C. 1805 to a child suffering from spina bifida who is the child of a Vietnam veteran.

(Authority: 38 U.S.C. 1805(d))

9. In § 3.275, paragraph (i) is added to read as follows:

§ 3.275 Criteria for evaluating net worth.

* * * * *

(i) Monetary allowance under 38 U.S.C. 1805 for a child suffering from spina bifida who is a child of a Vietnam veteran. There shall be excluded from the corpus of estate or net worth of a claimant any allowance paid under the provisions of 38 U.S.C. 1805 to a child suffering from spina bifida who is the child of a Vietnam veteran.

(Authority: 38 U.S.C. 1805(d))

10. In § 3.403, the introductory text and paragraphs (a) through (e) are redesignated as paragraph (a) introductory text and paragraphs (a)(1) through (a)(5), respectively, and paragraph (b) is added to read as follows:

§ 3.403 Children.

* * * * *

(b) Monetary allowance under 38 U.S.C. 1805 for a child suffering from spina bifida who is a child of a Vietnam veteran (§ 3.814). An award of the monetary allowance under 38 U.S.C. 1805 to a child suffering from spina bifida who is the child of a Vietnam veteran will be either date of birth if claim is received within one year of that date, or, date of claim, but not earlier than October 1, 1997.

(Authority: 38 U.S.C. 1806, 5110(n); sec. 422(c), Pub. L. 104-204, 110 Stat. 2926)

11. In § 3.503, the introductory text and paragraphs (a) through (j) are redesignated as paragraph (a) introductory text and paragraphs (a)(1) through (a)(10), respectively, and paragraph (b) is added to read as follows:

§ 3.503 Children.

* * * * *

(b) Monetary allowance under 38 U.S.C. 1805 for a child suffering from spina bifida who is a child of a Vietnam veteran (§ 3.814). The effective date of discontinuance of the monthly allowance under 38 U.S.C. 1805 to a child suffering from spina bifida who is the child of a Vietnam veteran will be the last day of the month before the month in which the death of the child occurred.

(Authority: 38 U.S.C. 501)

12. Section 3.814 is added under the undesignated centerheading "Special Benefits" to read as follows:

§ 3.814 Monetary allowance under 38 U.S.C. 1805 for a child suffering from spina bifida who is a child of a Vietnam veteran.

(a) VA shall pay a monthly allowance based upon the level of disability determined under the provisions of paragraph (d) of this section to or for a child who it has determined is suffering from spina bifida and who is a child of a Vietnam veteran. Receipt of this allowance shall not affect the right of the child, or the right of any individual based on the child's relationship to that individual, to receive any other benefit to which the child, or that individual, may be entitled under any law administered by VA. If a child suffering from spina bifida is the natural child of two Vietnam veterans, he or she is entitled to only one monthly allowance under this section.

(b) Applicants for the monetary allowance under this section must submit an application to the VA regional office and include the information mandated on the following VA form entitled "Application for Spina Bifida Benefits:"

(c) Definitions.

(1) Vietnam veteran. For the purposes of this section, the term "Vietnam veteran" means a veteran who performed active military, naval, or air service in the Republic of Vietnam during the Vietnam era. Service in the Republic of Vietnam includes service in the waters offshore and service in other locations if the conditions of service involved duty or visitation in the Republic of Vietnam.

(2) Child. For the purposes of this section, the term "child" means a natural child of a Vietnam veteran, regardless of age or marital status, conceived after the date on which the veteran first served in the Republic of Vietnam during the Vietnam era. Notwithstanding the provisions of § 3.204(a)(1), VA shall require the types of evidence specified in §§ 3.209 and 3.210 sufficient to establish in the judgment of the Secretary that a child is the natural child of a Vietnam veteran.

(3) Spina bifida. For the purposes of this section, the term "spina bifida" means any form and manifestation of spina bifida except spina bifida occulta.

(d)(1) VA shall determine the level of disability suffered by the child in accordance with the following criteria:

(i) Level I. The child is able to walk without braces or other external support (although gait may be impaired), has no sensory or motor impairment of upper extremities, has an IQ of 90 or higher, and is continent of urine and feces.

(ii) Level II. Provided that none of the child's disabilities are severe enough to be evaluated at Level III, and the child: is ambulatory, but only with braces or other external support; or, has sensory or motor impairment of upper extremities, but is able to grasp pen, feed self, and perform self care; or, has an IQ

of at least 70 but less than 90; or, requires drugs or intermittent catheterization or other mechanical means to maintain proper urinary bladder function, or mechanisms for proper bowel function.

(iii) Level III. The child is unable to ambulate; or, has sensory or motor impairment of upper extremities severe enough to prevent grasping a pen, feeding self, and performing self care; or, has an IQ of 69 or less; or, has complete urinary or fecal incontinence.

(2) Provided that they are adequate for assessing the level of disability due to spina bifida under the provisions of paragraph (d)(1), VA may accept statements from private physicians, or examination reports from government or private institutions, for the purpose of rating spina bifida claims without further examination. In the absence of such information, VA will schedule an examination for the purpose of assessing the level of disability.

(3) Unless or until VA is able to obtain medical evidence adequate to assess the level of disability due to spina bifida, or to reassess the level of disability when required to do so under the provisions of paragraph (d)(4) or (5) of this section, VA will rate the disability of a person eligible for this monetary allowance at no higher than Level I.

(4) Children under the age of one year will be rated at Level I unless a pediatric neurologist or a pediatric neurosurgeon certifies that, in his or her medical judgment, there is a neurological deficit that will prevent the child from ambulating; from grasping a pen, feeding him or herself, or performing self care; or from achieving urinary or fecal continence. If such a deficit is present, the child will be rated at Level III. In either case, VA will reassess the level of disability when the child reaches the age of one year.

(5) VA will reassess the level of disability due to spina bifida whenever it receives medical evidence indicating that a change is warranted. For individuals between the ages of one and twenty-one, however, it will reassess the level of disability at intervals of not more than five years. Thereafter, it will reassess the level of disability only if evidence indicates there has been a material change in the level of disability or that the current rating may be incorrect.

(Authority: 38 U.S.C. 501, 1805)

13. The Cross Reference following § 3.57 is amended by removing "§ 3.403(a)" and "§ 3.503(c)" and adding, in their places, "§ 3.403(a)(1)" and "§ 3.503(a)(3)", respectively.

14. Each Cross Reference following §§ 3.659 and 3.703 is amended by removing "§ 3.503(g)" and adding, in its place, "§ 3.503(a)(7)".

15. The Cross Reference following § 3.707 is amended by removing "§ 3.503(h)" and adding, in its place, "§ 3.503(a)(8)".

16. The Cross Reference following § 3.807 is amended by removing "§ 3.503(h)" and adding, in its place, "§ 3.503(a)(8).".

REGULATORY AMENDMENT

3-98-1

Regulations Affected: 38 CFR 3.811

EFFECTIVE DATE OF THE REGULATION: January 6, 1998

Date Secretary Approved Regulation: December 23, 1997

Federal Register Citation: 63 FR 412-13 (January 6, 1998)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Pub. L. 92-425 provides for payment of a guaranteed minimum annual income (the so-called minimum-income-widow annuity, hereinafter referred to as the minimum income annuity) to certain surviving spouses of persons entitled to military retired or retainer pay at the time of their death. To be eligible, a person must: (1) be the surviving spouse of a military retiree who died on or before March 20, 1974; (2) be eligible for VA nonservice-connected death pension; (3) have annual income that is less than the maximum annual rate of pension under 38 U.S.C. 1541(b); and (4) be ineligible to receive an annuity under the Survivor Benefit Plan (10 U.S.C. 1447-1455).

Section 638 of the National Defense Authorization Act for Fiscal Year 1997, Pub. L. 104-201, transfers responsibility for the payment of the minimum income annuity to the Secretary of Veterans Affairs from the Department of Defense (DoD). However, DoD remains responsible for funding this benefit and determining basic eligibility. In certain instances, the Department of Transportation will determine basic eligibility. This transfer is effective on July 1, 1997, and applies with respect to payments of benefits for any month after June 1997.

Pub. L. 104-201 also provides that the minimum income annuity shall not affect the pension eligibility of the surviving spouse even though, as a result of including the amount of the annuity as pension income, no amount of pension is due. We interpret this provision to mean that an individual is still to be considered "eligible for pension" from VA for purposes of determining basic eligibility for the minimum income annuity even if that individual's income is excessive for VA pension purposes when the minimum income annuity is added to any other countable income.

We have added a new section, 3.811, to title 38, Code of Federal Regulations, to reflect these statutory provisions.

Under DoD procedures (DoD Financial Management Regulation, Chapter 10, 91001), the minimum income annuity is payable to surviving spouses receiving Spanish-American War pension without regard to income. Since the pension paid to survivors of Spanish-American War veterans under 38 U.S.C. 1536 is not an income-based program, we will continue to pay the minimum income annuity to those beneficiaries in the same manner as DoD.

Pub. L. 92-425 as amended specifies that annual income for minimum income annuity purposes is to be determined in the same manner as VA determines income for pension purposes. Consistent with that requirement, we will determine a beneficiary's annual income for the purpose of the minimum income annuity under the provisions of §§ 3.271 and 3.272 for beneficiaries receiving improved pension, or under §§ 3.260 through 3.262 for beneficiaries receiving old law or section 306 pensions, except that the amount of the minimum income annuity will be excluded from the calculation.

38 U.S.C. 5123 requires VA to round down the amounts of section 306 pension and pension payable under 38 U.S.C. 1521, 1541 and 1542 to the nearest dollar. There is no similar requirement in title 10, United States Code, for computing the minimum income annuity. Therefore, we will not round the monthly minimum income benefit to the nearest whole dollar.

Pub. L. 92-425 as amended provides that the amount of the minimum income annuity is calculated by subtracting the income of the surviving spouse, exclusive of VA pension, but including benefits payable under 10 U.S.C. 1431-1436 (Retired Servicemen's Family Protection Plan (RSFPP)) from the maximum annual pension rate under 38 U.S.C. 1541(b). Since RSFPP benefits are countable as income for improved pension purposes, for beneficiaries receiving improved pension, VA will determine the minimum income annuity payment by subtracting the annual income for pension purposes from the maximum annual pension rate under 38 U.S.C. 1541(b).

Since RSFPP benefits are not countable income for old law and section 306 pensions (See 38 CFR 3.261(a)(14)), for beneficiaries receiving old law and section 306 pensions, VA will determine the minimum income annuity payment by reducing the maximum annual pension rate under 38 U.S.C. 1541(b) by the amount of benefits payable under the RSFPP, if any, that the beneficiary receives from DoD, and the annual income for pension purposes.

VA will recompute the monthly minimum income annuity payment whenever there is a change to the maximum annual rate of pension in effect under 38 U.S.C. 1541(b), and whenever there is a change in the beneficiary's income.

Since a beneficiary must be eligible for VA pension in order to be entitled to the minimum income annuity, if the beneficiary's eligibility to nonservice-connected death pension terminates for any reason, VA will terminate the minimum income annuity effective the same date.

For the reasons set forth in the preamble, 38 CFR Part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for Part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. Section 3.811 is added to read as follows:

§ 3.811 Minimum income annuity.

(a) Eligibility. The minimum income annuity authorized by Pub. L. 92-425 as amended is payable to a person:

(1) Who the Department of Defense or the Department of Transportation has determined meets the eligibility criteria of section 4(a) of Pub. L. 92-425 as amended other than section 4(a)(1) and (2); and

(2) Who is eligible for pension under subchapter III of chapter 15 of title 38, United States Code, or section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978; and

(3) Whose annual income, as determined in establishing pension eligibility, is less than the maximum annual rate of pension in effect under 38 U.S.C. 1541(b).

(b) Computation of the minimum income annuity payment.

(1) Annual income. VA will determine a beneficiary's annual income for minimum income annuity purposes under the provisions of §§ 3.271 and 3.272 of this part for beneficiaries receiving improved pension, or under §§ 3.260 through 3.262 of this part for beneficiaries receiving old law or section 306 pensions, except that the amount of the minimum income annuity will be excluded from the calculation.

(2) VA will determine the minimum income annuity payment for beneficiaries entitled to improved pension by subtracting the annual income for minimum income annuity purposes from the maximum annual pension rate under 38 U.S.C. 1541(b).

(3) VA will determine the minimum income annuity payment for beneficiaries receiving old law and section 306 pensions by reducing the maximum annual pension rate under 38 U.S.C. 1541(b) by the amount of the Retired Servicemen's Family Protection Plan benefit, if any, that the beneficiary receives and subtracting from that amount the annual income for minimum income annuity purposes.

(4) VA will recompute the monthly minimum income annuity payment whenever there is a change to the maximum annual rate of pension in effect under 38 U.S.C. 1541(b), and whenever there is a change in the beneficiary's income.

(c) An individual otherwise eligible for pension under subchapter III of chapter 15 of title 38, United States Code, or section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 shall be considered eligible for pension for purposes of determining eligibility for the minimum income annuity even though as a result of adding the amount of the minimum income annuity authorized under Pub. L. 92-425 as amended to any other countable income, no amount of pension is due.

(d) Termination. Other than as provided in paragraph (c) of this section, if a beneficiary receiving the minimum income annuity becomes ineligible for pension, VA will terminate the minimum income annuity effective the same date.

(Authority: Pub. L. 92-425 as amended (10 U.S.C. 1448 note); Sec. 638, Pub. L. 104-201, 110 Stat. 2581)

REGULATORY AMENDMENT

3-98-2

Regulations Affected: 38 CFR 3.7(x)

EFFECTIVE DATE OF THE REGULATION: June 2, 1997

Date Secretary Approved Regulation: December 23, 1997

Federal Register Citation: 63 FR 413 (January 6, 1998)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 401 of Pub. L. 95-202 stated that the service of certain groups that had rendered service to the Armed Forces of the United States in the capacity of civilian employment or contractual service shall be considered active duty for the purposes of all laws administered by VA. In order for members of such a group to be eligible for VA benefits, the Secretary of Defense, or his or her designee, must determine that the service of the group constituted active military service and issue discharges to members of the group.

In the Federal Register of July 7, 1997 (62 FR 36263-64), the Secretary of the Air Force published a notice that she had determined that the service of both U.S. Flight Crew and Aviation Ground Support Employees of Northeast Airlines Atlantic Division, Who Served Overseas as a Result of Northeast Airlines' Contract With the Air Transport Command During the Period December 7, 1941, Through August 14, 1945, and U.S. Civilian Flight Crew and Aviation Ground Support Employees of Braniff Airways, Who Served Overseas in the North Atlantic or Under the Jurisdiction of the North Atlantic Wing, Air Transport Command (ATC), as a Result of a Contract With the ATC During the Period February 26, 1942, Through August 14, 1945, constituted active military service and that members of these groups are entitled to VA benefits. The effective date of the determination by the Secretary of the Air Force was June 2, 1997. VA has amended 38 CFR 3.7(x) to recognize that the service of these groups constitutes active military service for the purposes of laws administered by VA.

Additionally, we have amended the heading and introductory text of 38 CFR 3.7 to make it easier for interested individuals to clearly identify the topic of the regulation from the table of contents.

For the reasons set forth in the preamble, 38 CFR Part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for Part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. In § 3.7, the section heading and introductory text are revised and new paragraphs (x)(29) and (x)(30) are added to read as follows:

§ 3.7 Individuals and groups considered to have performed active military, naval, or air service.

The following individuals and groups are considered to have performed active military, naval, or air service:

* * * * *

(x) * * *

(29) U.S. Flight Crew and Aviation Ground Support Employees of Northeast Airlines Atlantic Division, Who Served Overseas as a Result of Northeast Airlines' Contract With the Air Transport Command During the Period December 7, 1941, Through August 14, 1945.

(30) U.S. Civilian Flight Crew and Aviation Ground Support Employees of Braniff Airways, Who Served Overseas in the North Atlantic or Under the Jurisdiction of the North Atlantic Wing, Air Transport Command (ATC), as a Result of a Contract With the ATC During the Period February 26, 1942, Through August 14, 1945.

(Authority: Sec. 401, Pub. L. 95-202, 91 Stat. 1449)

REGULATORY AMENDMENT
3-98-3

Regulations Affected: 38 CFR 3.317

EFFECTIVE DATE OF THE REGULATION: March 6, 1998
(Applicability date November 2, 1994)

Date Secretary Approved Regulation: February 27, 1998

Federal Register Citation: 63 FR 11122 (March 6, 1998)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

In response to the needs and concerns of Persian Gulf veterans, Congress enacted the "Persian Gulf War Veterans' Benefits Act," Title I of the "Veterans' Benefits Improvements Act of 1994," Pub. L. 103-446. That statute added a new section 1117 to Title 38, United States Code authorizing the Secretary of Veterans Affairs to compensate any Persian Gulf veteran suffering from chronic disability resulting from an undiagnosed illness or combination of undiagnosed illnesses that became manifest either during active duty in the Southwest Asia theater of operations during the Persian Gulf War or to a degree of ten percent or more within a presumptive period, as determined by the Secretary, following service in the Southwest Asia theater of operations during the Persian Gulf War. The statute specified that in establishing a presumptive period the Secretary should review any credible scientific or medical evidence, the historical treatment afforded other diseases for which service connection is presumed, and other pertinent circumstances regarding the experience of Persian Gulf veterans.

In the Federal Register of February 3, 1995, VA published a final rule adding a new section 3.317 to title 39, Code of Federal Regulations to establish the regulatory framework necessary for the Secretary to pay compensation under the authority granted by the Persian Gulf War Veterans' Benefits Act. As part of that rulemaking VA, having determined that there was little or no scientific or medical evidence at that time that would be useful in determining an appropriate presumptive period, established a two-year post-Gulf-service presumptive period based on the historical treatment of disabilities for which manifestation periods had been established and pertinent circumstances regarding the experiences of Persian Gulf veterans as they were then known.

In the Federal Register of April 29, 1997, VA published an interim rule with a request for comments that revised the presumptive period for disabilities due to undiagnosed illnesses suffered by Persian Gulf veterans. As revised, the presumptive period encompasses any such disability that becomes manifest through the year 2001.

For the reasons set forth in the preamble, 38 CFR Part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for Part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

§ 3.317 [Amended]

2. In § 3.317, paragraph (a)(1)(i) is amended by removing "two years after the date on which the veteran last performed military, naval, or air service in the Southwest Asia theater of operations during the Persian Gulf War" and adding in its place, "December 31, 2001".

3. In § 3.317, the authority citation immediately following paragraph (d)(2) is revised to read as follows:

§ 3.317 Compensation for certain disabilities due to undiagnosed illnesses.

* * * * *

Authority: 38 U.S.C. 1117.

REGULATORY AMENDMENT

3-98-4

Regulations Affected: 38 CFR 3.358(a), 3.361, 3.362, 3.363, and 3.800

EFFECTIVE DATE OF THE REGULATION: October 1, 1997

Date Secretary Approved Regulation: May 11, 1998

Federal Register Citation: 63 FR 45004-007 (August 24, 1998)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 1151 of title 38, United States Code, previously authorized the award of compensation or dependency and indemnity compensation for any additional disability or death of a veteran which did not result from the veteran's own willful misconduct but which did result from an injury or aggravation of an injury suffered as the result of hospitalization, medical or surgical treatment, or the pursuit of a course of vocational rehabilitation awarded under any of the laws administered by VA or as a result of having submitted to an examination under any such law. 38 CFR 3.358 and 3.800 contain the regulatory provisions implementing those statutory provisions.

Effective for claims filed on or after October 1, 1997, section 422(a) of Pub. L. 104-204, 110 Stat. 2874, 2926, (1996) amended 38 U.S.C. 1151 to authorize an award of compensation or dependency and indemnity compensation for a veteran's "qualifying additional disability" or "qualifying death." Under 38 U.S.C. 1151 as amended, an additional disability or death qualifies for compensation or dependency and indemnity compensation if it (1) was not the result of the veteran's willful misconduct; (2) was caused by hospital care, medical or surgical treatment, or examination furnished the veteran under any law administered by VA, either by a VA employee or in a VA facility; and (3) was proximately caused by carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault on VA's part in furnishing the care, treatment, or examination or by an event not reasonably foreseeable. An additional disability or death also qualifies for benefits if it was not the result of the veteran's willful misconduct and was proximately caused by VA's provision of training and rehabilitation services as part of an approved rehabilitation program under 38 U.S.C. chapter 31. This document adds new 38 CFR 3.361 to implement 38 U.S.C 1151 as amended, new 38 CFR 3.362 to codify rules concerning the offset of benefits awarded under 38 U.S.C. 1151 if the beneficiary has also recovered damages under the Federal Tort Claims Act, and new 38 CFR 3.363 to consolidate regulatory provisions previously contained in §§ 3.358 and 3.800.

Section 422(b)(2) of Pub. L. 104-204, 110 Stat. 2874, 2927, provides that 38 U.S.C. 1151 as amended shall govern all administrative determinations of eligibility for benefits under 38 U.S.C. 1151 made for claims filed on or after the effective date set forth in section 422(b)(1), which is October 1, 1996. However, section 422(c) of Pub. L. 104-204, 110 Stat. 2874, 2927, provides that, notwithstanding section 422(b)(1) or any other provision of the act, the amendments shall not take effect until October 1, 1997, unless Congress enacts legislation other than Pub. L. 104-204 to provide an earlier effective date. Congress has not enacted such legislation. Therefore, we apply new §§ 3.361 through 3.363 only to claims received by VA on or after October 1, 1997, and continue to apply §§ 3.358 and 3.800 to claims received by VA before October 1, 1997. These applicability rules are reflected in new §§ 3.358(a), 3.361(a), 3.362(a), 3.363(a), and 3.800(a).

New § 3.361(b), concerning additional disability, is derived from § 3.358(b)(1) with appropriate changes made to reflect the amendments made by section 422 of Pub. L. 104-204 and editorial changes made to improve clarity. Similarly, proposed § 3.361(c), concerning cause, is derived from § 3.358(b)(2) and (c)(1).

As amended by section 422 of Pub. L. 104-204, 38 U.S.C. 1151(a)(1) requires for entitlement that a veteran's additional disability or death be proximately caused either by "an event not reasonably foreseeable" or by "carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault" on VA's part in furnishing the hospital care, medical or surgical treatment, or examination that caused the additional disability or death. We believe that Congress, by listing several synonymous terms relating to negligence, intended not to provide alternative standards of liability, but rather to establish a single standard which would trigger entitlement to 38 U.S.C. 1151 benefits if not met in VA's furnishing of hospital care, medical or surgical treatment, or examination. We further believe that the single standard Congress intended to establish is tort-variety negligence. We recognize that there is not a single standard of liability governing tort claims under the Federal Tort Claims Act, but rather that the standard applied may vary from state to state. However, we also believe that Congress did not intend entitlement to a veterans' benefit to depend on a claimant's state of residence. Accordingly, we apply a uniform standard in the adjudication of claims under 38 U.S.C. 1151. Therefore, in new § 3.361(d)(1)(i), we interpret 38 U.S.C. 1151 as providing entitlement to benefits if VA, in furnishing hospital care, medical or surgical treatment, or examination, fails to exercise the degree of care that would be expected of a reasonable health care provider in furnishing hospital care, medical or surgical treatment, or examination.

New § 3.361(d)(1)(ii), concerning consent to care, treatment, or examination, is derived from § 3.358(c)(3). However, we include a requirement that consent be informed, in accordance with 38 CFR 17.32. As reflected in new § 3.361(d)(2), we leave to the factfinder in each claim the determination as to whether the proximate cause of a veteran's additional disability or death was an event not reasonably foreseeable, and for the factfinder, in making that determination, to apply the standard of what a reasonable health care provider would have foreseen. New § 3.361(d)(3), concerning proximate cause by the provision of rehabilitation and training services, is derived from § 3.358(c)(5) with appropriate changes made to reflect the amendments made by section 422 of Pub. L. 104-204 and editorial changes made to improve clarity.

The definition of "Department employee" in new § 3.361(e)(1) is derived from 5 U.S.C. 2105(a), which defines "employee" for title 5 (Government Organization and Employees) purposes, modified to refer only to VA employees who are engaged in the furnishing of health care services. The definition of "Department facility" in new § 3.361(e)(2) reflects a provision of 38 U.S.C. 1151(a) as amended by section 422 of Pub. L. 104-204. 38 U.S.C. 1151(a)(1) refers to "a Department facility as defined in section 1701(3)(A)" of title 38, United States Code. Section 1701(3)(A) defines "facilities of the Department" as facilities over which the Secretary has direct jurisdiction. We therefore define "Department facility" in the same way.

New § 3.361(f)(1) excludes hospital care or medical services furnished pursuant to a contract made under 38 U.S.C. 1703 because, under section 1703's terms, such care or services are furnished in a non-Department facility, and the day-to-day operations of such a facility's employees are not subject to the Secretary's supervision. The exclusion in new § 3.361(f)(2) of nursing home care furnished under 38 U.S.C. 1720 is derived from § 3.358(c)(6). New § 3.361(f)(3) excludes hospital care or medical services provided under 38 U.S.C. 8153 in a facility over which the Secretary does not have direct jurisdiction because care or services under section 8153 are not provided by VA employees, but may or may not be furnished in a VA facility. New § 3.361(f)(3) excludes only such care and services in fact not provided in a VA facility. New § 3.361(g) is derived from § 3.800(b).

New § 3.362(b), concerning the amount of a tort recovery to be offset from a veteran's compensation awarded under 38 U.S.C. 1151(a), is derived from § 3.800(a)(2). New § 3.362(c), concerning the amount of a tort recovery to be offset from a survivor's dependency and indemnity compensation (DIC) awarded under 38 U.S.C. 1151(a), is derived from § 3.800(a)(2) and the Office of the General Counsel precedent opinion (VAOPGCPREC) 79-90. That opinion held that the amount to be offset from a DIC award under 38 U.S.C. 1151 depends on the nature of the damages recovered by the claimant under the Federal Tort Claims Act. Amounts recovered by a claimant as damages under a typical "wrongful-death statute" may be offset from a DIC award under 38 U.S.C. 1151, even if the damages are paid to a nominal party as trustee for the veteran's survivors. Each survivor receiving such damages is subject to offset of DIC under 38 U.S.C. 1151 to the extent of sums included in the tort claim's judgment, settlement, or compromise to compensate for harm suffered by that survivor. On the other hand,

amounts recovered by a claimant, acting as personal representative of a decedent veteran's estate, as damages under a "survival statute" may not be offset from a DIC award under 38 U.S.C. 1151.

New § 3.362(d), concerning offset of structured settlements, is derived from the principles espoused in VAOPGCPREC 79-90. Structured settlements are settlements or compromises in which the Government, rather than simply paying to a plaintiff a sum, in settlement or compromise of a claim under the Federal Tort Claims Act, buys an annuity or otherwise funds payments, which may differ in total amount from the amount expended by the Government, to be made to the plaintiff at some future time. We will offset from a compensation or DIC award only the veteran's or survivor's proportional share of the Government's cost of such a settlement, including the veteran's or survivor's proportional share of attorney fees. Furthermore, the offset begins as soon as compensation or DIC payments are made after the settlement becomes final, not when the settlement payments are actually made to the beneficiary.

New § 3.362, concerning a bar to benefits due to alternative recoveries before December 1, 1962, is derived from § 3.800(a)(3).

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. In § 3.358, the section heading and paragraph (a) are revised to read as follows:

§ 3.358 Compensation for disability or death from hospitalization, medical or surgical treatment, examinations or vocational rehabilitation training (§ 3.800).

(a) General. This section applies to claims received by VA before October 1, 1997. If VA determines that a veteran has an additional disability resulting from a disease or injury or aggravation of an existing disease or injury suffered as a result of training, hospitalization, medical or surgical treatment, or examination, it will pay compensation for such additional disability. For claims received by VA on or after October 1, 1997, see § 3.361.

* * * * *

3. Section 3.361 is added to Subpart A to read as follows:

§ 3.361 Benefits under 38 U.S.C. 1151(a) for additional disability or death due to hospital care, medical or surgical treatment, examination, or training and rehabilitation services.

(a) Claims subject to this section. This section applies to claims received by VA on or after October 1, 1997. This includes original claims and claims to reopen, revise, reconsider, or otherwise readjudicate a previous claim for benefits under 38 U.S.C. 1151 or its predecessors. For claims received by VA before October 1, 1997, see § 3.358.

(b) Determining whether a veteran has an additional disability. To determine whether a veteran has an additional disability, VA compares the veteran's condition immediately before the beginning of the hospital care, medical or surgical treatment, examination, or training and rehabilitation services upon which the claim is based to the veteran's condition after such care, treatment, examination, or services have stopped. VA considers each involved body part or system separately.

(c) Establishing the cause of additional disability or death. (1) Actual causation required. To establish causation, the evidence must show that the hospital care, medical or surgical treatment, or examination

resulted in the veteran's additional disability or death. Merely showing that a veteran received care, treatment, or examination and that the veteran has an additional disability or died is not sufficient to establish cause.

(2) Continuance or natural progress of a disease or injury. Hospital care, medical or surgical treatment, or examination cannot cause the continuance or natural progress of a disease or injury for which the care, treatment, or examination was furnished unless VA's failure to timely diagnose and properly treat the disease or injury proximately caused the continuance or natural progress. The provision of training and rehabilitation services cannot cause the continuance or natural progress of a disease or injury for which the services were provided.

(3) Veteran's failure to follow medical instructions. Additional disability or death caused by a veteran's failure to follow properly given medical instructions is not caused by hospital care, medical or surgical treatment, or examination.

(d) Establishing the proximate cause of additional disability or death. (1) Care, treatment, or examination. To establish that carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault on VA's part in furnishing hospital care, medical or surgical treatment, or examination proximately caused a veteran's additional disability or death, the evidence must show that the hospital care, medical or surgical treatment, or examination caused the veteran's additional disability or death (as explained in paragraph (c) of this section) and

(i) VA failed to exercise the degree of care that would be expected of a reasonable health care provider; or

(ii) VA furnished the hospital care, medical or surgical treatment, or examination without the veteran's or, in appropriate cases, the veteran's representative's informed consent. To determine whether there was informed consent, VA will consider whether the health care providers complied with the requirements of § 17.32 of this chapter. Consent may be express (i.e., given orally or in writing) or implied (i.e., suggested by all the pertinent facts).

(2) Events not reasonably foreseeable. Whether the proximate cause of a veteran's additional disability or death was an event not reasonably foreseeable is to be determined in each claim based on what a reasonable health care provider would have foreseen.

(3) Training and rehabilitation services. To establish that the provision of training and rehabilitation services proximately caused a veteran's additional disability or death, the evidence must show that the veteran's participation in an essential activity or function of the training or services provided or authorized by VA, as part of an approved rehabilitation program under 38 U.S.C. chapter 31, proximately caused the disability or death. It need not show that VA approved that specific activity or function, as long as the activity or function is generally accepted as being a necessary component of the training or services VA provided or authorized.

(e) Department employees and facilities. (1) A Department employee is an individual

(i) who is appointed by the Department in the civil service under title 38, United States Code, or title 5, United States Code, as an employee as defined in 5 U.S.C. 2105;

(ii) who is engaged in furnishing hospital care, medical or surgical treatment, or examinations under authority of law; and

(iii) whose day-to-day activities are subject to supervision by the Secretary of Veterans Affairs.

(2) A Department facility is a facility over which the Secretary of Veterans Affairs has direct jurisdiction.

(f) Activities which are not hospital care, medical or surgical treatment, or examination furnished by a Department employee or in a Department facility. The following are not hospital care, medical or

surgical treatment, or examination furnished by a Department employee or in a Department facility within the meaning of 38 U.S.C. 1151(a):

(1) Hospital care or medical services furnished under a contract made under 38 U.S.C. 1703.

(2) Nursing home care furnished under 38 U.S.C. 1720.

(3) Hospital care or medical services, including examination, provided under 38 U.S.C. 8153 in a facility over which the Secretary does not have direct jurisdiction.

(g) Benefits payable under 38 U.S.C. 1151 for a veteran's death. (1) Death before January 1, 1957. The benefit payable under 38 U.S.C. 1151(a) to an eligible survivor for a veteran's death occurring before January 1, 1957, is death compensation. See §§ 3.5(b)(2) and 3.702 for the right to elect dependency and indemnity compensation.
(2) Death after December 31, 1956. The benefit payable under 38 U.S.C. 1151(a) to an eligible survivor for a veteran's death occurring after December 31, 1956, is dependency and indemnity compensation.

(Authority: 38 U.S.C. 1151)

4. Section 3.362 is added to read as follows:

§ 3.362 Offsets under 38 U.S.C. 1151(b) of benefits awarded under 38 U.S.C. 1151(a).

(a) Claims subject to this section. This section applies to claims received by VA on or after October 1, 1997. This includes original claims and claims to reopen, revise, reconsider, or otherwise readjudicate a previous claim for benefits under 38 U.S.C. 1151 or its predecessors.

(b) Offset of veterans' awards of compensation. If a veteran's disability is the basis of a judgment under 28 U.S.C. 1346(b) awarded, or a settlement or compromise under 28 U.S.C. 2672 or 2677 entered, on or after December 1, 1962, the amount to be offset under 38 U.S.C. 1151(b) from any compensation awarded under 38 U.S.C. 1151(a) is the entire amount of the veteran's share of the judgment, settlement, or compromise, including the veteran's proportional share of attorney fees.

(c) Offset of survivors' awards of dependency and indemnity compensation. If a veteran's death is the basis of a judgment under 28 U.S.C. 1346(b) awarded, or a settlement or compromise under 28 U.S.C. 2672 or 2677 entered, on or after December 1, 1962, the amount to be offset under 38 U.S.C. 1151(b) from any dependency and indemnity compensation awarded under 38 U.S.C. 1151(a) to a survivor is only the amount of the judgment, settlement, or compromise representing damages for the veteran's death the survivor receives in an individual capacity or as distribution from the decedent veteran's estate of sums included in the judgment, settlement, or compromise to compensate for harm suffered by the survivor, plus the survivor's proportional share of attorney fees.

(d) Offset of structured settlements. This paragraph applies if a veteran's disability or death is the basis of a structured settlement or structured compromise under 28 U.S.C. 2672 or 2677 entered on or after December 1, 1962.

(1) The amount to be offset. The amount to be offset under 38 U.S.C. 1151(b) from benefits awarded under 38 U.S.C. 1151(a) is the veteran's or survivor's proportional share of the cost of the settlement or compromise to the United States, including the veteran's or survivor's proportional share of attorney fees.

(2) When the offset begins. The offset of benefits awarded under 38 U.S.C. 1151(a) begins the first month after the structured settlement or structured compromise has become final that such benefits would otherwise be paid.

(Authority: 38 U.S.C. 1151)

5. Section 3.363 is added to read as follows:

§ 3.363 Bar to benefits under 38 U.S.C. 1151.

(a) Claims subject to this section. This section applies to claims received by VA on or after October 1, 1997. This includes original claims and claims to reopen, revise, reconsider, or otherwise readjudicate a previous claim for benefits under 38 U.S.C. 1151 or its predecessors.

(b) Administrative awards, compromises, or settlements, or judgments that bar benefits under 38 U.S.C. 1151. If a veteran's disability or death was the basis of an administrative award under 28 U.S.C. 1346(b) made, or a settlement or compromise under 28 U.S.C. 2672 or 2677 finalized, before December 1, 1962, VA may not award benefits under 38 U.S.C. 1151 for any period after such award, settlement, or compromise was made or became final. If a veteran's disability or death was the basis of a judgment that became final before December 1, 1962, VA may award benefits under 38 U.S.C. 1151 for the disability or death unless the terms of the judgment provide otherwise.

(Authority: 38 U.S.C. 1151)

6. Section 3.800 is amended by adding introductory text to read as follows:

§ 3.800 Disability or death due to hospitalization, etc.

This section applies to claims received by VA before October 1, 1997. For claims received by VA on or after October 1, 1997, see §§ 3.362 and 3.363.
* * * * *

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Final Regulatory Amendment Rescinded

1. A final rule to amend adjudication regulations concerning awards of compensation or dependency and indemnity compensation for additional disability or death due to VA hospital care, medical or surgical treatment, examination, or training and rehabilitation services was published in the Federal Register on August 24, 1998, pages 45004-007, without prior notice and comment. Judicial review has been sought on the basis that the rulemaking required an opportunity for prior notice and comment. As provided in a settlement agreement, a document rescinding the final rule of August 24, 1998, was published in the Federal Register on January 8, 1999, pages 1131-32.

2. We intend to publish provisions similar to those in the rescinded rule as a proposed rule, subject to comment, in a future issue of the Federal Register. The rescinded rule will be considered to have no effect in any claim decided on or after August 24, 1998. Enclosed is a copy of the text of the rescinded regulatory amendment. Please provide copies for the appropriate personnel.

3. Until a new final regulation can be published, claims should be adjudicated under the provisions of 38 U.S.C. 1151 as amended by Pub. L. 104-204 (October 1, 1997). Also enclosed is the text of 38 U.S.C. 1151 as amended October 1, 1997.

4. If you have any questions concerning the final regulatory amendment or this letter, please contact Don England via E-Mail or by telephone at (202) 273-7210.

5. This letter is rescinded effective June 1, 1999.

/s/

Robert J. Epley, Director

Compensation and Pension Service

Enclosures

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. In § 3.358, the section heading and paragraph (a) are revised to read as follows:

§ 3.358 Compensation for disability or death from hospitalization, medical or surgical treatment, examinations or vocational rehabilitation training (§ 3.800).

(a) General. Where it is determined that there is additional disability resulting from a disease or injury or an aggravation of an existing disease or injury suffered as a result of training, hospitalization, medical or surgical treatment, or examination, compensation will be payable for such additional disability.

(Authority: 38 U.S.C. 1151)

* * * * *

§§ 3.361 through 3.363 [Removed]

3. Sections 3.361 through 3.363 are removed.

§ 3.800 [Amended]

4. The introductory text to § 3.800 is removed.

Effective October 1, 1997, Section 1151 is amended pursuant to section 422(a) of Public Law 104-204; 110 Stat. 2926, to read as follows:

§1151. Benefits for persons disabled by treatment or vocational rehabilitation

(a) Compensation under this chapter and dependency and indemnity compensation under chapter 13 of this title shall be awarded for a qualifying additional disability or a qualifying death of a veteran in the same manner as if such additional disability or death were service-connected. For purposes of this section, a disability or death is a qualifying additional disability or qualifying death if the disability or death was not the result of the veteran's willful misconduct and-

(1) the disability or death was caused by hospital care, medical or surgical treatment, or examination furnished the veteran under any law administered by the Secretary, either by a Department employee or in a Department facility as defined in section 1701(3)(A) of this title, and the proximate cause of the disability or death was-

(A) carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault on the part of the Department in furnishing the hospital care, medical or surgical treatment, or examination; or

(B) an event not reasonably foreseeable; or

(2) the disability or death was proximately caused by the provision of training and rehabilitation services by the Secretary (including by a service-provider used by the Secretary for such purpose under section 3115 of this title) as part of an approved rehabilitation program under chapter 31 of this title

(b) Where an individual is, on or after December 1, 1962, awarded a judgment against the United States in a civil action brought pursuant to section 1346(b) of title 28 or, on or after December 1, 1962, enters into a settlement or compromise under section 2672 or 2677 of title 28 by reason of a disability or death treated pursuant to this section as if it were service-connected, then no benefits shall be paid to such individual for any month beginning after the date such judgment, settlement, or compromise on account of such disability or death becomes final until the aggregate amount of benefits which would be paid but for this subsection equals the total amount included in such judgment, settlement, or compromise.

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REGULATORY AMENDMENT
3-98-5

Regulations Affected: 38 CFR 3.311(b)

EFFECTIVE DATE OF THE REGULATION: September 24, 1998

Date Secretary Approved Regulation: June 15, 1998

Federal Register Citation: 63 FR 50993-95 (September 24, 1998)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

The Veterans' Dioxin and Radiation Exposure Compensation Standards Act, Pub. L. 98-542, required VA to develop regulations establishing standards and criteria for adjudicating veterans' claims for service-connected compensation for diseases claimed to be the result of exposure to ionizing radiation. In response to that requirement, VA has defined the term "radiogenic disease" to mean a disease that may be induced by ionizing radiation and established a list of diseases that satisfy that definition at 38 CFR 3.311(b)(2). That list is not an exclusive list, however, and since 1985 VA has added a number of conditions to it.

When the Secretary determines that a significant statistical association exists between exposure to ionizing radiation and any disease under the standards established at 38 CFR 1.17(c), VA adds that disease to the list of radiogenic diseases found at 38 CFR 3.311(b)(2). Before making such a determination, the Secretary receives the advice of the Veterans Advisory Committee on Environmental Hazards (VACEH) based on its evaluation of scientific and medical studies.

On April 25-26, 1995, the VACEH held a public meeting in Washington, DC, and reviewed 53 medical and scientific studies having to do with radiation exposure and subsequent development of disease. Based upon its assessment of those studies and the scientific literature that it had previously reviewed and deemed to be valid, the VACEH concluded that it would be appropriate to consider prostate cancer as being associated with radiation exposure for purposes of VA's compensation system. Based on that recommendation, the Secretary has determined that an association exists between radiation exposure and prostate cancer.

In response to a request from the Under Secretary for Benefits, the VACEH addressed the question of the radiogenicity of cancer generally. The VACEH concluded that, on the basis of current scientific knowledge, exposure to ionizing radiation can be a contributing factor in the development of any malignancy. The degree to which radiation exposure is a factor varies depending on the type of malignancy, the amount, rate and type of radiation exposure, and other relevant risk factors such as age at the time of exposure. After reviewing this recommendation, the Secretary has determined that an association exists between radiation exposure and any other cancer not listed at 38 CFR 3.311(b)(2).

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. In §3.311, paragraph (b)(2)(xxi) is amended by removing "and"; and paragraph (b)(2)(xxii) is amended by removing "." and adding, in its place, ";"; and new paragraphs (b)(2)(xxiii) and (b)(2)(xxiv) are added to read as follows:

§ 3.311 Claims based on exposure to ionizing radiation.

* * * * *

(b) * * *

(2) * * *

(xxiii) Prostate cancer; and

(xxiv) Any other cancer.

* * * * *

REGULATORY AMENDMENT
3-98-6

Regulations Affected: 38 CFR 3.256 and 3.277

EFFECTIVE DATE OF THE REGULATION: October 6, 1998

Date Secretary Approved Regulation: May 18, 1998

Federal Register Citation: 63 FR 53593-96 (October 6, 1998)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

The term "eligibility verification report" means a VA form requesting information, such as income and marital status, that VA needs to determine or verify eligibility for its need-based benefit programs, such as old law pension and section 306 pension. The term "old law pension" means the disability and death pension programs that were in effect on June 30, 1960. The term "section 306 pension" means those disability and death pension programs in effect on December 31, 1978.

Old law and section 306 pension are need-based benefits in that an individual's eligibility for either depends on his or her income being below a certain limit. If an individual's income exceeds the limit, the individual is no longer eligible. Also, the rate of pension paid is affected by the number of dependents the eligible individual has. For these reasons, EVRs request information concerning income and marital status.

Current 38 CFR 3.256(b)(3) requires every old law and section 306 pension recipient, as a condition to continuing to receive pension, to furnish VA an EVR upon request. Current 38 CFR 3.256(b)(2) requires VA to require an EVR under the following circumstances: (i) if the Social Security Administration has not verified the recipient's Social Security number and, if the recipient is married, his or her spouse's Social Security number; (ii) if there is any reason to believe that the recipient or, if the recipient's spouse's income could affect entitlement, his or her spouse may have received income other than Social Security benefits during the current or previous calendar year; or (iii) if the Secretary determines that an EVR is necessary to preserve program integrity. This interim final rule requires VA to require an EVR from an old-law or section-306 pension recipient only if the Secretary determines that an EVR is necessary to preserve program integrity.

VA has determined that it is no longer necessary to require EVRs from old law or section 306 pension recipients solely on the bases described in 38 CFR 3.256(b)(2)(i) and (ii). VA required EVRs in these circumstances to help determine whether the recipient's income exceeded applicable limits. However, the annual income of all old law and section 306 pension recipients has been below applicable limits every year since 1978, and we believe it unlikely that their income will exceed applicable limits in the future. If a recipient's income does exceed the applicable limit, 38 CFR 3.256(a) will still require that he or she promptly notify VA.

Based on these facts, we have determined that it is no longer necessary to require old law and section 306 pension recipients to submit EVRs based on unverified Social Security numbers or suspected additional income.

Requiring fewer EVRs from old law and section 306 pensioners will reduce the reporting burden for these elderly beneficiaries (the average age is 75) without significantly increasing the risk of erroneous pension payments. Because the rates of payment do not change, changes in income have no effect on payments except in the rare instance of income exceeding the income limit. Furthermore, VA has data exchange programs with other agencies such as the Internal Revenue Service, the Social Security Administration, the Railroad Retirement Board, and the Office of Personnel Management. These computer matching programs increase the likelihood that VA will learn of increases in income in those rare instances where the beneficiary failed to report the change. This amendment will also reduce

workload at VA regional offices and enable VA to redirect scarce resources to other types of claims processing.

VA will still require old law and section 306 pensioners to furnish EVRs if it determines that it is necessary to preserve program integrity, which means it is necessary for VA, or an agency with oversight authority over VA, to verify that EVR-exempt beneficiaries are accurately reporting changes in entitlement factors. 38 CFR 3.256 is amended accordingly.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:
PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. Section 3.256 is revised to read as follows:

§ 3.256 Eligibility reporting requirements.

(a) Obligation to report changes in factors affecting entitlement. Any individual who has applied for or receives pension or parents' dependency and indemnity compensation must promptly notify the Secretary in writing of any change affecting entitlement in any of the following:

(1) Income;

(2) Net worth or corpus of estate;

(3) Marital status;

(4) Nursing home patient status;

(5) School enrollment status of a child 18 years of age or older; or

(6) Any other factor that affects entitlement to benefits under the provisions of this Part.

(b) Eligibility verification reports. (1) For purposes of this section the term eligibility verification report means a form prescribed by the Secretary that is used to request income, net worth (if applicable), dependency status, and any other information necessary to determine or verify entitlement to pension or parents' dependency and indemnity compensation.

(2) VA will not require old law or section 306 pensioners to submit eligibility verification reports unless the Secretary determines that doing so is necessary to preserve program integrity.

(3) The Secretary shall require an eligibility verification report from individuals receiving parents' dependency and indemnity compensation under the following circumstances:

(i) If the Social Security Administration has not verified the beneficiary's Social Security number and, if the beneficiary is married, his or her spouse's Social Security number.

(ii) If there is reason to believe that the beneficiary or, if the spouse's income could affect entitlement, his or her spouse may have received income other than Social Security during the current or previous calendar year; or

(iii) If the Secretary determines that an eligibility verification report is necessary to preserve program integrity.

(4) An individual who applies for or receives pension or parents' dependency indemnity compensation as defined in §§ 3.3 or 3.5 of this part shall, as a condition of receipt or continued receipt of benefits, furnish the Department of Veterans Affairs an eligibility verification report upon request.

(c) If VA requests that a claimant or beneficiary submit an eligibility verification report but he or she fails to do so within 60 days of the date of the VA request, the Secretary shall suspend the award or disallow the claim.

(Authority: Sec. 306(a)(2) and (b)(3). Pub. L. 95-588, 92 Stat. 2508-2509; 38 U.S.C. 1315(e))

3. Section 3.277 is republished as follows:

§3.277 Eligibility reporting requirements.

(a) Evidence of entitlement. As a condition of granting or continuing pension, the Department of Veterans Affairs may require from any person who is an applicant for or a recipient of pension such information, proofs, and evidence as is necessary to determine the annual income and the value of the corpus of the estate of such person, and of any spouse or child whom the person is receiving or is to receive increased pension (such child is hereinafter in this section referred to as a dependent child), and, in the case of a child applying for or in receipt of pension in his or her own behalf (hereinafter in this section referred to as a surviving child), of any person with whom such child is residing who is legally responsible for such child's support.

(b) Obligation to report changes in factors affecting entitlement. Any individual who has applied for or receives pension must promptly notify the Secretary in writing of any change affecting entitlement in any of the following:

(1) Income;

(2) Net worth or corpus of estate;

(3) Marital status;

(4) Nursing home patient status;

(5) School enrollment status of a child 18 years of age or older; or

(6) Any other factor that affects entitlement to benefits under the provisions of this Part.

(c) Eligibility verification reports. (1) For purposes of this section the term eligibility verification report means a form prescribed by the Secretary that is used to request income, net worth, dependency status, and any other information necessary to determine or verify entitlement to pension.

(2) The Secretary shall require an eligibility verification report under the following circumstances:

(i) If the Social Security Administration has not verified the beneficiary's Social Security number and, if the beneficiary is married, his or her spouse's Social security number;

(ii) If there is reason to believe that the beneficiary or his or her spouse may have received income other than Social Security during the current or previous calendar year; or

(iii) If the Secretary determines that an eligibility verification report is necessary to preserve program integrity.

(3) An individual who applies for or receives pension as defined in § 3.3 of this part, as a condition of receipt or continued receipt of benefits, furnish the Department of Veterans Affairs an eligibility verification report upon request.

(d) If VA requests that a claimant or beneficiary submit an eligibility verification report but he or she fails to do so within 60 days of the date of the VA request, the Secretary shall suspend the award or disallow the claim.

(Authority: 38 U.S.C. 1506)

REGULATORY AMENDMENT
3-98-7

Regulations Affected: 38 CFR 3.8 11

EFFECTIVE DATE OF THE REGULATION: November 10, 1998

Date Secretary Approved Regulation: October 29, 1998

Federal Register Citation: 63 FR 62943(November 10, 1998)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 645 of the National Defense Authorization Act for Fiscal Year 1998, Pub. L. 105-85, § 645, 111 Stat. 1629, 1801-1802 (1997) (10 U.S.C. 1448 note), transferred responsibility for paying the gratuitous annuity authorized by section 653 of the National Defense Authorization Act, Fiscal Year 1989, Pub. L. 100-456, § 653, 102 Stat. 1918, 1991-1992 (1988), from the Department of Defense (DoD) to the Secretary of Veterans Affairs. However, DoD or the Department of Transportation remains responsible for funding this annuity and determining basic eligibility. This gratuitous annuity, initially in the amount of $165 a month, but since adjusted for changes in the Consumer Price Index, is paid to certain surviving spouses of persons who died before November 1, 1953, and were entitled to retired or retainer pay on the date of death. The statute provides that VA will combine the payment of this gratuitous annuity with the payment of the minimum income annuity authorized by Pub. L. 92-425, § 4, 86 Stat. 706, 712 (1972) (10 U.S.C. 1448 note). Section 638 of the National Defense Authorization Act for Fiscal Year 1997, Pub. L. 104-201, § 638, 110 Stat. 2422, 2581 (1996), transferred responsibility for paying a guaranteed minimum annual income (the so-called minimum-income-widow annuity, or minimum income annuity) to the Secretary of Veterans Affairs from DoD. We have amended 38 CFR 3.811 accordingly.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. In § 3.811, paragraph (d) is redesignated as paragraph (e); and the section heading and the heading for paragraph
(a) are revised, a new paragraph (d) is added, and the authority citation at the end of the section is revised, to read as follows:

§ 3.811 Minimum income annuity and gratuitous annuity.

(a) Eligibility for minimum income annuity. * * *

* * * * *

(d) If the Department of Defense or the Department of Transportation determines that a minimum income annuitant also is entitled to the gratuitous annuity authorized by Pub. L. 100-456 as amended, which is payable to certain surviving spouses of servicemembers who died before November 1, 1953, and were entitled to retired or retainer pay on the date of death, VA will combine the payment of the gratuitous annuity with the minimum income annuity payment.

* * * * *

(Authority: Sec. 4, Pub. L. 92-425, 86 Stat. 706, 712, as amended (10 U.S.C. 1448 note))

REGULATORY AMENDMENT
3-99-1

Regulations Affected: 38 CFR 3.55

EFFECTIVE DATE OF THE REGULATION: October 1, 1998

Date Secretary Approved Regulation: April 14, 1999

Federal Register Citation: 64 FR 30244-45 (June 7, 1999)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. The comments are not regulatory.

A surviving spouse of a veteran must be unmarried to receive VA benefits. The law regarding the eligibility for benefits of a surviving spouse of a veteran who remarries after the veteran's death and whose later remarriage later terminates has changed several times in recent years.

Prior to January 1, 1971, remarriage of a surviving spouse of a deceased veteran was a bar to benefits unless that marriage was void or annulled. Public Law 91-376 amended 38 U.S.C. 103(d) by adding subsections 103(d)(2) and (d)(3) to permit the payment or resumption of payment of benefits to a surviving spouse whose remarriage was terminated by death or divorce, or who had ceased living with another person and holding himself or herself out openly to the public as that person's spouse.

The Omnibus Budget Reconciliation Act of 1990 (Public Law 101-598) deleted 38 U.S.C. 103(d)(2) and (d)(3). The effect of this change was to eliminate VA's authority to reinstate entitlement to death benefits for a surviving spouse who had remarried after the veteran's death unless the marriage was void or annulled, or to reinstate entitlement to death benefits for a surviving spouse who ceased living with another person and holding himself or herself out openly as that person's spouse.

Section 8207 of the Transportation Equity Act for the 21st Century , Public Law 105-178, amended 38 U.S.C. 1311, effective October 1, 1998, to reinstate eligibility for only dependency and indemnity compensation to a surviving spouse of a veteran whose marriage is terminated by death, divorce, or annulment unless VA determines that the divorce or annulment was secured through fraud or collusion. Additionally, Public Law 105-178 reinstates eligibility for dependency and indemnity compensation to a surviving spouse of a veteran who ceases living with another person and holding himself or herself out openly to the public as that person's spouse. 38 CFR is amended accordingly.

For the reason set forth in the preamble, 38 CFR part 3 is amended as follows::

PART 3 - ADJUDICATION

Subpart A - Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. In § 3.55, paragraphs (a)(3) and (a)(4) are re-designated as paragraphs (a)(4) and (a)(6), respectively, and new paragraphs (a)(3) and (a)(5) are added to read as follows:

§ 3.55 Reinstatement of benefits eligibility based upon terminated marital relationships

(a)

(3) On or after October 1, 1998, remarriage of a surviving spouse terminated by death, divorce, or annulment, will not bar the furnishing of dependency and indemnity compensation, unless the Secretary determines that that divorce or annulment was secured through fraud or collusion.

(Authority: 38 U.S.C. 1311(e))

(5) On or after October 1, 1998, the fact that a surviving spouse has lived with another person and has held himself or herself out openly to the public as the spouse of such other person will not bar the furnishing of dependency and indemnity compensation to the surviving spouse if he or she ceases living with such other person and holding himself or herself out openly to the public as such other person's spouse.

(Authority: 38 U.S.C. 1311(e))

REGULATORY AMENDMENT
3-99-2

Regulations Affected: 38 C.F.R. §3.381 and §3.382; 38 C.F.R. §4.149

EFFECTIVE DATE OF THE REGULATION: June 8, 1999

Date Secretary Approved Regulation: April 21, 1999

Federal Register Citation: 64 FR 30392-93 (June 8, 1999)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

38 CFR Part 4, the Schedule for Rating Disabilities, provides evaluations for dental conditions considered disabling in nature. There are, however, other dental conditions which are not considered disabling and consequently do not fall under the purview of the rating schedule. The issue of service connection for these conditions arises only for the purpose of determining eligibility to outpatient dental treatment. These conditions include carious teeth, replaceable missing teeth, dental or alveolar abscesses, periodontal disease, and Vincent's stomatitis (also referred to as Vincent's disease, Vincent's infection, or acute necrotizing gingivitis). These conditions were listed in the former 38 CFR §4.149, in the Schedule for Rating Disabilities. Because these conditions are not evaluated for compensation, but only to determine eligibility for treatment, it is more appropriate to list them in 38 CFR Part 3, which contains general rules for determining service connection. Therefore, §4.149 has been deleted.

Prior to the current revision, §3.381 provided that service connection will be granted for certain dental conditions shown after a "reasonable period of service"; however, this subjective term was not defined. The new rule replaces this subjective term with the objective requirement of 180 days or more of active service in decisions pertaining to service connection for dental conditions that develop over a period of time. Such conditions include dental caries, periodontal disease, and disease of pathology of third molars or teeth in which an existing filling requires replacement. Because these conditions take time to develop, (often a year or two in permanent teeth), it is more likely than not that caries or pathology that become apparent within the first 180 days of service pre-existed that service.

The new rule also eliminates overlapping provisions in 38 CFR §§ 3.381 and 3.382 which did not clearly state requirements for service connection or which appeared to be possibly conflicting. Section 3.381(d) now includes specific rules for determining whether dental conditions that are noted at entry into service and treated during active duty are service connected for treatment purposes. These provisions provide concrete guidelines for decisions related to tooth extractions and restorations, as well as for missing teeth.

Former §3.381(c) which addressed the principle of secondary service connection for dental diseases and injuries was deleted because it was superfluous given the provisions governing secondary service connection already contained in §3.310. Likewise, paragraphs (a) and (b) of §3.382 were deleted because its statements related to the types of evidence needed to establish service connection were redundant of provisions contained elsewhere in the regulations which adequately describe evidence requirements for establishing service connection. (*See* 38 CFR §3.303, §3.304)

Former §3.381(d) specifically stated that the presumption of soundness does not apply to non-compensable dental conditions. While no longer explicitly stated in the revised regulation, the presumption of soundness is clearly inapplicable based on 38 U.S.C. §1110 and §1111. Section 1111 requires VA to consider every veteran
to have been in sound condition at the time of entry except as to defects noted at that time. It specifically references §1110 of Title 38 which applies only to payment of compensation for disability. Section 1111 is therefore not applicable to determining eligibility to outpatient dental treatment under 38 U.S.C. §1712. In addition, §1153 of Title 38 U.S.C. applies only to disabilities. Because non-

compensable dental conditions are not considered to be disabilities, §1153 is also not applicable to 38 U.S.C. §1712 determinations.

The revised rule retains the general principle contained in former §3.381(b) which stated that treatment during service is not considered *per se* aggravation of a dental condition noted as present at the time of entry because such treatment is considered ameliorative. However, the phrase "*per se"* has been deleted and is replaced with a statement that treatment in service is not evidence that a condition noted at entry has been aggravated unless additional pathology developed after 180 days or more of service. This is consistent with the change reflected in §3.381(d) requiring 180 days of active duty service as a prerequisite to considering specified dental conditions as service connected for purposes of treatment.

Paragraph 3.381(e) lists conditions that will not be service connected for treatment purposes, replacing former §3.382(c). Current medical terminology has been used to describe these conditions with "calculus" replacing "salivary deposits," and "periodontal disease" replacing "gingivitis," "Vincent's disease," and "pyorrhea." Impacted or malposed teeth are considered developmental defects as is the presence of third molars (wisdom teeth). These conditions are not service connected unless separate pathology develops after 180 days of active service. The use of the 180-day time period has been explained above. Periodontal disease is related to dental hygiene and can be affected by other factors such as diet, abnormal stress, other disease processes, and reaction to certain drugs or chemicals. With proper treatment, most periodontal disease resolves with no residuals. Therefore, service connection for acute periodontal disease is not subject to service condition in the former rule and remains not subject to service connection in the present rule. However, chronic periodontal disease (formerly described as "Pyorrhea"), which may result in tooth extraction, will warrant service connection for the lost teeth.

For the reasons set forth in the preamble, 38 CFR Part 3 is amended as follows:

1. The Authority citation for part 3 continues to read as follows:

AUTHORITY: 38 U.S. C. 501 (a), unless otherwise noted.

2. Section 3.381 is amended by revising the heading and text to read as follows:

§ 3.381 Service connection of dental conditions for treatment purposes.

(a) Treatable carious teeth, replaceable missing teeth, dental or alveolar abscesses, and periodontal disease will be considered service-connected solely for the purpose of establishing eligibility for
outpatient dental treatment as provided in section 17.161 of this chapter.

(b) The rating activity will consider each defective or missing tooth and each disease of the teeth and periodontal tissues separately to determine whether the condition was incurred or aggravated in line of duty during active service. When applicable, the rating activity will determine whether the condition is due to combat or other in-service trauma, or whether the veteran was interned as a prisoner of war.

(c) In determining service connection, the condition of teeth and periodontal tissues at the time of entry into active duty will be considered. Treatment during service, including filling or extraction of a tooth, or placement
of a prosthesis, will not be considered evidence of aggravation of a condition that was noted at entry, unless additional pathology developed after 180 days or more of active service.

(d) The following principles apply to dental conditions noted at entry and treated during service:

(1) Teeth noted as normal at entry will be service-connected if they were filled or extracted after 180 days or more of active service.

(2) Teeth noted as filled at entry will be service-connected if they were extracted, or if the existing filling was replaced, after 180 days or more of active service.

(3) Teeth noted as carious but restorable at entry will not be service connected on the basis that they were filled during service. However, new caries that developed 180 days or more after such a tooth was filled will be service-connected.

(4) Teeth noted as carious but restorable at entry, whether or not filled, will be service-connected if extraction was required after 1 80 days or more of active service.

(5) Teeth noted at entry as non-restorable will not be service-connected, regardless of treatment during service.

(6) Teeth noted as missing at entry will not be service connected, regardless of treatment during service.

(e) The following will not be considered service-connected for treatment purposes:

(1) calculus;

(2) acute periodontal disease;

(3) third molars, unless disease or pathology of the tooth developed after 180 days or more of active service, or was due to combat or in-service trauma;

(4) impacted or malposed teeth, and other developmental defects, unless disease or pathology of these teeth developed after 180 days or more of active service.

(f) Chronic periodontal disease. Teeth extracted because of chronic periodontal disease will be service-connected only if they were extracted after 180 days or more of active service.

(Authority: 38 U.S.C. 1712)

§ 3.382 Evidence to establish service connection for dental disabilities. [Removed]

3. Section 3.382 is removed and reserved.

PART 4 SCHEDULE FOR RATING DISABILITIES

Dental and Oral Conditions

4. The Authority citation for part 4 continues to read as follows:

AUTHORITY: 38 U.S.C. 11 55.

§ 4.149 Rating diseases of the teeth and gums. [Removed]

5. Section 4.149 is removed and reserved.

REGULATORY AMENDMENT
3-99-3

Regulations Affected: 38 CFR 3.20(b)

EFFECTIVE DATE OF THE REGULATION: June 8, 1999

Date Secretary Approved Regulation: May 21, 1999

Federal Register Citation: 64 FR 30391-92 (June 8, 1999)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 5111(a) of title 38, United States Code, prohibits payment of compensation, pension, or DIC benefits for any period before the first day of the month following the month in which an award or increased award of benefits was effective. In effect, VA generally may not pay first-time or increased benefits for any part of the first calendar month of entitlement. (See also 38 CFR 3.31).

Section 5111(c) provides certain exceptions to the general prohibition in § 5111(a), including the following:

"[Section 5111] shall apply to payments made pursuant to section 5310 of this title only if the monthly amount of [DIC] or pension payable to the surviving spouse is greater than the amount of compensation or pension the veteran would have received, but for such veteran's death, for the month in which such veteran's death occurred." (§ 5111(c)(1))

Section 5310 of title 38, United States Code, provides authority under which VA may pay to a surviving spouse the amount of benefits which the veteran would otherwise have received for the month of his or her death. (When a veteran receiving compensation or pension dies, VA terminates his or her benefit payments effective the last day of the month prior to the month of death. See 38 U.S.C. § 5112(b)(1).) Under § 5310(a), if a surviving spouse is entitled to certain death benefits for the month of the veteran's death, the amount of benefits payable for that month "shall be not less" than the amount of compensation or pension the veteran would have received if he or she had not died.

VA has implemented the provisions of § 5111(c)(1) at 38 C.F.R. §§ 3.20(b) and 3.31(c)(1). In a recent opinion (VAOPGCPREC 10-98), VA's General Counsel indicated that the reference in § 5111(c)(1) to "payments made pursuant to section 5310" means payments made pursuant to what is now § 5310(a). At the time § 5111(c)(1) was enacted, § 5310(b) did not exist, and its subsequent addition to the statute did not affect the intent of § 5111(c)(1). In the same opinion, the General Counsel pointed out that language in 38 C.F.R. 3.20(b) is inconsistent with 38 U.S.C. § 5111(c)(1). Section 5111(c)(1) provides, with respect to payments under § 5310, that payment for the first calendar month of entitlement is prohibited only if the amount of DIC or death pension payable exceeds the amount of compensation or pension that would have been payable to the veteran. Section 3.20(b), however, provides that payment for the first calendar month is permitted only if the amount of compensation or pension that would have been payable to the veteran exceeds the amount of DIC or death pension payable. These two provisions give different results if the amount of DIC or death pension payable equals the amount of compensation or pension that would have been payable to the veteran. In this situation, the statute would allow payment for the month of death, but the regulation would not. To that extent, 38 CFR 3.20(b) is inconsistent with § 5111(c)(1) of the statute.

Accordingly, we are amending § 3.20(b) to make it consistent with the statute. It now provides that a surviving spouse may receive payment for the month of the veteran's death if the veteran's rate of benefits is equal to or greater than the rate of death pension or DIC payable to the surviving spouse.

This final rule simply corrects VA regulations to reflect statutory requirements.

For the reason set forth in the preamble, 38 CFR part 3 is amended as follows::

PART 3 - ADJUDICATION

Subpart A - Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

§ 3.20 [Amended]

2. In § 3.20, the first sentence of paragraph (b) is amended by adding "equal to or" immediately after "if such rate is".

REGULATORY AMENDMENT
3-99-4

Regulations Affected: 38 CFR 3.551(i)

EFFECTIVE DATE OF THE REGULATION: August 5, 1997

Date Secretary Approved Regulation: May 11, 1999

Federal Register Citation: 64 FR 32807 (June 18, 1999)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

Section 8003 of Public Law 101-500 required VA to limit the pension benefits of any veteran having neither spouse nor child and who receives Medicaid-covered nursing home care to no more than $90 per month. This statutory provision expired September 30, 1992. Section 602 of Public Law 102-568 extended the expiration date of that statutory provision until September 30, 1997. In addition, it imposed a similar limitation on payment of death pension to surviving spouses who receive Medicaid-covered nursing home care and have no children. Section 12005 of Public Law 103-66 further extended the expiration date until September 30, 1998 for these limitations on payment of pension benefits to veterans and surviving spouses.

Section 8015 of the balanced Budget Act of 1997, Public Law 105-33, extends the ending date until September 30, 2002.

This document amends 38 CFR 3.551(i) to reflect this statutory change which is effective August 5, 1997, the date of enactment of Public Law 105-33.

This final rule reflects statutory requirements.

For the reason set forth in the preamble, 38 CFR part 3 is amended as follows::

PART 3 - ADJUDICATION

Subpart A - Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

§ 3.551 [Amended]

2. In § 3.551(i) is amended by removing "September 30, 1998" and adding, in its place, "September 30, 2002.

REGULATORY AMENDMENT
3-99-5

Regulation affected: 38 CFR 3.304(f).

EFFECTIVE DATE OF REGULATION: March 7, 1997

Date Secretary Approved Regulation: May 11, 1999

Federal Register Citation: 64 FR 32807 (June 18, 1999)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. The comment is not regulatory.

PTSD is classified by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) as an anxiety disorder resulting from exposure to an extreme traumatic stressor involving direct personal experience of an event that involved actual or threatened death or serious injury or other threat to one's physical integrity; witnessing an event that involved death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror. PTSD is characterized by persistent reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal.

VA regulations at 38 CFR 3.304(f) provide that service connection for PTSD requires medical evidence establishing a clear diagnosis of the condition, credible supporting evidence that the claimed in-service stressor actually occurred, and a link, established by medical evidence, between current symptomatology and the claimed in-service stressor. If the claimed stressor is related to combat, service department evidence that the veteran engaged in combat or that the veteran was awarded the Purple Heart, Combat Infantryman Badge, or similar combat citation will be accepted, in the absence of evidence to the contrary, as conclusive evidence of the claimed in-service stressor.

Section 1154(b) of title 38, United States Code, which is the statutory authority for § 3.304(f), provides that, where a veteran engaged in combat with the enemy, VA must accept as sufficient proof of service-connection for a claimed disease or injury satisfactory lay or other evidence of service incurrence or aggravation of such disease or injury, if consistent with the circumstances, conditions, or hardships of such service, notwithstanding the fact that there is no official record of the incurrence or aggravation of the claimed disease or injury. In Cohen v. Brown, 10 Vet. App. 128 (1997), the Court of Veterans Appeals found a deficiency in § 3.304(f) in that it does not adequately reflect, for the purposes of establishing an in-service stressor, the relaxed adjudicative evidentiary requirements provided by 38 U.S.C. 1154(b) for establishing service incurrence of an event. The Court noted that, although § 3.304(f) states that proof of an in-service stressor that is claimed to be related to combat may be shown by service department evidence that the veteran engaged in combat, or that the veteran received a particular decoration or award, § 3.304(f) does not expressly provide that a combat veteran's lay testimony alone may establish an in-service stressor pursuant to 38 U.S.C. 1154(b). The Court reiterated its conclusion in Zarycki v. Brown, 6 Vet. App. 91, 98 (1993), that, under 38 U.S.C. 1154(b), where it is determined that the veteran engaged in combat with the enemy and the claimed stressor is related to such combat, the veteran's lay testimony regarding the claimed stressor must be accepted as conclusive as to its occurrence and that no further development for corroborative evidence is required, provided that the testimony is "satisfactory" and consistent with the circumstances, conditions, or hardships of the veteran's service. VA has amended § 3.304(f) accordingly to provide that, if a veteran engaged in combat and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, occurrence of the claimed stressor may be established by the veteran's lay testimony alone.

Previously 38 CFR 3.304(f) provided that "service department evidence that the veteran engaged in combat or that the veteran was awarded the Purple Heart, Combat Infantryman Badge, or similar combat citation" was conclusive evidence of the claimed inservice stressor. As the Court stated in Cohen, 38 U.S.C. 1154(b) does not require the acceptance of a veteran's assertion that he was engaged in combat. The determination of combat status is a question to be decided on the basis of the evidence of record in each case. For this reason, we have removed the above cited language. Citations can, of course, still serve as evidence that the veteran engaged in combat.

Additionally, we have amended that portion of § 3.304(f) regarding prisoner-of-war-related stressors in a similar manner. 38 U.S.C. 1154(a) requires that the Secretary include, in regulations pertaining to service-connection for disabilities, provisions requiring that due consideration be given to the places, types, and circumstances of the veteran's military service. POW experience is another type of situation where events often can never be fully documented and therefore warrants the same relaxed adjudication requirements for service connection of PTSD as for those veterans who engaged in combat.

The Court in Cohen v. Brown also pointed out that, although on October 8, 1996, VA issued a final rule amending the Schedule for Rating Disabilities (38 CFR Part 4) pertaining to mental disorders which adopted the nomenclature of DSM-IV (See 61 FR 52695-702), no amendment to § 3.304(f) was made. The Court noted that § 3.304(f) does not specifically set forth any requirements regarding the sufficiency of a stressor and the adequacy of symptomatology to support a diagnosis of PTSD. We have therefore amended § 3.304(f) to require that the medical evidence diagnosing PTSD comply with 38 CFR 4.125(a), which requires that diagnoses of mental disorders conform to DSM-IV.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. In § 3.304, paragraph (f) is revised to read as follows:

§ 3.304 Direct service connection; wartime and peacetime.

* * * * *

(f) Post-traumatic stress disorder. Service connection for post-traumatic stress disorder requires medical evidence diagnosing the condition in accordance with § 4.125(a) of this chapter; a link, established by medical evidence, between current symptoms and an in-service stressor; and credible supporting evidence that the claimed in-service stressor occurred. If the evidence establishes that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, occurrence of the claimed in-service stressor may be established by the veteran's lay testimony alone. If the evidence establishes that the veteran was a prisoner-of-war under the provisions of § 3.1(y) of this part and the claimed stressor is related to that prisoner-of-war experience, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, occurrence of the claimed in-service stressor may be established by the veteran's lay testimony alone.

(Authority: 38 U.S.C. 1154(b))

REGULATORY AMENDMENT
3-99-6

Regulation Affected: 38 CFR 3.1003(b)

EFFECTIVE DATE OF THE REGULATION: October 19, 1996

Date Secretary Approved Regulation: September 14, 1999

Federal Register Citation: 64 FR 54206-54207 (October 6, 1999)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. These comments are not regulatory.

Section 5122 of title 38, United States Code, governs payment of the proceeds of VA benefit check(s) received by a payee but not negotiated before his or her death. VA has implemented § 5122 at 38 CFR 3.1003.

Under section 5122, VA shall upon return and cancellation of an original benefit check pay the amount represented by the check in the same manner as it pays accrued benefits under 38 U.S.C. § 5121. Section 5121 requires VA to pay accrued benefits to the first living person(s) in the following order: (A) veteran's surviving spouse; (B) veteran's surviving children (in equal shares); and (C) veteran's dependent parents (in equal shares). Section 5121 (a) also provides that, "[i]n all other cases," accrued benefits may be paid only as necessary to reimburse the person who bore the expenses of the payee's last sickness and burial. Section 5122 further provides that any amount not paid in this manner shall be paid to the estate of the deceased payee, unless the estate will escheat, i.e., revert to the state because there is no one eligible to inherit it.

Prior to October 19, 1996, § 5122 required settlement by the General Accounting Office (GAO) before payment could be made to an estate. However, § 202(t) of the General Accounting Office Act of 1996, Public Law 104-316, effective October 19, 1996, amended § 5122 to delete reference to settlement by GAO. VA's Office of the General Counsel has advised that under § 5122, VA is now authorized to pay amounts due to the estates of deceased payees without reference to any other agency. We are, therefore, amending 38 CFR 3.1003(b) to bring VA's regulation into conformity with the amended statute by removing reference to settlement by GAO.

We also are amending § 3.1003(b) to replace the legal term "escheat" with the words "revert to the state because there is no one eligible to inherit it." We believe that many will not understand the term "escheat" and have, therefore, chosen to replace it with words that express the same legal meaning but are easier for the general public to understand.
The effective date of this amendment is October 19, 1996, the effective date of § 202(t) of Public Law 104-316.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

§ 3.1003 [Amended]

2. In § 3.1003, paragraph (b) is amended by removing "upon settlement by the General Accounting Office"; and by removing "escheat" and adding, in its place, "revert to the state because there is no one eligible to inherit it".

REGULATORY AMENDMENT
3-00-1

Regulations Affected: 38 CFR 3.22 and 3.54(c)

Effective Date of the Regulation: January 21, 2000

Date Secretary Approved Regulation: September 7, 1999

Federal Register Citation: 65 FR 3388-3392 (January 21, 2000)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. These comments are not regulatory.

History of 38 CFR 3.22

Under chapter 13 of title 38, United States Code, VA is authorized to pay DIC to certain survivors of veterans who died as a result of service-connected disability. In 1978, Congress enacted Pub. L. 95-479, which authorized VA to pay DIC to the survivors of a veteran whose death was not caused by service-connected disability, but who, at the time of death, "was in receipt of (or but for the receipt of retired or retirement pay was entitled to receive)" compensation for a service-connected disability rated 100 percent disabling for 10 years immediately preceding death, or for a period of at least five years extending from date of discharge from service until date of death. That provision was codified in 38 U.S.C. 410(b)(1). In 1979, VA issued 38 CFR 3.22 to implement the statute. (44 Fed. Reg. 22716, 22718 (1979).)

A 1981 opinion by the VA General Counsel (Op. G.C. 2-81) concluded that § 410(b)(1) did not permit a DIC award to the survivors of a veteran who was not actually in receipt of compensation for a total disability for a full ten years prior to death, but who would have been in receipt of such benefits if not for a clear and unmistakable error by VA in a decision rendered during the veteran's lifetime.

In 1982, Congress enacted Pub. L. 97-306, which amended § 410(b)(1) in response to the General Counsel's 1981 decision. The amended statute, now codified at 38 U.S.C. 1318(b), authorized payment of DIC in cases where the veteran "was in receipt of or entitled to receive (or but for the receipt of retired or retirement pay was entitled to receive)" compensation for a service-connected disability rated totally disabling for 10 years immediately preceding death or a period of five years from the date of discharge. The legislative history stated that the purpose of the amendment was "to provide that the requirement that the veteran have been in receipt of compensation for a service-connected disability rated as total for a period of 10 years prior to death (or for 5 years continuously from the date of discharge) is met if the veteran would have been in receipt of such compensation for such period but for a clear and unmistakable error regarding the award of a total disability rating." (Explanatory Statement of Compromise Agreement, 128 Cong. Rec. H7777 (1982), reprinted in 1982 U.S.C.C.A.N. 3012, 3013.)

In 1983, VA revised § 3.22 to state that DIC would be payable under § 410(b)(1) (now § 1318(b)) when the veteran "was in receipt of or for any reason (including receipt of military retired or retirement pay or correction of a rating after the veteran's death based on clear and unmistakable error) was not in receipt of but would have been entitled to receive compensation at the time of death" for service-connected disability rated totally disabling for 10 years prior to death or five years continuously from date of discharge to date of death. (48 Fed. Reg. 41160, 41161 (1983).)

In Wingo v. West, 11 Vet. App. 307 (1998), the United States Court of Appeals for Veterans Claims (CAVC) interpreted § 3.22(a) as permitting a DIC award in a case where the veteran had never established entitlement to VA compensation for a service-connected total disability and had never filed a claim for such benefits which could have resulted in entitlement to compensation for the required period. The CAVC concluded that the language of § 3.22(a) would permit a DIC award where it is determined that the veteran "hypothetically" would have been entitled to a total disability rating for the required period if he or she had applied for compensation during his or her lifetime.

The CAVC's interpretation of § 3.22(a) does not accurately reflect VA's intent in issuing that regulation. Section 1318 of the statute authorizes DIC where the veteran was "in receipt of or entitled to receive" compensation for total service-connected disability for a specified period preceding death. The statute does not authorize VA to award DIC benefits in cases where the veteran merely had hypothetical, as opposed to actual, entitlement to compensation. VA does not have authority to provide by regulation for payment of DIC in a manner not authorized by § 1318. Section 3.22(a) is an interpretive rule that was intended to explain the requirements of § 1318, and not to establish any substantive rights beyond those authorized by § 1318. However, VA acknowledges that the language of § 3.22(a) has apparently caused confusion regarding VA's interpretation of § 1318. Accordingly, VA is revising § 3.22(a) to ensure that it clearly expresses VA's interpretation of § 1318.

Definition of "Entitled to Receive"

In order to clarify the requirements of section 1318, VA is revising section 3.22 to expressly define the statutory term "entitled to receive". VA is defining that term to refer to each specific circumstance where a veteran had a service-connected disability rated totally disabling by VA but was not receiving VA compensation for such disability at the time of death. Those circumstances are as follows.

In certain circumstances, VA may pay a veteran's compensation directly to his or her dependents. (See 38 U.S.C. 1158, 5307, 5308(c).) VA may also withhold a veteran's compensation in order to offset the veteran's indebtedness to the United States arising out of participation in a program administered by VA. (See 38 U.S.C. 5314.) In such cases, where the veteran's compensation is being applied to satisfy an obligation of the veteran, VA believes that the veteran may be considered to have been entitled to receive compensation within the meaning of § 1318.

There are other circumstances in which a veteran who has established entitlement to compensation for disability rated totally disabling by VA may not have been receiving payments of compensation at the time of death. A veteran will be considered to have been entitled to receive compensation for such disability at the time of death if he or she had filed a claim and would have received compensation for the required period but for clear and unmistakable error by VA. Additionally, a veteran will be considered to have been entitled to receive compensation if, at the time of death, the veteran had a service-connected disability (or disabilities) that was rated 100 percent disabling by VA for the required period, but the veteran was not receiving compensation because he or she had not waived military retired or retirement pay, or because VA was withholding payments under certain circumstances. Payments of compensation may be withheld under 10 U.S.C. 1174(h)(2) to offset the amount of certain payments to the veteran from the Department of Defense. It may also be necessary for VA to withhold compensation if the veteran's whereabouts is unknown. Additionally, under 38 U.S.C. 5308, VA may withhold payments to aliens located in the territory of an enemy of the United States or any of its allies. A veteran is entitled to receive payments withheld under § 5308 if it is shown that the veteran was not guilty of mutiny, treason, sabotage, or rendering assistance to an enemy of the United States or its allies (38 U.S.C. 5309). Accordingly, revised § 3.22(b) states that the phrase "entitled to receive" refers to veterans who were not receiving payments at the time of death for one of the reasons stated above.

This definition also reflects VA's conclusion that the language "rated totally disabling" in § 1318 requires that the disability or disabilities have been rated totally disabling by VA. Section 1155 of title 38, United States Code, requires the Secretary of Veterans Affairs to "adopt and apply a schedule of ratings of reductions in earning capacity from specific injuries or combinations of injuries." Under this authority, VA has created its Schedule for Rating Disabilities (38 CFR Part 4). Given the very specific requirements of § 1155 as well as 38 U.S.C. § 1114, which establishes the rates of compensation for the ten levels of disability including disabilities "rated as total" (§ 1114(j)), we believe that the term "rated" as it is used in § 1318 can only mean "rated by VA".

Other changes

New paragraph (c) of § 3.22 is a restatement of material previously contained in paragraph (a). New paragraph (c) provides that a rating based on individual unemployability under 38 CFR 4.16 qualifies as disability rated by VA as totally disabling. New paragraph (d) of § 3.22 provides the criteria for being

considered a surviving spouse for purposes of § 1318 and § 3.22. These criteria are merely a restatement of 38 U.S.C. 1318(c) and 38 CFR 3.54(c)(2). We are simultaneously removing section 3.54(c)(2) as unnecessary. New paragraphs (e) through (h) are redesignations of former paragraphs (b) through (e), respectively.

Title 38 CFR Part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for Part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

[§ 3.22 Amended]

2. In § 3.22, the section heading is revised, paragraph (a) is redesignated as paragraphs (a) through (d) and revised, existing paragraphs (b) through (e) are redesignated as paragraphs (e) through (h), respectively, and redesignated paragraph (f) is revised, to read as follows:

§ 3.22 DIC benefits for survivors of certain veterans rated totally disabled at time of death.

(a) Even though a veteran died of non-service-connected causes, VA will pay death benefits to the surviving spouse or children in the same manner as if the veteran's death were service-connected, if:

(1) the veteran's own willful misconduct did not cause his or her death, and

(2) At the time of death, the veteran was receiving, or was entitled to receive, compensation for service-connected disability that was:

(i) rated by VA as totally disabling for a continuous period of at least 10 years immediately preceding death; or

(ii) rated by VA as totally disabling continuously since the veteran's release from active duty and for at least 5 years immediately preceding death.

(b) For purposes of this section, "entitled to receive" means that at the time of death, the veteran had service-connected disability rated totally disabling by VA but was not receiving compensation because:

(1) VA was paying the compensation to the veteran's dependents;

(2) VA was withholding the compensation under authority of 38 U.S.C. § 5314 to offset an indebtedness of the veteran;

(3) the veteran had applied for compensation but had not received total disability compensation due solely to clear and unmistakable error in a VA decision concerning the issue of service connection, disability evaluation, or effective date;

(4) the veteran had not waived retired or retirement pay in order to receive compensation;

(5) VA was withholding payments under the provisions of 10 U.S.C. § 1174(h)(2);

(6) VA was withholding payments because the veteran's whereabouts was unknown, but the veteran was otherwise entitled to continued payments based on a total service-connected disability rating; or

(7) VA was withholding payments under 38 U.S.C. 5308 but determines that benefits were payable under 38 U.S.C. 5309.

(c) For purposes of this section, "rated by VA as totally disabling" includes total disability ratings based on unemployability (§ 4.16 of this chapter).

(d) To be entitled to benefits under this section, a surviving spouse must have been married to the veteran-

(1) for not less than 1 year immediately preceding the date of the veteran's death; or

(2) for any period of time if a child was born of the marriage, or was born to them before the marriage.

(Authority: 38 U.S.C. 1318)

(e) * * *

(f) *Social security and worker's compensation.* Benefits received under social security or worker's compensation are not subject to recoupment under paragraph (e) of this section even though such benefits may have been awarded pursuant to a judicial proceeding.

(g) * * *

(h) * * *

* * * * *

§ 3.54 [Amended]

3. In § 3.54, paragraph (c)(2) is removed, and paragraphs (c)(1), c(1)(i), (c)(1)(ii), and (c)(1)(iii) are redesignated as paragraphs (c), (c)(1), (c)(2), and (c)(3), respectively.

REGULATORY AMENDMENT
3-00-2

Regulations Affected: 38 CFR 3.57(a) and 3.667

Effective Date of the Regulation: March 8, 2000

Date Secretary Approved Regulation: February 29, 2000

Federal Register Citation: 65 FR 12116-12117 (March 8, 2000)

The purpose of the following summary of this regulatory amendment is to inform all concerned why this change is being made. This summary is not regulatory.

A veteran who is entitled to compensation under the provisions of 38 U.S.C. 1114 or 1134 is also entitled, under certain circumstances, to additional compensation for dependents, including a child. A veteran who is entitled to pension under the provisions of 38 U.S.C. 1521 is entitled to a higher annual rate of pension because of dependents, including a child. Dependency and indemnity compensation and death pension are also monetary benefits affected by the number of the surviving spouse's dependent children. Under certain circumstances, they may be entitled to these benefits in their own right.

A "child" is defined in 38 U.S.C. 101(4)(A)(iii) to include a person who is unmarried, and after attaining the age of eighteen years and until completion of education or training (but not after attaining the age of twenty-three years) is pursuing a course of instruction at an approved educational institution. The implementing regulation is at 38 CFR 3.57(a)(1)(iii).

Section 104(a) of title 38, United States Code, provides that for the purpose of determining whether or not benefits are payable (except those under chapter 35, title 38, United States Code) for a child over the age of eighteen and under the age of twenty-three years who is attending a school, college, academy, seminary, technical institute, university, or other educational institution, the Secretary may approve or disapprove such educational institutions.

In a precedent opinion dated March 19, 1998 (VAOPGCPREC 3-98), VA's General Counsel held that the term "educational institution" should be interpreted as including only institutions which are similar in type to the institutions specifically enumerated in 38 U.S.C. 104(a). According to the General Counsel, a home-school program differs from those institutions because the program is not offered to other students, but rather is created to serve the needs of a particular student. Also, a home-school is not a permanent organization but rather disbands at completion of the student's program or withdrawal of the student. The General Counsel concluded, therefore, that a person who is receiving instruction in a home-school program is not pursuing a course of instruction at an educational institution and therefore does not qualify as a child within the meaning of 38 U.S.C. 101(4)(A)(iii). This document amends 38 CFR 3.57(a)(1)(iii) accordingly. We are also making non-substantive amendments to 38 CFR 3.667.

For the reasons set forth above, 38 CFR part 3 is amended as follows:

PART 3—ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

2. In Sec. 3.57, paragraph (a)(1)(iii) is revised to read as follows:

Sec. 3.57 Child.

(a) * * *

(1) * * *

(iii) Who, after reaching the age of 18 years and until completion of education or training (but not after reaching the age of 23 years) is pursuing a course of instruction at an approved educational institution. For the purposes of this section and Sec. 3.667, the term ``educational institution'' means a permanent organization that offers courses of instruction to a group of students who meet its enrollment criteria. The term includes schools, colleges, academies, seminaries, technical institutes, and universities, but does not include home-school programs.

(Authority: 38 U.S.C. 101(4)(A), 104(a))

* * * * *

Sec. 3.667 [Amended]

3. Section 3.667 is amended by removing ``approved school'' and ``approved course of instruction'' wherever they appear and adding, in their place, ``approved educational institution''.

4. Section 3.667 is further amended as follows:

a. Paragraphs (a)(2) and (a)(4) are amended by removing ``based upon a course which'' and adding, in its place, ``based upon a course of instruction at an approved educational institution which'';

b. The first sentence of paragraph (b) is amended by removing ``attending school'' and adding, in its place, ``attending an approved educational institution''; and

c. The last sentence of paragraph (a)(5) and paragraph (d) are revised to read as follows:

Sec. 3.667 School attendance.

(a) * * *

(5) * * * Where the child was receiving dependency and indemnity compensation in its own right prior to age 18 and was not attending an approved educational institution on the 18th birthday but commences attendance at an approved educational institution after the 18th birthday, payments may be resumed from the commencing date of the course if evidence of such school attendance is filed within 1 year from that date.

* * * * *

(d) Transfers to other schools. When benefits have been authorized based upon school attendance and it is shown that during a part or all of that period the child was pursuing a different course in the same approved educational institution or a course in a different approved educational institution, payments previously made will not be disturbed.

* * * * *

REGULATORY AMENDMENT
3-00-3

Regulations Affected: 38 CFR 3.256 and 3.277

Effective Date of the Regulation: March 30, 2000

Date Secretary Approved Regulation:, February 29, 2000

Federal Register Citation: 65 FR 16827-16828 (March 30, 2000)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

On October 6, 1998, VA published in the Federal Register an interim final rule generally exempting old law and section 306 pension beneficiaries from the requirements to submit annual eligibility verification reports (EVRs). (63 FR 53593-96, October 6 1998.) The term "old law pension" means the disability and death pension programs that were in effect on June 30, 1960. The term "section 306 pension" means those disability and death pension programs that were in effect on December 31, 1978. VA uses EVRs to request information, such as income and marital status, that VA needs to determine or verify eligibility for its need-based benefit programs.

We asked interested persons to submit comments on or before December 7, 1998. We received no comments. Based on the rationale stated in the interim final rule and in this document, we are adopting the interim final rule without change, except that we are adding statements explaining that the information collections are approved by the Office of Management and Budget (OMB) under control number 2900-0101. We also affirm the information in the interim final rule document concerning the Regulatory Flexibility Act.

Title 38 CFR Part 3 is amended as follows:

PART 3—ADJUDICATION

Subpart A—Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A, continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

Secs. 3.256 and 3.277 [Amended]

2. In Secs. 3.256 and 3.277, a parenthetical is added at the end of each section to read as follows:

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0101.)

REGULATORY AMENDMENT
3-00-4

Regulations Affected: 38 C.F.R. §3.29(c), §3.31, §3.114(a), §3.216, §3.814 (c, e, f), §17.901, §17.902, §17.903, §21.8012 and §21.8014.

Effective Date of the Regulation: October 1, 1997

Date Secretary Approved Regulation: February 2, 2000

Federal Register Citation: 65 FR 35280-35283 (June 2, 2000)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. These comments are not regulatory.

Section 421 of Pub. L. 104-204 added a new chapter 18 to title 38, United States Code, authorizing VA to provide certain benefits to children suffering from spina bifida who are the natural children of Vietnam veterans. VA published three sets of regulations to implement the provisions of section 421 of Pub. L. 104-204, i.e. regulations concerning monetary allowances, provision of healthcare, and provision of vocational training and rehabilitation, in the FEDERAL REGISTER of September 30, 1997 (62 FR 51273-296).

Section 404 of Pub. L. 105-114, the Veterans' Benefits Act of 1997, enacted on November 21, 1997, amended chapter 18 of title 38, United States Code. This document revises VA's regulations to implement those statutory amendments. The changes concerning the definition of "Vietnam veteran," the definition of "child," and the submission of social security numbers concern all three sets of regulations. The other changes made by this document only concern the monetary allowance regulations.

Public Law No. 104-204 defined the term "Vietnam veteran" as a "veteran" who performed active military, naval, or air service in the Republic of Vietnam "during the Vietnam era." Public Law No. 105-114 amended that definition to refer to an "individual" who performed active military, naval, or air service in the Republic of Vietnam "during the period beginning on January 9, 1962, and ending on May 7, 1975, without regard to the characterization of the individual's service." We are amending 38 CFR 3.814(c)(1) of the monetary allowance regulations accordingly. This change also affects the spina bifida regulations concerning provision of healthcare (see 38 CFR 17.901) and provision of vocational training and rehabilitation (see 38 CFR 21.8012).

Public Law No. 104-204 defined the term "child" as meaning a natural child of a Vietnam veteran, regardless of age or marital status, who was conceived after the date on which the veteran first entered the Republic of Vietnam "during the Vietnam era." Public Law No. 105-114 amended the definition of "child" by changing "during the Vietnam era" to "during the period beginning on January 9, 1962, and ending on May 7, 1975." We are amending 38 CFR 3.814(c)(2) of the monetary allowance regulations accordingly. This change also affects the spina bifida regulations concerning provision of healthcare (see 38 CFR 17.901) and provision of vocational training and rehabilitation (see 38 CFR 21.8012).

Public Law No. 105-114 revised 38 U.S.C. 1806 so that various administrative provisions of title 38, United States Code, including the following, are applicable to those applying for or receiving spina bifida benefits: 38 U.S.C. 5101(c), 5110(a), 5110(b)(2), 5110(g), 5110(i), 5111, 5112(a), 5112(b)(9), and 5112(b)(10). Accordingly, we are making the following changes.

- We are amending 38 CFR 3.216 to provide that anyone applying for or receiving benefits for a child suffering from spina bifida, as a condition for receipt or continued receipt of benefits, must furnish VA, upon request, his or her social security number, and the social security number of anyone based upon whom benefits are sought or received (38 U.S.C. 5101(c)).

- We are amending 38 CFR 3.814 of the monetary allowance regulations to provide that the effective date of a monthly award for a child suffering from spina bifida based on an original claim, a claim

reopened after final adjudication, or a claim for increase will be fixed in accordance with the facts found, but will not be earlier than the date of receipt of the application for benefits (38 U.S.C. 5110(a)).

- We are amending 38 CFR 3.814 to provide that the effective date of an increased monthly award for a child suffering from spina bifida will be the earliest date as of which it is ascertainable that an increase in disability had occurred, if application is received by VA within one year of that date (38 U.S.C. 5110(b)(2)).

- We are amending 38 CFR 3.114 to provide that any award or increase of a monthly award for a child suffering from spina bifida pursuant to any law or administrative issue will not be effective prior to the effective date of the law or administrative issue and will not be retroactive more than one year from the date of application or the date of administrative determination of entitlement, whichever is earlier (38 U.S.C. 5110(g)).

- We are amending 38 CFR 3.814 to provide that a monthly award for a child suffering from spina bifida benefits based on a disallowed claim reopened on the basis of a correction of military records will be effective on the date application was made for the correction, or the date the disallowed claim was filed, whichever is later, but not retroactive for more than one year from the reopening of the disallowed claim (38 U.S.C. 5110(i)).

- We are amending 38 CFR 3.31 to provide that the payment of a monthly award for a child suffering from spina bifida may not be made for any period before the first day of the month following the month in which the award or increase became effective (38 U.S.C. 5111).

- We are amending 38 CFR 3.814 to provide that the effective date of a reduction or discontinuance of a monthly award for a child suffering from spina bifida will be fixed in accordance with the facts found, that reduction or discontinuance of such benefits by reason of beneficiary error will be the effective date of the award, and that reduction or discontinuance of such benefits by reason of administrative error will be effective as of the date of last payment (38 U.S.C. 5112(a), (b)(9), (b)(10)).

Public Law No. 104-204 provided that the amounts of the monthly monetary allowance to a child with spina bifida are subject to adjustment under the provisions of 38 U.S.C. 5312, which provides for the adjustment of certain VA benefit rates whenever there is an increase in benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.). 38 U.S.C. 5312(c)(2) provides that whenever rates are so increased, the Secretary may round those rates in such manner as the Secretary considers equitable and appropriate. The Secretary has determined that since all other benefits administered under VA's adjudication regulations (38 CFR part 3) are paid in even dollar amounts, for ease of administration it is appropriate to round rate increases concerning the spina bifida monetary benefit.

Under procedures established at 38 CFR 3.29, when adjusting the annual basic benefit rates for the pension programs and parents' dependency and indemnity compensation, if the resulting amounts are not even dollar amounts, VA rounds them to the next higher dollar. In computing monthly rates from the adjusted annual rates, if the resulting amounts are not even dollar amounts, VA rounds to the next lower dollar. Since Pub. L. 104-204 authorized the monetary allowance for spina bifida at a monthly rate rather than an annual rate, it is necessary to round only one time when determining a revised rate. Under 38 CFR 3.29, if rounding is necessary after the first calculation, the resulting rate is always rounded up. We believe therefore that since only one rounding is required to revise the monetary allowance for spina bifida, it is both equitable and appropriate to round up. We are amending § 3.29 accordingly.

Public Law No. 105-114 provides that the amendments to chapter 18 of title 38, United States Code, are effective as of October 1, 1997.

Title 38 CFR parts 3, 17, and 21 are amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. In § 3.29, paragraph (c) is added, to read as follows:

§ 3.29 Rounding.

* * * * *

(c) Monthly rates under 38 U.S.C. 1805. When increasing the monthly monetary allowance rates under § 3.814 for children suffering from spina bifida (see § 3.27(c)), VA will round any resulting rate that is not an even dollar amount to the next higher dollar.

(Authority: 38 U.S.C. 1805(b)(3), 5312(c)(2))

3. Section 3.31 is amended as follows:

a. The introductory text is amended in the first sentence by removing "compensation, pension or dependency and indemnity compensation" and adding, in its place, "compensation, pension, dependency and indemnity compensation, or the monetary allowance under 38 U.S.C. 1805 for a child suffering from spina bifida who is a child of a Vietnam veteran"; and

b. Paragraph (c)(4)(ii) and the authority citation at the end of the section are revised to read as follows:

§ 3.31 Commencement of the period of payment.

* * * * *

(c) * * *

(4) * * *

(ii) Increases in Improved Pension, parents' dependency and indemnity compensation, or the monetary allowance for children suffering from spina bifida pursuant to § 3.27, or

* * * * *

(Authority: 38 U.S.C. 1806, 5111)

4. Section 3.114 is amended as follows:

a. Paragraph (a) introductory text is amended by removing "Where pension, compensation, or dependency and indemnity compensation" in each place it appears and adding, in its place, "Where pension, compensation, dependency and indemnity compensation, or the monetary allowance under 38 U.S.C. 1805 for a child suffering from spina bifida who is a child of a Vietnam veteran"; and

b. The authority citation at the end of paragraph (a) is revised to read as follows:

§ 3.114 Change of law or Department of Veterans Affairs issue.

* * * * *

(Authority: 38 U.S.C. 1806, 5110(g))

* * * * *

5. In § 3.216, the section heading is amended by removing "number" and adding, in its place, "numbers"; the first sentence is amended immediately following "of this part" by adding ", or the monetary allowance for a child suffering from spina bifida who is a child of a Vietnam veteran under § 3.814 of this part,"; and the authority citation is revised to read as follows:

§ 3.216 Mandatory disclosure of social security numbers.

* * * * *

(Authority: 38 U.S.C. 1806, 5101(c))

6. Section 3.814 is amended as follows:

a. Paragraph (c)(1) is amended by removing "a veteran" and adding, in its place, "an individual"; by removing "during the Vietnam era" and adding, in its place, "during the period beginning on January 9, 1962, and ending on May 7, 1975, without regard to the characterization of the individual's service";

b. Paragraph (c)(2) is amended by removing "during the Vietnam era" and adding, in its place, "during the period beginning on January 9, 1962, and ending on May 7, 1975"; and

c. Paragraphs (e) and (f) are added immediately following paragraph (d)(5) and the authority citation at the end of the section is revised to read as follows:

§ 3.814 Monetary allowance under 38 U.S.C. 1805 for a child suffering from spina bifida who is a child of a Vietnam veteran.

* * * * *

(e) Effective dates. Except as otherwise provided, VA will award the monetary allowance for children suffering from spina bifida based on an original claim, a claim reopened after final disallowance, or a claim for increase as of the date VA received the claim or the date entitlement arose, whichever is later.

(1) VA will increase benefits as of the earliest date the evidence establishes that the level of severity increased, but only if the beneficiary applies for an increase within one year of that date.

(2) If a claimant reopens a previously disallowed claim based on corrected military records, VA will award the benefit from the latest of the following dates: the date the veteran or beneficiary applied for a correction of the military records; the date the disallowed claim was filed; or, the date one year before the date of receipt of the reopened claim.

(f) Reductions and discontinuances. VA will generally reduce or discontinue awards according to the facts found except as provided in §§ 3.105 and 3.114(b).

(1) If benefits were paid erroneously because of beneficiary error, VA will reduce or discontinue benefits as of the effective date of the erroneous award.

(2) If benefits were paid erroneously because of administrative error, VA will reduce or discontinue benefits as of the date of last payment.

* * * * *

(Authority: 38 U.S.C. 1805, 1806, 5110, 5112)

PART 17 - MEDICAL

1. The authority citation for part 17 continues to read as follows:

AUTHORITY: 38 U.S.C. 501, 1721 unless otherwise noted.

2. The authority citation at the end of § 17.901 is revised to read as follows:

§ 17.901 Definitions.

* * * * *

Authority: 38 U.S.C. 101(2), 1801-1806, Public Law 105-114)

3. The authority citation at the end of § 17.902 is revised to read as follows:

§ 17.902 Preauthorization.

* * * * *
(Authority: 38 U.S.C. 101(2), 1801-1806, Public Law 105-114)

4. The authority citation at the end of § 17.903 is revised to read as follows:

§ 17.903 Payment.

* * * * *

(Authority: 38 U.S.C. 101(2), 1801-1806, Public Law 105-114)

PART 21 – VOCATIONAL REHABILITATION AND EDUCATION

Subpart M—Vocational Training and Rehabilitation for Vietnam Veterans' Children With Spina Bifida

1. The authority citation for part 21, subpart M continues to read as follows:

AUTHORITY: 38 U.S.C. 101, 501, 512, 1151 note, 1801-1806, 5112, unless otherwise noted.

2. The authority citation at the end of § 21.8012 is revised to read as follows:

§ 21.8012 Definitions and abbreviations.

* * * * *

(Authority: 38 U.S.C. 101(2), 1801, 1804, Public Law 105-114)

3. The authority citation at the end of § 21.8014 is revised to read as follows:

§ 21.8014 Application.

* * * * *

(Authority: 38 U.S.C. 101(2), 1801, 1804, Public Law 105-114)

REGULATORY AMENDMENT
3-00-5

Regulations Affected: 38 C.F.R. §3.22(a), §3.55(a), and §3.309(d).

Effective Dates of the Rulemaking: The amendments to 38 CFR §3.22 and §3.309 are effective November 30, 1999. The amendment to 38 CFR §3.55 is effective December 1, 1999.

Date Secretary Approved Rulemaking: June 28, 2000

Federal Register Citation: 65 FR 43699-43700 (July 14, 2000)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. These comments are not regulatory.

On November 30, 1999, the President signed into law the Veterans Millennium Health Care and Benefits Act, Pub. L. 106-117 (the Act). Three provisions of the Act directly affect the payment of VA benefits. These provisions concern: 1) payment of dependency and indemnity compensation (DIC) to the surviving spouses of certain former prisoners of war (POWs); 2) provision of health care, education and home loan benefits to surviving spouses upon termination of their remarriages; and 3) addition of bronchiolo-alveolar carcinoma to the list of diseases that VA presumes are the result of exposure to radiation during active military service.

DIC benefits are generally payable to the survivors of veterans who died from their service-connected disabilities. In addition, 38 U.S.C. 1318 authorizes VA to pay DIC benefits to survivors of veterans whose deaths were not service-connected but who were continuously rated totally disabled due to service-connected disabilities for ten years or more immediately preceding the veteran's death, or for five years from the date of such veteran's discharge. Section 501 of Pub. L. 106-117 authorizes payment of DIC to the survivors of former POWs who died after September 30, 1999, and who were continuously rated totally disabled due to a service-connected disability for a period of not less than one year immediately preceding death. This provision is effective November 30, 1999, the date of enactment. This document amends 38 CFR 3.22, to reflect this change.

In 1998, Pub. L. 105-178 restored eligibility to DIC to a surviving spouse of a veteran if that person's subsequent remarriage had been terminated by death or divorce, or if a subsequent relationship had been terminated. Eligibility to DIC was restored effective October 1, 1998. This law restored eligibility *only* to DIC. Eligibility to ancillary benefits—including VA Civilian Health Care and Medical Program (CHAMPVA), chapter 35 education, and home loan guaranty benefits—was not restored.

Section 502 of Pub. L. 106-117 restores eligibility to health care benefits under 38 U.S.C. chapter 17 (CHAMPVA), education benefits under chapter 35, and home loan guaranty benefits under chapter 37 to a surviving spouse if his or her remarriage has been terminated by death or divorce, or if a surviving spouse has ceased living with another person and holding himself or herself out openly to the public as that person's spouse. Section 502 states that its changes shall take effect on the first day of the first month beginning after the month in which the Act is enacted, i.e., December 1, 1999. This document amends 38 CFR 3.55 to reflect these changes.

Section 503 of the Act adds bronchiolo-alveolar carcinoma to the list of diseases that VA presumes result from exposure to radiation during active military service. This provision of the law is effective November 30, 1999. This document amends 38 CFR 3.309(d) to reflect these changes.

Title 38 CFR part 3 is amended as follows:

PART 3—ADJUDICATION

Subpart A—Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

§ 3.22 [Amended]

2. Section 3.22 is amended by:

a. In paragraph (a)(2)(i), removing the word "or" after the semi-colon at the end of the paragraph.

b. In paragraph (a)(2)(ii), removing the period at the end of the paragraph and adding, in its place, "; or".

c. Adding paragraph (a)(2)(iii) to read as follows:

§3.22 DIC benefits for survivors of certain veterans rated totally disabled at the time of death.

(a) * * *

(2) * * *

(iii) Rated by VA as totally disabling for a continuous period of not less than one year immediately preceding death, if the veteran was a former prisoner of war who died after September 30, 1999.

(Authority: 38 U.S.C. 1318(b))

* * * * *

3. Section 3.55 is amended by redesigning paragraphs (a)(4), (a)(5), and (a)(6) as paragraphs (a)(5), (a)(6) and (a)(8), respectively; and new paragraphs (a)(4) and (a)(7) are added to read as follows:

§ 3.55 Reinstatement of benefits eligibility based upon terminated marital relationships.

(a) * * *

(4) On or after December 1, 1999, remarriage of a surviving spouse terminated by death, divorce, or annulment, will not bar the furnishing of benefits relating to medical care for survivors and dependents under 38 U.S.C. 1713, educational assistance under 38 U.S.C. chapter 35, or housing loans under 38 U.S.C. chapter 37, unless the Secretary determines that the divorce or annulment was secured through fraud or collusion.

(Authority: 38 U.S.C. 103(d))

* * * * *

(7) On or after December 1, 1999, the fact that a surviving spouse has lived with another person and has held himself or herself out openly to the public as the spouse of such other person will not bar the furnishing of benefits relating to medical care for survivors and dependents under 38 U.S.C. 1713, educational assistance under 38 U.S.C. chapter 35, or housing loans under 38 U.S.C. chapter 37 to the surviving spouse if he or she ceases living with such other person and holding himself or herself out openly to the public as such other person's spouse.

(Authority: 38 U.S.C. 103(d)).

* * * * *

4. Section 3.309 is amended by adding paragraph (d)(2)(xvi) and an authority citation after the Note at the end of paragraph (d)(2)(xv) to read as follows:

§3.309 Disease subject to presumptive service connection.

* * * * *

(d) * * *

(2) * * *

(xvi) Bronchiolo-alveolar carcinoma.

(Authority: 38 U.S.C. 1112(c)(2))

REGULATORY AMENDMENT
3-01-1

Regulation affected: 38 CFR 3.814

EFFECTIVE DATE OF REGULATION: April 5, 2001

Date Secretary approved regulation: February 15, 2001

Federal Register Citation: 66 FR 13435 (March 6, 2001)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Based on a review of a sample of spina bifida claims adjudicated under previous regulations at 38 CFR 3.814 concerning the monthly monetary payment to an individual born with spina bifida who is a child of a Vietnam veteran, and, based on actual medical evidence used to adjudicate these claims, we assessed the effectiveness of the evaluation criteria and the manner in which they were applied. Based on that assessment, a further review of the medical literature, and suggestions from several service organizations, we revised section 3.814 to clarify the criteria to ensure that they are applied consistently and to add a provision allowing the Director of the Compensation and Pension Service to adjust the payment level for individuals with disabling impairments due to spina bifida that are not addressed in the evaluation criteria.

We noted that raters applied the criteria based on the effects of lower extremity impairment inconsistently to individuals who occasionally use braces or a wheelchair, or who use them only outside the home. We therefore clarified the criteria so that the assessment is based on whichever mode of ambulation represents the individual's primary means of mobility in the community.

Regarding the effects of bowel and bladder impairment, we noted that the terms "proper urinary bladder function" and "proper bowel function" were interpreted differently by different raters. We therefore revised the criteria for bladder impairment to base them on the extent to which the impairment affects the ability of the individual to engage in ordinary day-to-day activities based on the length of time the individual is usually able to remain dry during waking hours, and whether or not the individual requires the use of medication or some other means to achieve that level of control. This change takes into account the fact that individuals who are ordinarily able to remain dry for three hours may occasionally have an accidental involuntary release of urine due to an acute illness, miscalculations in controlling fluid intake, etc. Basing evaluations on the frequency of inability to remain dry for at least three hours at a time during waking hours will assure that individuals with bladder impairment are consistently evaluated.

Regarding the effects of bowel impairment, we revised the criteria to take into account the extent to which fecal leakage limits the individual's ability to engage in ordinary day-to-day activities, in order to enable raters to consistently and objectively evaluate individuals who, although neither totally continent nor incontinent, have partial control of the effects of bowel or bladder impairment. We did this by basing the evaluation on the extent and frequency of fecal leakage and the degree to which the individual is able to control or modify the effects of impairment through bowel management techniques or other treatment (which would include suppositories, enemas, medication, biofeedback, behavior modification, diet, manual evacuation, etc.). An individual who requires bowel management techniques or other treatment to control the effects of bowel impairment, but has only occasional or minimal fecal leakage, and does not need to wear absorbent materials at least four days a week, is evaluated at Level II. An individual who, despite the use of bowel management techniques or other treatment to control the effects of bowel impairment, has fecal leakage of such severity or frequency that he or she must wear absorbent materials at least four days a week, is evaluated at Level III. An individual who regularly requires manual evacuation or digital stimulation to empty the bowel is evaluated at Level III, since these procedures may significantly interfere with ordinary day-to-day activities. These replace the current criteria for current Level III that there be "complete fecal incontinence." We also added a provision concerning individuals with colostomy, which is a relatively common procedure with

different possible outcomes, to direct that "a colostomy that requires wearing a bag" will be evaluated at Level III and "a colostomy that does not require wearing a bag" will be evaluated at Level II.

Because of concerns that individuals with conditions such as blindness or seizures resulting from spina bifida might be underpaid under the current criteria, we added a new provision to § 3.814 to allow the Director of the Compensation and Pension Service to increase the payment level of an individual who would otherwise be paid at Level I or II and has one or more disabilities, such as blindness, uncontrolled seizures, or renal failure that result either from spina bifida or from treatment procedures for spina bifida, to the level that, in his or her judgment, best represents the extent to which the disabilities limit the individual's ability to engage in ordinary day-to-day activities, including activities outside the home.

Since many of those entitled to this benefit are now adolescents or adults, we changed the words "child" or "children" to "individual" or "individuals" throughout § 3.814. We also amended the regulations to provide that, when VA is required to reassess an individual's level of disability for purposes of the monetary allowance, VA will pay the individual at Level I in the absence of evidence adequate to support a higher level of disability or if the individual fails to report, "without good cause" for a scheduled examination.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as set forth below:

PART 3—ADJUDICATION

SUBPART A—Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A, continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. In § 3.814, the heading for the section and paragraphs (a), (c), and (d) are revised to read as follows:

Monetary Allowance under 38 U.S.C. 1805 for an individual suffering from spina bifida who a child of a Vietnam veteran.

(a) VA will pay a monthly allowance based upon the level of disability determined under the provisions of paragraph (d) of this section to or for an individual who it has determined is suffering from spina bifida and whose biological father or mother is or was a Vietnam veteran. Receipt of this allowance will not affect the right of the individual or any other related individual to receive any other benefit to which he or she may be entitled under any law administered by VA. An individual suffering from spina bifida is entitled to only one monthly allowance under this section, even if the individual's biological father and mother are or were both Vietnam veterans.

* * * * *

(c) * * *

(2) Individual. For the purposes of this section, the term "individual" means a person, regardless of age or marital status, whose biological father or mother is or was a Vietnam veteran and who was conceived after the date on which the veteran first served in the Republic of Vietnam during the Vietnam era. Notwithstanding the provisions of Sec. 3.204(a)(1), VA shall require the types of evidence specified in Secs. 3.209 and 3.210 sufficient to establish in the judgment of the Secretary that an individual's biological father or mother is or was a Vietnam veteran.

(d) (1) Except as otherwise specified in this paragraph, VA will determine the level of payment as follows:

(i) Level I. The individual walks without braces or other external support as his or her primary means of mobility in the community, has no sensory or motor impairment of the upper extremities, has an IQ of 90 or higher, and is continent of urine and feces without the use of medication or other means to control incontinence.

(ii) Level II. Provided that none of the disabilities is severe enough to warrant payment at Level III, and the individual: walks with braces or other external support as his or her primary means of mobility in the community; or, has sensory or motor impairment of the upper extremities, but is able to grasp pen, feed self, and perform self care; or, has an IQ of at least 70 but less than 90; or, requires medication or other means to control the effects of urinary bladder impairment and is unable no more than two times per week to remain dry for at least three hours at a time during waking hours; or, requires bowel management techniques or other treatment to control the effects of bowel impairment but does not have fecal leakage severe or frequent enough to require wearing of absorbent materials at least four days a week; or, has a colostomy that does not require wearing a bag.

(iii) Level III. The individual uses a wheelchair as his or her primary means of mobility in the community; or, has sensory or motor impairment of the upper extremities severe enough to prevent grasping a pen, feeding self, and performing self care; or, has an IQ of 69 or less; or, despite the use of medication or other means to control the effects of urinary bladder impairment, at least three times per week is unable to remain dry for three hours at a time during waking hours; or, despite bowel management techniques or other treatment to control the effects of bowel impairment, has fecal leakage

severe or frequent enough to require wearing of absorbent materials at least four days a week; or, regularly requires manual evacuation or digital stimulation to empty the bowel; or, has a colostomy that requires wearing a bag.

(2) If an individual who would otherwise be paid at Level I or II has one or more disabilities, such as blindness, uncontrolled seizures, or renal failure that result either from spina bifida, or from treatment procedures for spina bifida, the Director of the Compensation and Pension Service may increase the monthly payment to the level that, in his or her judgment, best represents the extent to which the disabilities resulting from spina bifida limit the individual's ability to engage in ordinary day-to-day activities, including activities outside the home. A Level II or Level III payment will be awarded depending on whether the effects of a disability are of equivalent severity to the effects specified under Level II or Level III.

(3) VA may accept statements from private physicians, or examination reports from government or private institutions, for the purpose of rating spina bifida claims without further examination, provided the statements or reports are adequate for assessing the level of disability due to spina bifida under the provisions of paragraph (d)(1) of this section. In the absence of adequate medical information, VA will schedule an examination for the purpose of assessing the level of disability.

(4) VA will pay an individual eligible for a monetary allowance due to spina bifida at Level I unless or until it receives medical evidence supporting a higher payment. When required to reassess the level of disability under paragraph (d)(5) or (d)(6) of this section, VA will pay an individual eligible for this monetary allowance at Level I in the absence of evidence adequate to support a higher level of disability or if the individual fails to report, without good cause, for a scheduled examination. Examples of good cause include, but are not limited to, the illness or hospitalization of the claimant, death of an immediate family member, etc.

(5) VA will pay individuals under the age of one year at Level I unless a pediatric neurologist or a pediatric neurosurgeon certifies that, in his or her medical judgment, there is a neurological deficit that will prevent the individual from ambulating, grasping a pen, feeding himself or herself, performing self care, or from achieving urinary or fecal continence. If any of those deficits are present, VA will pay the individual at Level III. In either case, VA will reassess the level of disability when the individual reaches the age of one year.

(6) VA will reassess the level of payment whenever it receives medical evidence indicating that a change is warranted. For individuals between the ages of one and twenty-one, however, it must reassess the level of payment at least every five years.

(Authority: 38 U.S.C. 501, 1805)

REGULATORY AMENDMENT
3-01-2

Regulations affected: 38 CFR 3.300 and 3.310(a)

Effective Date of Regulations: June 10, 1998

Date Secretary Approved Regulations: February 5, 2001

Federal Register Citation: 66 FR 18195 (April 6, 2001)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

This document amends VA adjudication regulations governing determinations of whether disability or death is service-connected. These changes are necessary to implement a statutory amendment providing that a disability or death will not be service-connected on the basis that it resulted from injury or disease attributable to a veteran's use of tobacco products during service.

Section 9014(a) of the ``Internal Revenue Service Restructuring and Reform Act of 1998," Public Law 105-206, amended section 8202 of the ``Transportation Equity Act for the 21st Century," Public Law 105-178, by adding section 1103 to title 38, United States Code. Subsection (a) of section 1103 provides that ``a veteran's disability or death shall not be considered to have resulted from personal injury suffered or disease contracted in the line of duty in the active military, naval, or air service for purposes of this title on the basis that it resulted from injury or disease attributable to the use of tobacco products by the veteran during the veteran's service."

Subsection (b) of section 1103 provides that subsection (a) does not preclude service connection for disability or death that is otherwise shown to have been incurred or aggravated during service or that becomes manifest to the requisite degree of disability during any applicable presumptive period specified in section 1112 or 1116 of title 38, United States Code. This document amends VA regulations by adding new Sec. 3.300 to title 38, Code of Federal Regulations, to implement the provisions of 38 U.S.C. 1103.

Section 3.300(a) provides that, for claims received by VA after June 9, 1998, a disability or death will not be considered service-connected on the basis that it resulted from injury or disease attributable to the veteran's use of tobacco products during service. Section 3.300(a) also defines ``tobacco products" to mean ``cigars, cigarettes, smokeless tobacco, pipe tobacco, and roll-your-own tobacco."

Section 3.300(b) provides that Sec. 3.300(a) does not prohibit service connection for a disability or death if it resulted from a disease or injury otherwise shown to have been incurred or aggravated during service, or that became manifest to the required degree of disability within a period that establishes eligibility for a presumption of service connection under 38 CFR 3.307, 3.309, 3.313, or 3.316, or that may be secondarily service-connected under Sec. 3.310(b). It defines "otherwise shown" as meaning "that the disability or death can be service-connected on some basis other than the veteran's use of tobacco products during service, or that the disability became manifest or death occurred during service."

Sections 3.307 and 3.309 implement the statutory presumptions of 38 U.S.C. 1112 and 1116, which are specifically mentioned at 38 U.S.C. 1103(b). These sections of the statute govern the presumptions that the following diseases are service-connected: chronic and tropical diseases (section 1112(a)); diseases appearing in former prisoners of war (section 1112(b)); diseases appearing in radiation-exposed veterans (section 1112(c)); and diseases associated with exposure to certain herbicide agents (section 1116).

Sections 3.313 and 3.316 are regulatory, rather than statutory, presumptions issued pursuant to the general rulemaking authority of the Secretary of Veterans Affairs. 38 U.S.C. 501(a). They govern, respectively, service connection for non-Hodgkins' lymphoma developing subsequent to service in Vietnam and service connection for diseases developing subsequent to exposure to mustard gas and

Lewisite. Also, Sec. 3.310(b), a regulatory presumption, governs secondary service connection of ischemic heart disease and other cardiovascular disease as the proximate result of certain service-connected amputations of the lower extremities. Title 38 U.S.C. 1103(b) explicitly provides that nothing in section 1103(a) shall be construed as precluding establishment of service connection if disability or death resulted from a disease or injury otherwise shown to have been incurred or aggravated during service or that appeared to the required degree within a statutory presumptive period.

In our view, 38 U.S.C. 1103 was not intended to affect a veteran's ability to establish service connection on the basis of any legal presumption, including regulatory presumptions authorized by 38 U.S.C. 501(a) as well as statutory presumptions. Section 1103(a) only precludes establishment of service connection for a disability or death ``on the basis that'' it resulted from injury or disease attributable to the veteran's use of tobacco products. We believe that section 1103(b) was enacted as a safeguard to assure that VA did not misinterpret section 1103(a) as barring otherwise valid claims for service connection. Based on our interpretation of section 1103, new Sec. 3.300(b) specifies that if disability or death can be service-connected under the regulatory presumptions of Sec. 3.310(b), 3.313, or 3.316, a claim will not be denied on the basis of Sec. 3.300(a).

New Sec. 3.300(c) provides that, for claims received by VA after June 9, 1998, a disability that is proximately due to or the result of an injury or disease previously service-connected on the basis of the veteran's use of tobacco products during service will not be service-connected. According to current Sec. 3.310(a), ``[d]isability which is proximately due to or the result of a service-connected disease or injury shall be service connected.'' Section 3.310(a) provides for service connection of disability not itself incurred or aggravated in service but nevertheless resulting from a disease or injury incurred or aggravated in service. Just as with directly service-connected disabilities, secondarily service-connected disabilities are the result of service-incurred or service-aggravated injury or disease, only they are somewhat more remotely related to such disease or injury. When a disability is proximately due to or the result of an injury or disease previously service-connected on the basis of the veteran's use of tobacco products during service, the secondary condition results from a disease or injury attributable to the use of tobacco products. Consequently, service connection of such a condition is barred by 38 U.S.C. 1103(a). New Sec. 3.300(c) therefore provides that secondary service connection may not be established under Sec. 3.310(a) in a claim received by VA after June 9, 1998, for a disability proximately due to or the result of an injury or disease previously service-connected on the basis that it is attributable to a veteran's tobacco use during service. Under Sec. 3.300(c), a condition cannot be service-connected under Sec. 3.310(a) as secondary to a disease such as nicotine dependence, for example, that was previously service-connected solely on the basis that it resulted from the veteran's use of tobacco products during service. We are also amending Sec. 3.310(a) to make explicit that it is subject to the provisions of Sec. 3.300(c).

Section 8202 of Public Law 105-178, as amended (38 U.S.C. 1103 note), provides that 38 U.S.C. 1103 shall apply to claims received by VA after June 9, 1998.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as set forth below:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. Section 3.300 is added immediately under the undesignated center heading “Ratings and Evaluations; Basic Entitlement Considerations” to read as follows:

§ 3.300 Claims based on the effects of tobacco products.

(a) For claims received by VA after June 9, 1998, a disability or death will not be considered service-connected on the basis that it resulted from injury or disease attributable to the veteran’s use of tobacco

products during service. For the purpose of this section, the term "tobacco products" means cigars, cigarettes, smokeless tobacco, pipe tobacco, and roll-your-own tobacco.

(b) The provisions of paragraph (a) of this section do not prohibit service connection if:

(1) The disability or death resulted from a disease or injury that is otherwise shown to have been incurred or aggravated during service. For purposes of this section, "otherwise shown" means that the disability or death can be service-connected on some basis other than the veteran's use of tobacco products during service, or that the disability became manifest or death occurred during service; or

(2) The disability or death resulted from a disease or injury that appeared to the required degree of disability within any applicable presumptive period under §§ 3.307, 3.309, 3.313, or 3.316; or

(3) Secondary service connection is established for ischemic heart disease or other cardiovascular disease under § 3.310(b).

(c) For claims for secondary service connection received by VA after June 9, 1998, a disability that is proximately due to or the result of an injury or disease previously service-connected on the basis that it is attributable to the veteran's use of tobacco products during service will not be service-connected under
§ 3.310(a).

(Authority: 38 U.S.C. 501(a), 1103, 1103 note)

3. In § 3.310, paragraph (a) is amended by removing "Disability" and adding, in its place, "Except as provided in § 3.300(c), disability".

REGULATORY AMENDMENT
3-01-3

Regulation affected: 38 CFR §3.104(a), §3.105(b), and §3.2600

Effective Date of Regulation: June 1, 2001

Date Secretary Approved Regulation: February 15, 2001

Federal Register Citation: 66 FR 21871 (May 2, 2001)

The purpose of the following information on these new VA regulations is to inform all concerned why they are being promulgated. This information is not regulatory.

Background

These new regulations add provisions to allow any claimant who files a timely Notice of Disagreement to obtain a *de novo* review of their claims at the Veterans Service Center level before deciding whether to proceed with the traditional appeal process. This option will offer claimants a more efficient means for resolving disagreements concerning claims.

These new regulations are based on the requirement in 38 U.S.C. 7105(d)(1) that, when a claimant files a Notice of Disagreement with the decision of an agency of original jurisdiction, the agency will ``take such development or review action as it deems proper under the provisions of regulations not inconsistent with'' title 38 of the United States Code. These new regulations will apply only to decisions that have not yet become final (by appellate decision or failure to timely appeal) and with which the claimant has disagreed.

Section 3.2600, "Review of Benefit Claims Decisions", is being published in the recently created subpart D containing ``universal adjudication rules'' that apply to claims which are governed by part 3 of title 38. Section 3.2100, "Scope of Applicability", specifies the scope of the provisions in subpart D. This includes claims for benefits such as compensation, pension, dependency and indemnity compensation, burial benefits, and special benefits listed at §§ 3.800 through 3.814. The ``universal adjudication rules'' also apply to claims for eligibility determinations (such as character of military discharge, military duty status and dependency status), apportionment of benefits to dependents, and waiver of recovery of overpayments. Subpart D and §3.2100 were added to the CFR on April 6, 2001.

Procedures for *De Novo* Review

These new regulations provide that, upon receipt of a Notice of Disagreement, VA will notify the claimant in writing of his or her right to a review. To obtain such a review, the claimant will have to request it when they file their Notice of Disagreement or anytime not later than 60 days of the date VA mails the notice. These regulations also provide that a claimant may not have more than one of these reviews of the same decision. We believe that one review is sufficient to resolve those claims that can be resolved before proceeding with appellate review.

Under the new 38 CFR §3.2600, an Adjudication Officer, Veterans Service Center Manager, or Decision Review Officer, at VA's discretion will conduct the review. An individual who did not participate in the decision being reviewed will conduct the review. This requirement is similar to that for VA personnel conducting hearings under 38 CFR §3.103(c)(1). The reviewer may conduct whatever development he or she considers necessary to resolve disagreements concerning decisions with which the claimant has expressed disagreement in the Notice of Disagreement, consistent with applicable law. This may include an attempt to obtain additional evidence or the holding of an informal conference with the claimant. Upon the request of the claimant, the reviewer will conduct a hearing under §3.103(c).

The review will be based on all the evidence of record and applicable law. Further, the review decision must include a summary of the evidence, a citation to pertinent laws, a discussion of how those laws affect the decision, and a summary of the reasons for the decision. This will ensure that the reviewer

provides a fresh look at the case and provides an appropriate record of the decision making process. If the claimant does not withdraw his or her Notice of Disagreement as a result of this review process, VA will proceed with the traditional appellate process by issuing a Statement of the Case.

Clear and Unmistakable Error

Under §3.2600, the reviewer will be authorized to grant a benefit sought in the claim, but will not be authorized to revise the decision in a manner that is less advantageous to the claimant than the decision under review. This will ensure that the claimant is not penalized for seeking a review. However, the reviewer will have the authority to reverse or revise any decision of the agency of original jurisdiction (including the decision being reviewed or any prior decision that has become final due to failure to timely appeal) on the grounds of clear and unmistakable error, even if disadvantageous to the claimant. All Service Center decision-makers already have this authority (see 38 CFR §3.105(a)).

We have also amended 38 CFR §3.105(b) (which concerns revision of decisions based on difference of opinion) to specify that a decision may be revised under §3.2600 without being recommended to Central Office. This clarifies that the proposed review process created by §3.2600 is not subject to the requirements of §3.105(b). (We have also amended §3.104 to make clear that not only §3.105 but also §3.2600 are valid bases for revision of decisions on the same factual basis as the initial decision by the agency of original jurisdiction.)

Effective Date

We believe that including claims which are pending at various stages of the appellate process in the new *de novo* review process would be administratively difficult because this process is designed to occur prior to the traditional appellate process. Therefore, we have decided that these new regulations will apply to all claims in which a Notice of Disagreement is filed on or after June 1, 2001. Also, This will provide claimants with a date certain on which the *de novo* review will be available.

No Change to the Traditional Appeal Process

We have established a new *de novo* review procedure that will be available to any claimant who files a Notice of Disagreement with a decision on a claim governed by 38 CFR part 3. The new *de novo* review procedure will not change the procedures or rights involved with appeals of such claims decisions to the Board of Veterans' Appeals. It is an additional, optional procedure to be conducted, if at all, between a claimant's filing a Notice of Disagreement and VA's issuance of a Statement of the Case. If *de novo* review under Sec. 3.2600 is not requested with the Notice of Disagreement or after the Notice of Disagreement is filed but within 60 days after VA mails notice of the right of such review to the claimant,
then the appeal will proceed in accordance with the traditional appeal process: VA will issue a Statement of the Case. However, a claimant may not pursue *de novo* review and the traditional appeal simultaneously. A traditional appeal is suspended until *de novo* review is complete. Otherwise, there will be a risk of duplicative development and inconsistent decisions made in the same claim.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

Sec. 3.104 Amended

2. In Sec. 3.104, paragraph (a), the second sentence is amended by removing ``Sec. 3.105'' and adding, in its place, ``Sec. 3.105 and Sec. 3.2600''.

Sec. 3.105 Amended

3. In Sec. 3.105, paragraph (b) is amended by adding, as the last sentence, ``However, a decision may be revised under Sec. 3.2600 without being recommended to Central Office."

Subpart D--Universal Adjudication Rules That Apply to Benefit Claims Governed by Part 3 of this Title

4. The authority citation for part 3, subpart D continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

5. A new undesignated center heading and Sec. 3.2600 are added to subpart D to read as follows:

Revisions

Sec. 3.2600 Review of benefit claims decisions.

(a) A claimant who has filed a timely Notice of Disagreement with a decision of an agency of original jurisdiction on a benefit claim has a right to a review of that decision under this section. The review will be conducted by an Adjudication Officer, Veterans Service Center Manager, or Decision Review Officer, at VA's discretion. An individual who did not participate in the decision being reviewed will conduct
this review. Only a decision that has not yet become final (by appellate decision or failure to timely appeal) may be reviewed. Review under this section will encompass only decisions with which the claimant has expressed disagreement in the Notice of Disagreement. The reviewer will consider all evidence of record and applicable law, and will give no deference to the decision being reviewed.

(b) Unless the claimant has requested review under this section with his or her Notice of Disagreement, VA will, upon receipt of the Notice of Disagreement, notify the claimant in writing of his or her right to a review under this section. To obtain such a review, the claimant must request it not later than 60 days after the date VA mails the notice. This 60-day time limit may not be extended. If the claimant
fails to request review under this section not later than 60 days after the date VA mails the notice, VA will proceed with the traditional appellate process by issuing a Statement of the Case. A claimant may not have more than one review under this section of the same decision.

(c) The reviewer may conduct whatever development he or she considers necessary to resolve any disagreements in the Notice of Disagreement, consistent with applicable law. This may include an attempt to obtain additional evidence or the holding of an informal conference with the claimant. Upon the request of the claimant, the reviewer will conduct a hearing under Sec. 3.103(c).

(d) The reviewer may grant a benefit sought in the claim notwithstanding Sec. 3.105(b), but, except as provided in paragraph (e) of this section, may not revise the decision in a manner that is less advantageous to the claimant than the decision under review. A review decision made under this section will include a summary of the evidence, a citation to pertinent laws, a discussion of how those laws affect the decision, and a summary of the reasons for the decision.

(e) Notwithstanding any other provisions of this section, the reviewer may reverse or revise (even if disadvantageous to the claimant) prior decisions of an agency of original jurisdiction (including the decision being reviewed or any prior decision that has become final due to failure to timely appeal) on the grounds of clear and unmistakable error (see Sec. 3.105(a)).

(f) Review under this section does not limit the appeal rights of a claimant. Unless a claimant withdraws his or her Notice of Disagreement as a result of this review process, VA will proceed with the traditional appellate process by issuing a Statement of the Case.

(g) This section applies to all claims in which a Notice of Disagreement is filed on or after June 1, 2001.

(Authority: 38 U.S.C. 5109A and 7105(d))

REGULATORY AMENDMENT
3-01-4

Regulation affected: 38 CFR §3.309(e)

Effective Date of Regulation: July 9, 2001

Date Secretary Approved Regulation: April 19, 2001

Federal Register Citation: 66 FR 23166 (May 8, 2001)

The purpose of the following information on this new VA regulation is to inform all concerned why it is being promulgated. This information is not regulatory.

The Department of Veterans Affairs (VA) has amended its adjudication regulations concerning presumptive service connection for certain diseases for which there is no record during service. This amendment is necessary to implement a decision of the Secretary of Veterans Affairs under the authority granted by 38 U.S.C. 1116 that there is a positive association between exposure to herbicides used in the Republic of Vietnam during the Vietnam era and the subsequent development of Type 2 diabetes. The intended effect of this amendment is to establish presumptive service connection for that condition based on herbicide exposure.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

2. In Sec. 3.309, paragraph (e), the listing of diseases is amended by adding ``Type 2 diabetes (also known as Type II diabetes mellitus or adult-onset diabetes)" between ``Chloracne or other acneform disease consistent with chloracne" and ``Hodgkin's disease" to read as follows:

Sec. 3.309 Diseases subject to presumptive service connection.

* * * * *

(e) * * *

Type 2 diabetes (also known as Type II diabetes mellitus or adult-onset diabetes)

* * * * *

(Authority: 38 U.S.C. 501(a) and 1116).

REGULATORY AMENDMENT
3-01-5

Regulations affected: 38 CFR 3.203(a)

Effective Date of Regulations: April 27, 2001

Date Secretary Approved Regulations: February 15, 2001

Federal Register Citation: 66 FR 19857 (April 18, 2001)

The purpose of the following information on this new VA regulation is to inform all concerned why it is being promulgated. This information is not regulatory.

The Department of Veterans Affairs (VA) has amended its adjudication regulations concerning the nature of evidence that VA will accept as proof of military service. In the past VA only accepted original service documents or copies issued by the service department or public custodian of records for verification purposes. This change authorizes VA to accept photocopies of service documents as evidence of military service if they are certified to be copies of documents acceptable to VA by an accredited agent, attorney, or service organization representative who has successfully completed VA-prescribed training on military records. The intended effect of the amendment is to streamline the processing of claims for benefits.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for Part 3, subpart A continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

2. In Sec. 3.203, at the end of paragraph (a)(1) remove ``custody; and'' and add the following:

Sec. 3.203 Service records as evidence of service and character of discharge.

(a) * * *

(1)* * * custody or, if the copy was submitted by an accredited agent, attorney or service organization representative who has successfully completed VA-prescribed training on military records, and who certifies that it is a true and exact copy of either an original document or of a copy issued by the service department or a public custodian of records; and''.

* * * * *

REGULATORY AMENDMENT
3-01-6

Regulations affected: 38 CFR 3.102, 3.156(a), 3.159 and 3.326(a)

Effective date of regulation: This rule is effective November 9, 2000, except for the amendment to 38 CFR 3.156(a), which is effective August 29, 2001.

Applicability dates: Except for the amendment to 38 CFR 3.156(a), the second sentence of 38 CFR 3.159(c), and 38 CFR 3.159(c)(4)(iii), the provisions of this final rule apply to any claim for benefits received by VA on or after November 9, 2000, as well as to any claim filed before that date but not decided by VA as of that date.

Date Secretary approved regulation: July 17, 2001

Federal Register Citation: 66 FR 45620-32 (August 29, 2001)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

This document amends the Department of Veterans Affairs (VA) adjudication regulations 38 CFR 3.156 and 3.159, to implement the provisions of the Veterans Claims Assistance Act of 2000 (the VCAA), which was effective on November 9, 2000. The intended effect of this regulation is to establish clear guidelines consistent with the intent of Congress regarding the timing and the scope of assistance VA will provide to a claimant who files a substantially complete application for VA benefits or who attempts to reopen a previously denied claim.

The amendment to 38 CFR 3.156(a), the second sentence of 38 CFR 3.159(c), and 38 CFR 3.159(c)(4)(iii) apply to any claim to reopen a finally decided claim received on or after August 29, 2001.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

Sec. 3.102 [Amended]

2. In Sec. 3.102, the fifth sentence is amended by removing ``evidence; the claimant is required to submit evidence sufficient to justify a belief in a fair and impartial mind that the claim is well grounded." and adding, in its place, ``evidence.".

3. Section 3.156(a) and its authority citation are revised to read as follows:

Sec. 3.156 New and material evidence.

(a) A claimant may reopen a finally adjudicated claim by submitting new and material evidence. New evidence means existing evidence not previously submitted to agency decisionmakers. Material evidence means existing evidence that, by itself or when considered with previous evidence of record, relates to an unestablished fact necessary to substantiate the claim. New and material evidence can be neither cumulative nor redundant of the evidence of record at the time of the last prior final denial of the claim sought to be reopened, and must raise a reasonable possibility of substantiating the claim.

(Authority: 38 U.S.C. 501, 5103A(f), 5108)

* * * * *

4. Section 3.159 is revised to read as follows:

Sec. 3.159 Department of Veterans Affairs assistance in developing claims.

(a) *Definitions*. For purposes of this section, the following definitions apply:

(1) *Competent medical evidence* means evidence provided by a person who is qualified through education, training, or experience to offer medical diagnoses, statements, or opinions. Competent medical evidence may also mean statements conveying sound medical principles found in medical treatises. It would also include statements contained in authoritative writings such as medical and scientific articles and research reports or analyses.

(2) *Competent lay evidence* means any evidence not requiring that the proponent have specialized education, training, or experience. Lay evidence is competent if it is provided by a person who has knowledge of facts or circumstances and conveys matters that can be observed and described by a lay person.

(3) *Substantially complete application* means an application containing the claimant's name; his or her relationship to the veteran, if applicable; sufficient service information for VA to verify the claimed service, if applicable; the benefit claimed and any medical condition(s) on which it is based; the claimant's signature; and in claims for nonservice-connected disability or death pension and parents' dependency and indemnity compensation, a statement of income.

(4) For purposes of paragraph (c)(4)(i) of this section, event means one or more incidents associated with places, types, and circumstances of service giving rise to disability.

(5) *Information* means non-evidentiary facts, such as the claimant's Social Security number or address; the name and military unit of a person who served with the veteran; or the name and address of a medical care provider who may have evidence pertinent to the claim.

(b) *VA's duty to notify claimants of necessary information or evidence.* (1) When VA receives a complete or substantially complete application for benefits, it will notify the claimant of any information and medical or lay evidence that is necessary to substantiate the claim. VA will inform the claimant which information and evidence, if any, that the claimant is to provide to VA and which information and evidence, if any, that VA will attempt to obtain on behalf of the claimant. VA will also request that the claimant provide any evidence in the claimant's possession that pertains to the claim. If VA does not receive the necessary information and evidence requested from the claimant within one year of the date of the notice, VA cannot pay or provide any benefits based on that application. If the claimant has not responded to the request within 30 days, VA may decide the claim prior to the expiration of the one-year period based on all the information and evidence contained in the file, including information and evidence it has obtained on behalf of the claimant and any VA medical examinations or medical opinions. If VA does so, however, and the claimant subsequently provides the information and evidence within one year of the date of the request, VA must readjudicate the claim.

(Authority: 38 U.S.C. 5103)

(2) If VA receives an incomplete application for benefits, it will notify the claimant of the information necessary to complete the application and will defer assistance until the claimant submits this information.

(Authority: 38 U.S.C. 5102(b), 5103A(3))

(c) *VA's duty to assist claimants in obtaining evidence.* Upon receipt of a substantially complete application for benefits, VA will make reasonable efforts to help a claimant obtain evidence necessary to substantiate the claim. In addition, VA will give the assistance described in paragraphs (c)(1), (c)(2),

and (c)(3) to an individual attempting to reopen a finally decided claim. VA will not pay any fees charged by a custodian to provide records requested.

(1) *Obtaining records not in the custody of a Federal department or agency.* VA will make reasonable efforts to obtain relevant records not in the custody of a Federal department or agency, to include records from State or local governments, private medical care providers, current or former employers, and other non-Federal governmental sources. Such reasonable efforts will generally consist of an initial request for the records and, if the records are not received, at least one follow-up request. A follow-up request is not required if a response to the initial request indicates that the records sought do not exist or that a follow-up request for the records would be futile. If VA receives information showing that subsequent requests to this or another custodian could result in obtaining the records sought, then reasonable efforts will include an initial request and, if the records are not received, at least one follow-up request to the new source or an additional request to the original source.

(i) The claimant must cooperate fully with VA's reasonable efforts to obtain relevant records from non-Federal agency or department custodians. The claimant must provide enough information to identify and locate the existing records, including the person, company, agency, or other custodian holding the records; the approximate time frame covered by the records; and, in the case of medical treatment records, the condition for which treatment was provided.

(ii) If necessary, the claimant must authorize the release of existing records in a form acceptable to the person, company, agency, or other custodian holding the records.

(Authority: 38 U.S.C. 5103A(b))

(2) *Obtaining records in the custody of a Federal department or agency.* VA will make as many requests as are necessary to obtain relevant records from a Federal department or agency. These records include but are not limited to military records, including service medical records; medical and other records from VA medical facilities; records from non-VA facilities providing examination or treatment at VA expense; and records from other Federal agencies, such as the Social Security Administration. VA will end its efforts to obtain records from a Federal department or agency only if VA concludes that the records sought do not exist or that further efforts to obtain those records would be futile. Cases in which VA may conclude that no further efforts are required include those in which the Federal department or agency advises VA that the requested records do not exist or the custodian does not have them.

(i) The claimant must cooperate fully with VA's reasonable efforts to obtain relevant records from Federal agency or department custodians. If requested by VA, the claimant must provide enough information to identify and locate the existing records, including the custodian or agency holding the records; the approximate time frame covered by the records; and, in the case of medical treatment records, the condition for which treatment was provided. In the case of records requested to corroborate a claimed stressful event in service, the claimant must provide information sufficient for the records custodian to conduct a search of the corroborative records.

(ii) If necessary, the claimant must authorize the release of existing records in a form acceptable to the custodian or agency holding the records.

(Authority: 38 U.S.C. 5103A(b))

(3) *Obtaining records in compensation claims.* In a claim for disability compensation, VA will make efforts to obtain the claimant's service medical records, if relevant to the claim; other relevant records pertaining to the claimant's active military, naval or air service that are held or maintained by a governmental entity; VA medical records or records of examination or treatment at non-VA facilities authorized by VA; and any other relevant records held by any Federal department or agency. The claimant must provide enough information to identify and locate the existing records including the custodian or agency holding the records; the approximate time frame covered by the records; and, in the case of medical treatment records, the condition for which treatment was provided.

(Authority: 38 U.S.C. 5103A(c))

(4) Providing medical examinations or obtaining medical opinions. (i) In a claim for disability compensation, VA will provide a medical examination or obtain a medical opinion based upon a review of the evidence of record if VA determines it is necessary to decide the claim. A medical examination or medical opinion is necessary if the information and evidence of record does not contain sufficient competent medical evidence to decide the claim, but:

(A) Contains competent lay or medical evidence of a current diagnosed disability or persistent or recurrent symptoms of disability;

(B) Establishes that the veteran suffered an event, injury or disease in service, or has a disease or symptoms of a disease listed in Sec. 3.309, Sec. 3.313, Sec. 3.316, and Sec. 3.317 manifesting during an applicable presumptive period provided the claimant has the required service or triggering event to qualify for that presumption; and

(C) Indicates that the claimed disability or symptoms may be associated with the established event, injury, or disease in service or with another service-connected disability.

(ii) Paragraph (4)(i)(C) could be satisfied by competent evidence showing post-service treatment for a condition, or other possible association with military service.

(iii) Paragraph (c)(4) applies to a claim to reopen a finally adjudicated claim only if new and material evidence is presented or secured.

(Authority: 38 U.S.C. 5103A(d))

(d) *Circumstances where VA will refrain from or discontinue providing assistance.* VA will refrain from providing assistance in obtaining evidence for a claim if the substantially complete application for benefits indicates that there is no reasonable possibility that any assistance VA would provide to the claimant would substantiate the claim. VA will discontinue providing assistance in obtaining evidence for a claim if the evidence obtained indicates that there is no reasonable possibility that further assistance would substantiate the claim. Circumstances in which VA will refrain from or discontinue providing assistance in obtaining evidence include, but are not limited to:

(1) The claimant's ineligibility for the benefit sought because of lack of qualifying service, lack of veteran status, or other lack of legal eligibility;

(2) Claims that are inherently incredible or clearly lack merit; and

(3) An application requesting a benefit to which the claimant is not entitled as a matter of law.

(Authority: 38 U.S.C. 5103A(a)(2))

(e) *Duty to notify claimant of inability to obtain records.* (1) If VA makes reasonable efforts to obtain relevant non-Federal records but is unable to obtain them, or after continued efforts to obtain Federal records concludes that it is reasonably certain they do not exist or further efforts to obtain them would be futile, VA will provide the claimant with oral or written notice of that fact. VA will make a record of any oral notice conveyed to the claimant. For non-Federal records requests, VA may provide the notice at the same time it makes its final attempt to obtain the relevant records. In either case, the notice must contain the following information:

(i) The identity of the records VA was unable to obtain;

(ii) An explanation of the efforts VA made to obtain the records;

(iii) A description of any further action VA will take regarding the claim, including, but not limited to, notice that VA will decide the claim based on the evidence of record unless the claimant submits the records VA was unable to obtain; and

(iv) A notice that the claimant is ultimately responsible for providing the evidence.

(2) If VA becomes aware of the existence of relevant records before deciding the claim, VA will notify the claimant of the records and request that the claimant provide a release for the records. If the claimant does not provide any necessary release of the relevant records that VA is unable to obtain, VA [[Page 45632]] will request that the claimant obtain the records and provide them to VA.

(Authority: 38 U.S.C. 5103A(b)(2))

(f) For the purpose of the notice requirements in paragraphs (b) and (e) of this section, notice to the claimant means notice to the claimant or his or her fiduciary, if any, as well as to his or her representative, if any.

(Authority: 38 U.S.C. 5102(b), 5103(a))

Sec. 3.326 [Amended]

5. In Sec. 3.326(a), the first sentence is amended by removing ``well-grounded''.

REGULATORY AMENDMENT
3-01-7

Regulations affected: 38 CFR § 3.6(a, e), § 3.353(b). § 3.452, § 3.501(i), § 3.551(i), § 3.557(b), § 3.558(a), § 3.559, § 3.1007, § 3.1604(d), § 13.70(a), § 13.71(b), and § 13.108

Effective Date of Regulations: November 1, 2000

Date Secretary Approved Regulations: May 21, 2000

Federal Register Citation: 66 FR 48558 (September 21, 2001)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 301 of the Veterans Benefits and Health Care Improvement Act of 2000 (the Act), Pub. L. No. 106-419, amended 38 U.S.C. 101(24), which defines the term "active military, naval, or air service" to also include periods of inactive duty training during which individuals become disabled or die from an acute myocardial infarction, a cardiac arrest, or a cerebrovascular accident that occurred during such training. Section 301 also amended 38 U.S.C. 106(d) to provide that if a person was disabled or died as a result of any of these three diseases having occurred while the person was proceeding directly to or returning directly from a period of active duty for training or inactive duty training, such person would be deemed to have been on active duty for training or inactive duty training, as the case may be. We have amended paragraphs (a) and (e) of 38 CFR 3.6 to reflect the new statutory requirements.

Section 304 of the Act amended 38 U.S.C. 5503(b)(1), which sets forth a limitation on the payment of benefits to certain incompetent veterans who are hospitalized or institutionalized at government expense, who have neither spouse nor child, and who have estates with values that equal or exceed a specified amount. Under prior law, benefits were discontinued when the value of such veterans' estates equaled or exceeded $1,500; payments could not be resumed until the value of those estates had been reduced to $500. Under section 304 of the Act, effective November 1, 2000, benefits may not be discontinued until the estate of an affected incompetent veteran equals or exceeds an amount equal to five times the rate of compensation payable under 38 U.S.C. 1114(j) (the rate payable to a totally disabled veteran with no dependents). Under the new provision, benefit payments discontinued because of the estate limitation may not be resumed until the veteran's estate has been reduced to one-half the amount of the new estate limitation.

Because the rate of compensation payable under 38 U.S.C. 1114(j) is generally increased on an annual basis to keep pace with inflation, VA would have to make annual regulatory amendments to ten different regulations if we were to simply insert new dollar amounts where the regulations currently specify $1,500 and $500. This would be extremely burdensome on VA and would invariably result in regulations that specify incorrect dollar amounts until amendments to reflect increases in those amounts made their way through the regulatory process.

To prevent this result, VA has amended 38 CFR 3.557(b) to describe the method required by section 304 of the Act for calculating the dollar values for the estates of incompetent veterans which will trigger discontinuance or resumption of benefit payments. Each time there is an increase in the rate of compensation payable under 38 U.S.C. 1114(j), VA will calculate the new dollar values for discontinuance and resumption and will publish those dollar values in the Notices section of the Federal Register. The new values will be effective on the same day that the increase in the section 1114(j) rate becomes effective. In this way VA will be spared the burden of annually amending numerous regulations, and the public will have access to both the calculation method and the actual dollar value calculated using that method.

In § 3.557(b) we are also deleting the introductory phrase "Effective December 1, 1959,". That phrase has no relevance to current claims processing.

In addition to § 3.557 there are several other regulations referring to the estate values that trigger discontinuance or resumption of benefits for certain incompetent veterans, either in their titles, text or cross-references. We have amended these regulations to remove references to specific dollar amounts. Where amounts appeared in the regulatory text, we have replaced them with references to the amounts calculated under § 3.557(b). Where specific amounts appeared in titles or cross-references we have amended them to eliminate reference to a dollar amount. The affected regulations are §§ 3.353, 3.452, 3.501, 3.558, 3.559, 3.1007, 13.70, 13.71 and 13.108.

Section 333 of the Act amended 38 U.S.C. 2303(b)(1), which governs eligibility for the plot or interment allowance when a veteran is buried in a cemetery, or a section of a cemetery, that is owned by a State or by an agency or a political subdivision of a State. The allowance was previously payable only if the cemetery, or section of the cemetery, was used solely for the interment of persons who were eligible for burial in a national cemetery. Section 333 expanded eligibility to include cemeteries, or sections of cemeteries, that are also used for the interment of persons who were members of a reserve component of the Armed Forces not otherwise eligible for burial in a national cemetery or who were former members of such a reserve component not otherwise eligible for burial in a national cemetery who were discharged or released from service under conditions other than dishonorable. We have amended § 3.1604(d)(1)(ii) to reflect these expanded eligibility criteria. These criteria apply only to the burial of persons dying on or after November 1, 2000.

Section 402(e) of the Act extended, until September 30, 2008, the expiration date for 38 U.S.C. 5503(f), which governs the amount of pension payable to certain veterans and surviving spouses receiving Medicaid-covered nursing home care. That provision was due to expire on September 30, 2002. We have amended § 3.551(i) to reflect the statutory change.

For the reasons set forth in the preamble, 38 CFR Parts 3 and 13 are amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. In § 3.6, paragraphs (a) and (e) are revised to read as follows:

§ 3.6 Duty periods.

(a) Active military, naval, and air service. This includes active duty, any period of active duty for training during which the individual concerned was disabled or died from a disease or injury incurred or aggravated in line of duty, and any period of inactive duty training during which the individual concerned was disabled or died from an injury incurred or aggravated in line of duty or from a covered disease which occurred during such training. For purposes of this section, the term "covered disease" is limited to--

(1) An acute myocardial infarction,

(2) A cardiac arrest, or

(3) A cerebrovascular accident.

(Authority: 38 U.S.C. 101(24))

* * * * *

(e) Travel status—training duty (disability or death from injury or covered disease). Any individual:

(1) Who, when authorized or required by competent authority, assumes an obligation to perform active duty for training or inactive duty training; and

(2) Who is disabled or dies from an injury or covered disease incurred while proceeding directly to or returning directly from such active duty for training or inactive duty training shall be deemed to have been on active duty for training or inactive duty training, as the case may be. The Department of Veterans Affairs will determine whether such individual was so authorized or required to perform such duty, and whether the individual was disabled or died from an injury or covered disease so incurred. In making such determinations, there shall be taken into consideration the hour on which the individual began to proceed or return; the hour on which the individual was scheduled to arrive for, or on which the individual ceased to perform, such duty; the method of travel performed; the itinerary; the manner in which the travel was performed; and the immediate cause of disability or death. Whenever any claim is filed alleging that the claimant is entitled to benefits by reason of this paragraph, the burden of proof shall be on the claimant.

(Authority: 38 U.S.C. 106(d))

§ 3.353 [Amended]

3. In § 3.353, paragraph (b)(1) is amended by removing "in excess of $1,500 (§ 3.557(b))" and adding, in its place, "that equals or exceeds the amount specified in § 3.557(b)(4)".

4. The “CROSS REFERENCES” section immediately following § 3.452 is revised to read as follows:

§ 3.452 Veterans benefits apportionable.

* * * * *

CROSS REFERENCES: Institutional awards. See § 3.852. Disappearance of veteran. See § 3.656. Reduction because of hospitalization. See § 3.551. Penal institutions. See § 3.666. Incompetents; estate equals or exceeds statutory limit and institutionalized. See § 3.557.

§ 3.501 [Amended]

5. In § 3.501, paragraph (i)(7) is amended by removing "$1,500" each time it appears and adding, in its place, "the amount specified in § 3.557(b)(4)".

§ 3.551 [Amended]

6. In § 3.551, paragraph (i) is amended by removing "2002" and adding, in its place, "2008".

7. Section 3.557 is amended by:

A. Revising the section heading and paragraph (b).
B. In paragraph (d) removing "$1,500" and adding, in its place, "the amount specified in paragraph (b)(4) of this section".
C. Revising The “CROSS REFERENCES” section immediately following § 3.557.

The revisions read as follows:

§ 3.557 Incompetents; estate equals or exceeds statutory limit and institutionalized.

* * * * *

(b) Where a veteran:

(1) Is rated incompetent by VA,

(2) Has neither spouse nor child,

(3) Is hospitalized, institutionalized or domiciled by the United States or any political subdivision, with or without charge, and

(4) Effective November 1, 2000, has an estate, derived from any source, which equals or exceeds an amount which is five times the rate of compensation specified in 38 U.S.C. 1114(j), further payments of pension, compensation or emergency officer's retirement pay will not be made, except as provided in paragraph (d) of this section, until the estate is reduced to one-half that amount. Whenever there is an increase in the rate of compensation payable under 38 U.S.C. 1114(j) for a veteran with a service-connected disability rated as total, effective on the date such increase becomes effective, the amount specified in paragraph (b)(4) shall be an amount equal to five times such increased rate of compensation. The dollar value of that increased amount, as well as the dollar value of one-half that amount, will be published in the Notices section of the Federal Register. If the veteran is hospitalized for observation and examination, the date treatment began is considered the date of admission.

* * * * *

CROSS REFERENCES: Veterans disability pension. See § 3.454(c). Reductions and discontinuances; general. See § 3.500. Reductions and discontinuances; veterans. See § 3.501. Amounts withheld or not paid incompetent veteran. See § 3.1007. Estate equals or exceeds statutory limit. See § 13.108 of this chapter. Determination of value of estate. See § 13.109 of this chapter.

8. In § 3.558, the section heading and paragraph (a) are revised to read as follows:

§ 3.558 Resumption and payment of withheld benefits; incompetents with estates that equaled or exceeded statutory limit.

(a) Where payment has been discontinued by reason of § 3.557(b), it will not be resumed during hospitalization except as provided in § 3.557(e) or paragraph (b) of this section until proper notice has been received showing the estate is reduced to one-half the amount specified in § 3.557(b)(4) or less. Payments will not be made for any period prior to the date on which the estate was reduced to one-half the amount specified in § 3.557(b)(4) or less.

(Authority: 38 U.S.C. 5503)

* * * * *

9. Section 3.559 is amended by:

A. Revising the section heading.

B. In paragraph (a), removing "$500" and adding, in its place, "one-half the amount specified in § 3.557(b)(4)".

C. In paragraph (b), removing "is then $1,500 or more" and adding, in its place, "equals or exceeds the amount specified in § 3.557(b)(4)".

The revision reads as follows:

§ 3.559 Resumption - where the estate equals or exceeds the statutory limit and includes chose in action.

* * * * *

§ 3.1007 [Amended]

10. Section 3.1007 is amended by removing "$1,500" and adding, in its place, "the amount specified in § 3.557(b)(4)".

Subpart B--Burial Benefits

11. The authority citation for part 3, subpart B continues to read as follows:

AUTHORITY: 105 Stat. 386, 38 U.S.C. 501(a), 2302-2308, unless otherwise noted.

12. In § 3.1604, paragraph (d)(1)(ii) is revised to read as follows:

§ 3.1604 Payments from non-Department of Veterans Affairs sources.

* * * * *

(d) * * *

(1) * * *

(ii) The deceased veteran is buried in a cemetery or a section thereof which is used solely for the interment of persons who are eligible for burial in a national cemetery or who, with respect to persons dying on or after November 1, 2000, were at the time of death members of a reserve component of the Armed Forces not otherwise eligible for such burial or were former members of such a reserve component not otherwise eligible for such burial who were discharged or released from service under conditions other than dishonorable.

* * * * *

PART 13--VETERANS BENEFITS ADMINISTRATION, FIDUCIARY ACTIVITIES

13. The authority citation for part 13 continues to read as follows:

AUTHORITY: 72 Stat. 1114, 1232, as amended, 1237; 38 U.S.C. 501, 5502, 5503, 5711, unless otherwise noted.

§ 13.70 [Amended]

14. In § 13.70, paragraph (a)(2) is amended by removing "$1,500" and adding, in its place, "the amount specified in § 3.557(b)(4) of this chapter".

§ 13.71 [Amended]

15. In § 13.71, paragraph (b) is amended by removing "$1,500" and adding, in its place, "the amount specified in § 3.557(b)(4) of this chapter".

16. Section 13.108 is amended by:

A. Revising the section heading.

B. In paragraph (a), removing "$1,500" and adding, in its place, "the amount specified in § 3.557(b)(4) of this chapter", and by removing "$500" and adding, in its place, "one-half the amount specified in § 3.557(b)(4) of this chapter".

C. In paragraph (c), removing "exceeds $1,500" and adding, in its place, "equals or exceeds the amount specified in § 3.557(b)(4) of this chapter".

The revision reads as follows:

§ 13.108 Estate equals or exceeds statutory limit; 38 U.S.C. 5503(b)(1).

* * * * *

REGULATORY AMENDMENT

3-01-8

Regulations affected: 38 CFR §§ 3.103(b), 3.204(a), 3.217, 3.256(a), and 3.277(b)

Effective Date of Regulations: December 10, 2001.

Date Secretary Approved Regulations: September 13, 2001

Federal Register Citation: 66 FR 56613 (November 9, 2001)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

For compensation, pension and dependency and indemnity compensation (DIC) benefits administered by VA, individual factors such as income, marital status, the beneficiary's number of dependents, may affect the amount of the benefit that he or she receives or they may affect his or her right to receive the benefit. Beneficiaries must report changes in these factors to VA in a timely manner; certain current VA regulations require that they report such changes in writing. However, there are other means by which beneficiaries could report such changes, including telephone, facsimile, or e-mail, that would allow beneficiaries to advise VA of the changes more quickly and thereby enable VA to adjust benefit payments more quickly. Furthermore, the office of the VA Inspector General has recommended that we eliminate the requirement that such reports be in writing in order to reduce the amounts of the overpayments created when beneficiaries report changes that require VA to reduce or terminate their benefits. For these reasons, we are amending VA's adjudication regulations at 38 CFR 3.204(a)(1), 3.256(a) and 3.277(b) to delete the requirement that beneficiaries report such changes in writing.

For VA to adopt these changes, clearly we must also have safeguards, both for beneficiaries and for VA, to ensure that VA adjusts benefit payments based only on information provided by the beneficiary (or his or her fiduciary) and that the information provided is documented for VA records. We address these issues by adding a new regulation at 38 CFR 3.217. We specify in paragraph (a) of that new section, that unless specifically provided otherwise elsewhere in the regulations, the submission of information that affects entitlement via e-mail, facsimile, or other written electronic means will satisfy a requirement that such information be submitted in writing. This paragraph also includes a note to clarify that the new section applies only to how such information is submitted; it does not relieve the claimant of any other evidence requirements, such as a requirement to use a specific form, to provide specific information or evidence, or to provide a certified statement or a signature.

This amendment authorizes VA to take action affecting entitlement to benefits based on oral or written information provided by a beneficiary or his or her fiduciary in paragraph (b) of new section 3.217. When an individual submits information in writing or by facsimile or e-mail, clearly there is, or in the case of e-mail VA may clearly create, a written document detailing the information provided and the date VA received it. However, because there is no such automatic recording of information that is provided orally, we amended the regulations so that VA may not take action based on oral information or statements unless the VA employee receiving the information takes specific actions during the conversation in which the information or statement is provided. We require the VA employee to take the following actions:

(1) Identify himself or herself as a VA employee who is authorized to receive the information or statement;

(2) Verify the identity of the provider as either the beneficiary or his or her fiduciary by obtaining specific information about the veteran or beneficiary, such as Social Security number, date of birth, branch and/or dates of military service, or other information, that can be verified from the beneficiary's VA records; and

(3) Inform the provider that VA will use the information or statement to calculate benefit amounts.

We also require the VA employee receiving the information to document all of the information or the statement received, as well as the steps taken to verify the identity of the provider, in the beneficiary's VA records. Just as importantly, we require the VA employee to document in the beneficiary's VA records that he or she informed the provider that VA would use the information or statement to calculate benefit amounts.

VA regulations at 38 CFR 3.103(b) generally prohibit VA from reducing or terminating an award of compensation, pension or DIC without first notifying the beneficiary of the adverse action and allowing him or her 60 days in which to submit evidence showing that VA should not take the adverse action. There are specific exceptions to that rule in which VA may issue a notice of the adverse action at the same time it takes the action rather than wait 60 days before taking the action. One of those exceptions is when an adverse action is based solely on written, factual, unambiguous information regarding income, net worth, dependency or marital status provided to VA by the beneficiary or his or her fiduciary with knowledge or notice that VA will use the information to calculate benefits. We revised Sec. 3.103(b) to allow VA to issue notice at the same time it takes adverse action, in lieu of the otherwise required 60-day advance notice, based on written or oral information as described above if the VA employee receiving the information met all of the requirements set out in proposed Sec. 3.217. The rule also states that VA will restore retroactively benefits that were reduced or terminated based on oral information or statements if within 30 days of the date of the notification of adverse action the beneficiary or his or her fiduciary asserts that the adverse action was based upon information or statements that were inaccurate or upon information that was not provided by the beneficiary or his or her fiduciary. This will not preclude VA from taking subsequent action that adversely affects benefits.

Many beneficiaries report these changes to VA by telephone because it is more convenient or in hopes of keeping VA from issuing payments to which they know they are not entitled. They are frustrated when VA advises them that it will issue at least two additional benefit payments unless the beneficiary reports the same information in writing. The change to § 3.103(b) in conjunction with the changes to §§ 3.204, 3.256 and 3.277 and the addition of § 3.217, addresses the concerns of both beneficiaries, by allowing VA to take action on reported changes in a more timely and customer friendly fashion, and the Office of the Inspector General by reducing the amounts of overpayments created because of adverse actions. The provisions contain sufficient added safeguards to ensure that the information and statements used for decision making are accurate and that we accept oral information or statements only under conditions that meet due process requirements.

For the reasons set out in the preamble, 38 CFR part 3 is amended as set forth below:

PART 3--Adjudication

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

2. Section 3.103 is amended by:

A. Revising paragraphs (b)(3) heading and revising paragraphs (b)(3) introductory text and (b)(3)(i).

B. Removing ``is" from paragraphs (b)(3)(ii), (b)(3)(iv), (b)(3)(v) and (b)(3)(vi).

C. Removing the comma at the end of paragraphs (b)(3)(ii), (b)(3)(iii) and (b)(3)(iv), and adding, in its place, a period.

D. Removing ", or" at the end of paragraph (b)(3)(v) and adding, in its place, a period.

E. Adding paragraph (b)(4).

F. Revising the authority citation at the end of the section.

The addition and revisions read as follows:

Sec. 3.103 Procedural due process and appellate rights.

* * * * *

(b) * * *

(2) Advance notice and opportunity for hearing.* * *

(3) Exceptions. In lieu of advance notice and opportunity for a hearing, VA will send a written notice to the beneficiary or his or her fiduciary at the same time it takes an adverse action under the following circumstances:

(i) An adverse action based solely on factual and unambiguous information or statements as to income, net worth, or dependency or marital status that the beneficiary or his or her fiduciary provided to VA in writing or orally (under the procedures set forth in Sec. 3.217(b)), with knowledge or notice that such information would be used to calculate benefit amounts.

* * * * *

(4) Restoration of benefits. VA will restore retroactively benefits that were reduced, terminated, or otherwise adversely affected based on oral information or statements if within 30 days of the date on which VA issues the notification of adverse action the beneficiary or his or her fiduciary asserts that the adverse action was based upon information or statements that were inaccurate or upon information that was not provided by the beneficiary or his or her fiduciary. This will not preclude VA from taking subsequent action that adversely affects benefits.

(Authority: 38 U.S.C. 501, 1115, 1506, 5104)

3. In § 3.204(a)(1), the word ``written'' is removed; and the information collection requirements parenthetical is added immediately preceding the authority citation at the end of the section to read as follows:

§ 3.204 Evidence of dependents and age.

* * * * *

(The office of Management and Budget has approved the information collection requirements in this section under control number 2900-0624.)

* * * * *

4. A new § 3.217 is added immediately preceding the undesignated center heading “Dependency, Income and Estates”:

§ 3.217 Submission of statements or information affecting entitlement to benefits.

(a) For purposes of this part, unless specifically provided otherwise, the submission of information or a statement that affects entitlement to benefits by e-mail, facsimile, or other written electronic means, will satisfy a requirement or authorization that the statement or information be submitted in writing.

Note to paragraph (a): Section 3.217(a) merely concerns the submission of information or a statement in writing. Other requirements specified in this part, such as a requirement to use a specific form, to

provide specific information, to provide a signature, or to provide a certified statement, must still be met.

(b) For purposes of this part, unless specifically provided otherwise, VA may take action affecting entitlement to benefits based on oral or written information or statements provided to VA by a beneficiary or his or her fiduciary. However, VA may not take action based on oral information or statements unless the VA employee receiving the information meets the following conditions:

(1) During the conversation in which the information or statement is provided, the VA employee:

(i) Identifies himself or herself as a VA employee who is authorized to receive the information or statement (these are VA employees authorized to take actions under §§ 2.3 or 3.100 of this chapter);

(ii) Verifies the identity of the provider as either the beneficiary or his or her fiduciary by obtaining specific information about the beneficiary that can be verified from the beneficiary's VA records, such as Social Security number, date of birth, branch of military service, dates of military service, or other information; and

(iii) Informs the provider that the information or statement will be used for the purpose of calculating benefit amounts; and

(2) During or following the conversation in which the information or statement is provided, the VA employee documents in the beneficiary's VA records the specific information or statement provided, the date such information or statement was provided, the identity of the provider, the steps taken to verify the identity of the provider as being either the beneficiary or his or her fiduciary, and that he or she informed the provider that the information would be used for the purpose of calculating benefit amounts.

(Authority: 38 U.S.C. 501, 1115, 1506, 5104)

5. Section § 3.256(a) is amended by removing ``in writing''; and the information collection requirements parenthetical at the end of the section is revised to read as follows:

§ 2.356(a) Eligibility reporting requirements.

(The Office of Management and Budget has approved the information collection requirements in this section under control numbers 2900-0101 and 2900-0624.)

* * * * *

6. Section § 3.277(b) introductory text is amended by removing ``in writing''; and the information collection requirements parenthetical at the end of the section is revised to read as follows:

3.277(b) Eligibility reporting requirements.

(The Office of Management and Budget has approved the information collection requirements in this section under control numbers 2900-0101 and 2900-0624.)

REGULATORY AMENDMENT

3-01-9

Regulations affected: 38 CFR § 3.317(a)

Effective Date of Regulations: November 9, 2001

Date Secretary Approved Regulations: October 12, 2001

Federal Register Citation: 66 FR 56614 (November 23, 2001)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

In response to the needs and concerns of veterans of the Persian Gulf War (Gulf War), Congress enacted the "Persian Gulf War Veterans' Benefits Act," Title I of the "Veterans' Benefits Improvements Act of 1994," Pub. L. 103-446. That statute added a new section 1117 to title 38, United States Code, authorizing the Secretary of Veterans Affairs to compensate a Gulf War veteran suffering from a chronic disability resulting from an undiagnosed illness or combination of undiagnosed illnesses that became manifest either during active duty in the Southwest Asia theater of operations during the Gulf War or to a degree of 10 percent or more within a presumptive period, as determined by the Secretary, following service in the Southwest Asia theater of operations during the Gulf War. The statute specified that, in establishing a presumptive period, the Secretary should review any credible scientific or medical evidence, the historical treatment afforded other diseases for which service connection is presumed, and other pertinent circumstances regarding the experience of Gulf War veterans.

In the Federal Register of February 3, 1995, VA published a final rule adding a new § 3.317 to title 38, Code of Federal Regulations, to establish the regulatory framework necessary for the Secretary to pay compensation under the authority granted by the Persian Gulf War Veterans' Benefits Act. (See 60 FR 6660) As part of that rulemaking, having determined that there was little or no scientific or medical evidence at that time that would be useful in determining an appropriate presumptive period, VA established a 2-year-post-Gulf-service presumptive period based on the historical treatment of disabilities for which manifestation periods had been established and pertinent circumstances regarding the experiences of Gulf War veterans as they were then known.

Because of concerns regarding the adequacy of the 2-year presumptive period for undiagnosed illnesses, the Secretary determined that the presumptive period should be extended with respect to disabilities due to undiagnosed illnesses that become manifest through December 31, 2001. In the Federal Register of April 29, 1997, VA published a final rule amending 38 CFR 3.317 to implement that determination. (See 62 FR 23138)

As required by statute, 38 U.S.C. 1118, the Institute of Medicine (IOM) of the National Academy of Sciences conducted a review of the available scientific literature concerning associations between diseases and exposure in military service to selected risk factors encountered or experienced during the Gulf War. In a report published on September 7, 2000, the IOM noted that research was still ongoing. They suggested additional areas of possible research and recommended that additional studies be conducted. The IOM will be conducting additional reviews of the scientific literature.

No end date for the Gulf War has been established by Congress or the President. (See 38 U.S.C. 101(33)) The servicemembers who conduct military operations after December 31, 2001, will have served in essentially the same physical conditions in which other servicemembers served from the end of the actual conflict through December 31, 2001. It is anticipated that servicemembers will be serving in the Gulf region after December 31, 2001. Thus, unless the manifestation period is extended, these individuals may be unfairly deprived of the benefits mandated by Congress.

In light of the continuing scientific and medical inquiry into the nature and cause of undiagnosed illnesses suffered by Gulf War veterans, the continuing military operations in the Gulf region, and the new claims still being received from Gulf War veterans, this document extends the presumptive period for disabilities due to undiagnosed illnesses that become manifest to a degree of 10 percent or more through December 31, 2006, a period of 5 years. It is expected that, during this period, at least two additional literature reviews will be conducted by the IOM. By then, it is anticipated, results of ongoing research may shed more light on disabilities resulting from Gulf War service and serve as a guide to future policies.

The presumptive period is based primarily on the need for completion of additional research, rather than evidence concerning the manifestation period of undiagnosed illnesses. Although this change has the effect of creating a longer presumptive period for Gulf War veterans who left the Southwest Asia theater of operations in the past, as compared to those who may be service there at present, it still provides an ample presumptive period (up to five years) for the latter individuals. Further, future extensions of the presumptive period are possible should they prove to be necessary for any group of veterans. Thus, this change does not disadvantage any Gulf War veteran.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3--ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity

Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

§ 3.317 [Amended]

2. In § 3.317, paragraph (a)(1)(i) is amended by removing “December 31, 2001” and adding, in its place, “December 31, 2006”.

REGULATORY AMENDMENT

3-01-10

Regulations affected: 38 CFR § 3.113, 3.2100, 3.2130

Effective Date of Regulations: April 6, 2001

Date Secretary Approved Regulations: February 15, 2001

Federal Register Citation: 66 FR 18194 (April 6, 2001)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

This amendment creates new section 3.2130 to restate the current regulation and to remove the obsolete requirement in the Adjudication Procedure Manual that eligibility verification reports signed by mark or thumbprint be accompanied by a separate sheet of paper certifying that the information contained on the form is true and correct. Paragraph (c) eliminates reference to the VA Form 4505 series as giving authority to VA employees to certify signatures by mark or thumbprint and substitutes a reference to 38 CFR 2.3. It is regulations, not forms, that give certain VA employees the authority to take affidavits, administer oaths, and certify documents. The regulations are also more readily available to the general public than VA Forms are. We believe this change more clearly identifies the VA employees authorized to certify signatures by mark or thumbprint.

Interested persons were invited to submit written comments on or before September 25, 2000. We received one comment from the National Service Director of the Disabled American Veterans. The comment suggested improving the proposed rule by permitting the acceptance of signatures on documents by mark or thumbprint when witnessed by accredited agents, attorneys, or service organization representatives. The commenter referred to VA's recently proposed amendment to 38 CFR 3.203 to authorize the acceptance of copies of military records certified as true and exact copies by claimants' representatives (65 FR 39580). This proposal was consistent with the partnership being developed between accredited representatives and VA for the purpose of improving claims processing. VA concurred with the commenter and modified the proposed rule to reflect the comment. Proposed Sec. 3.2130 has been amended by redesignating proposed paragraphs (b) and (c) as paragraphs (c) and (d) respectively, and by adding a new paragraph (b) to read ``They are witnessed by an accredited agent, attorney, or service organization representative, or''. No comments were received with regard to the addition of subpart D or Sec. 3.2100 on the scope of applicability of subpart D.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3—ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

§ 3.1137 [Removed]

2. Section 3.113 is removed.

Subpart C –[Reserved]

1. Subpart C is added and reserved.

2. A new subpart D is added to read as follows:

Subpart D—Universal Adjudication Rules That Apply to Benefit Claims Governed by Part 3 of This Title

General

Sec.
3.2130 Scope of Applicability.
3.2131 Will VA accept a signature by mark or thumbprint?

Subpart D—Universal Adjudication Rules That Apply to Benefit Claims Governed by Part 3 of This Title

Authority: 38 U.S.C. 501(a), unless otherwise noted.

General

1. Section 3.2100 is added to read as follows:

§ 3.2100 Scope of Applicability.

Unless otherwise specified, the provisions of this subpart apply only to claims governed by part 3 of this title.

(Authority: 38 U.S.C. 501(a)).

2. Section 3.2130 is added to read as follows:

§ 3.2130 Will VA accept a signature by mark or thumbprint?

VA will accept signatures by mark or thumbprint if:

(a) They are witnessed by two people who sign their names and give their addresses, or

(b) They are witnessed by an accredited agent, attorney, or service organization representative, or

(c) They are certified by a notary public or any other person having the authority to administer oaths for general purposes, or

(d) They are certified by a VA employee who has been delegated authority by the Secretary under 38 CFR 2.3.

(Authority: 38 U.S.C. 5101).

REGULATORY AMENDMENT

3-01-11

Regulations affected: 38 CFR § 3.808(d)

Effective Date of Regulations: August 24, 2001.

Date Secretary Approved Regulations: August 17, 2001.

Federal Register Citation: 66 FR 18194 (August 24, 2001)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

This amendment concerns the criteria for certification for eligibility for financial assistance for adaptive equipment for automobiles or other conveyances by updating cross-references to pertinent medical regulations that have been recodified. This rule merely consists of nonsubstantive changes.

For the reasons set forth in the preamble, 38 CFR part 3 is amended as follows:

PART 3—ADJUDICATION

Subpart A--Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

AUTHORITY: 38 U.S.C. 501(a), unless otherwise noted.

§ 3.808 [Amended]

2. In § 3.808, paragraph (d) is amended by removing “17.119a through 17.119c” and adding, in its place, “17.156, 17.157, and 17.158”

APPENDIX B

38 CFR Part 4 -- Rating Schedule

Regulatory Amendment Explanations

4-90-1 Through 4-01-1

REGULATORY AMENDMENT
4-90-1

Regulation Affected: 38 CFR 4.16(a)

EFFECTIVE DATE OF REGULATION: September 4, 1990

Date Secretary Approved Regulation: July 10, 1990

Federal Register Citation: 55 FR 31579-80

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 4.16. In a report entitled "Veterans Benefits: Improving the Integrity of VA's Unemployability Compensation Program", the GAO recommended that VA define marginal employment so that the criteria used in making determinations of marginal employment in claims for unemployability are consistent between rating boards. 38 CFR 4.16(a) has been amended to provide that marginal employment is not considered substantially gainful employment. Generally, marginal employment is deemed to exist when a veteran's earned annual income does not exceed the amount established by the Bureau of the Census as the poverty threshold for one person. This should not preclude a finding of marginal employment in some cases when earned annual income exceeds the poverty threshold. Consideration will be given in all claims to the nature of the employment and the reasons for termination.

REGULATORY AMENDMENT

4-90-2

Regulation Affected: 38 CFR 4.117

EFFECTIVE DATE OF REGULATION: October 26, 1990

Date Secretary Approved Regulation: October 2, 1990

Federal Register Citation: 55 FR 43123-5 (October 26, 1990)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 4.117. On March 29, 1990, the Centers for Disease Control released a study entitled "The Association of Selected Cancers with Service in the U.S. Military in Vietnam". That study found that Vietnam veterans have a roughly 50 percent increased risk of developing non-Hodgkin's lymphoma (NHL) after service in Vietnam. The Secretary has determined that there is a relationship between Vietnam service and the subsequent development of NHL. 38 CFR Part 3 has been amended to add section 3.313 to provide the criteria to be used in considering claims for service connection for NHL by Vietnam veterans.

38 CFR 4.117 has been amended to add a diagnostic code and evaluation criteria for NHL.

REGULATORY AMENDMENT

4-91-1

Regulation Affected: 38 CFR 4.73, 4.104 and 4.124a

EFFECTIVE DATE OF REGULATION: October 15, 1991

Date Secretary Approved Regulation: September 16, 1991

Federal Register Citation: 56 FR 51651-3 (October 15, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Under 38 CFR 1.17(c), when VA determines that a significant statistical association exists between exposure to a herbicide containing dioxin and any disease, 38 CFR 3.311a shall be amended to provide guidelines for the establishment of service connection for the disease. These determinations are to be made after receiving the advice of the Veterans Advisory Committee on Environmental Hazards (VACEH) based on its evaluation of scientific or medical studies.

In a public meeting on May 16-17, 1990, the VACEH met in Washington, DC. At that meeting, the VACEH considered more than 80 scientific and medical documents relating to the connection, if any, between exposure to a herbicide containing dioxin and the subsequent development of soft-tissue sarcoma (STS). The VACEH found that the relative weights of valid positive and valid negative studies permitted the conclusion that it is at least as likely as not that there is a significant statistical association between exposure to a herbicide containing dioxin and STS. The Secretary has accepted that recommendation.

There is disagreement even among pathologists as to what tumors the term "soft-tissue sarcoma" encompasses. With the assistance of VHA and the VACEH, we compiled a list of those tumors which we consider to be soft-tissue sarcomas and included it in the regulation. For compensation purposes, such tumors must be malignant and arise from tissue of mesenchymal origin, including muscle, fat, blood or lymph vessels, or connective tissue (but not cartilage or bone). Tumors of infancy or childhood, and those having a strong, known causal association with a specific etiology have been excluded because it is unlikely that there is a reasonable probability of a significant statistical association between such tumors and exposure to a herbicide containing dioxin.

STS is currently rated by analogy because there are no specific diagnostic codes in the rating schedule. 38 CFR Part 4 has been amended to add specific diagnostic codes for STS as well as evaluation criteria. In addition, diagnostic code 5327 has been amended to exclude STS and to revise the point at which evaluations are based on residual disability from 1 year to 6 months following cessation of treatment. The revision has been made because medical advances have reduced the recovery time needed following surgery, chemotherapy, etc.

Section 4.73. Diagnostic code 5327 has been revised to exclude STS, and new diagnostic code 5329 has been added.

Section 4.104. New diagnostic code 7123 has been added.

Section 4.124a. New diagnostic code 8540 has been added.

REGULATORY AMENDMENT

4-91-2

Regulation Affected: 38 CFR 4.17

EFFECTIVE DATE OF REGULATION: December 16, 1991

Date Secretary Approved Regulation: October 10, 1991

Federal Register Citation: 56 FR 57985 (November 15, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 8002 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, amended 38 U.S.C. 1502(a) to eliminate the presumption of total disability at age 65 for pension purposes.

Section 4.17. 38 CFR 4.17 has been amended to delete the presumption of permanent and total disability at age 65. 38 CFR 4.17 has also been amended to require for all veterans, regardless of age, a single disability rated as 60 percent or a combined evaluation of 70 percent, with one disability ratable at 40 percent or higher (see § 4.16(a)). Claims of any veterans who fail to meet the required percentages but are otherwise entitled and unemployable will continue to be referred to the Adjudication Officer under § 3.321(b)(2).

REGULATORY AMENDMENT

4-92-1

Regulations Affected: 38 CFR 4.88a, diagnostic codes 6351, 6352, and 6353

EFFECTIVE DATE OF REGULATION: March 24, 1992

Date Secretary Approved Regulation: February 7, 1992

Federal Register Citation: 57 FR 10134-6 (March 24, 1992)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Three diagnostic codes were previously used for rating HIV-related illnesses: diagnostic code 6351, Acquired immunodeficiency syndrome (AIDS); diagnostic code 6352, AIDS related complex (ARC); and diagnostic code 6353, HIV antibody positive. Diagnostic codes 6351 and 6352 were rated by reference to the underlying disease, and diagnostic code 6353 was assigned a 0 percent evaluation. The need for more specific rating criteria became clear when the multitude and complexity of symptoms associated with HIV infection were considered. Constitutional and neurological diseases can be rated under a variety of diagnostic codes, and since many analogies are possible, inconsistent evaluations often resulted. Opportunistic infections may resolve with minimal chronic impairment of the affected body system, but the average person's employment potential is markedly compromised. Although the HIV infection may not have progressed to the stage of AIDS or ARC, an individual may nevertheless be symptomatic and partially disabled.

Diagnostic codes 6352 and 6353 have been removed, and HIV-related illnesses are now rated under a single diagnostic code, 6351. This code contains evaluation criteria at the levels of 0, 10, 30, 60, and 100 percent which allow for rating by staging or symptomatology, whichever permits a higher evaluation. Separate evaluations under other diagnostic codes for manifestations of the disease are also permitted if a higher overall evaluation would thereby result.

Section 4.88a. Diagnostic codes 6351 (Acquired Immunodeficiency Syndrome), 6352 (Aids Related Complex), and 6353 (HIV Antibody positive) have been replaced by a single diagnostic code 6351 for HIV-related illnesses with evaluation criteria at the 0, 10, 30, 60, and 100 percentage levels.

REGULATORY AMENDMENT

4-93-1

Regulation affected: 38 CFR 4.31

EFFECTIVE DATE OF REGULATION: October 6, 1993

Date Secretary Approved Regulation: August 26, 1993

Federal Register Citation: 58 FR 52017-18 (October 6, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

A majority of the disabilities addressed in the VA's Schedule for Rating Disabilities (38 CFR part 4) do not specify criteria for a zero percent level. Once it has been determined that a disability is service-connected, it has been VA's consistent practice to assign a zero percent evaluation whenever the condition does not meet the stated minimum requirements for compensable evaluation. In recent decisions, however, the U.S. Court of Veterans Appeals (COVA) pointed out that unless an individual diagnostic code requires residual disability for a compensable evaluation, a zero percent evaluation is not authorized under §§ 3.357(a) and 4.31. See Rabideu v. Derwinski, U.S. Vet. App. No. 90-1296 and Conley v. Derwinski, U.S. Vet. App. No. 91-527. From the Court's analysis it is apparent that VA regulations are seen as being inconsistent with VA's longstanding practice of assigning a zero percent evaluation for any disability which does not meet the minimum requirements for a compensable evaluation.

We have amended § 4.31 to eliminate this perceived discrepancy between VA practice and regulations. We have changed the heading of § 4.31 from "A no-percent rating" to "Zero percent evaluations" to more accurately represent the issue addressed in the regulation.

We have deleted § 3.357(a) because it is a duplicate of § 4.31 and because the issue is more appropriately addressed in the rating schedule.

Section 4.31. Section 4.31 has been revised to provide that, in every instance where the schedule does not provide a zero percent evaluation for a diagnostic code, a zero percent evaluation shall be assigned when the requirements for a compensable evaluation are not met.

REGULATORY AMENDMENT

4-94-1

Regulation affected: 38 CFR 4.115, 4.115a.

EFFECTIVE DATE OF REGULATION: February 17, 1994

Date Secretary Approved Regulation: March 5, 1993

Federal Register Citation: 59 FR 2523-2529 (January 19, 1994)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

In December 1988, the General Accounting Office (GAO) recommended that VA prepare a plan for a comprehensive review of the rating schedule and, based on the results, revise the medical criteria accordingly. Based in part on this recommendation, the Compensation and Pension Service initiated a systematic review of the Schedule for Rating Disabilities (38 CFR Part 4) in order to remove outdated medical terminology and ambiguous rating criteria and to introduce recent medical advances.

We have made a number of editorial changes, primarily of syntax and punctuation, throughout these section, intended to clarify the rating criteria and represent no substantive amendment. We have deleted generic terms such as "severe", "moderate", and "mild" from various evaluation criteria and replaced them, wherever possible, with more objective, unambiguous descriptions of the levels of disability. We have also changed a number of terms to reflect current medical terminology and to clarify various anatomical aspects or treatment procedures.

We added two sentences to § 4.115 to clarify that hypertension or heart disease will be separately rated if absence of a kidney is the sole renal disability and that hypertension or heart disease will be separately rated if renal disease has progressed to the point where regular dialysis is required. This makes regulatory the long-established policy which is included in the Department of Veterans Benefits Manual of Adjudication Procedures, M21-1.

We have redesignated § 4.115a as § 4.115b and replaced the existing § 4.115a with an explanation of the three new dysfunction formulas which follow.

In order to allow a broader range of possible evaluations for many disabilities and a more accurate level of compensation for each, we have provided three general dysfunction formulas for disabilities of the genitourinary system. Diagnostic codes throughout the section refer to these criteria for evaluation of the predominant dysfunction. The evaluations prescribed for each category of dysfunction are generally consistent with percentages and criteria currently specified under the following diagnostic codes: 7502, nephritis, corresponding to renal dysfunction; 7512, cystitis with criteria relating to frequency of urination, corresponding to voiding dysfunction; 7518, stricture of urethra with criteria relating to dilation treatments, corresponding to urinary tract infection, and also relating to obstructed voiding as a category of voiding dysfunction; and, 7519, fistula of urethra with criteria relating to frequency of drainage, corresponding to continual urinary leakage as a category of voiding dysfunction.

Under renal dysfunction and diagnostic code 7530, chronic renal disease requiring regular hemodialysis, the word dialysis has been used instead of hemodialysis in order to include consideration of continuous ambulatory peritoneal dialysis, as well as hemodialysis, in the assignment of a total evaluation. Specific measurements of creatinine and blood urea nitrogen (BUN) are provided for the 100 and 80 percent evaluations under renal dysfunction. The term "nonprotein nitrogen" shown under

diagnostic code 7502, chronic nephritis, is obsolete and has been removed as a measure of kidney dysfunction. We have described hypertension requirements in terms of diagnostic code 7101, essential hypertension, under the 60, 30 and 0 percent levels of evaluation for renal dysfunction in order to promote a clear understanding of the rule and for internal consistency within the rating schedule.

We have deleted the one year period of convalescence under diagnostic code 7528, malignancies of the genitourinary system in favor of an indefinite period of convalescence with mandatory examination at the end of six months; any reduction in evaluation based on the findings of the examination will be implemented in accordance with § 3.105(e). This will provide the claimant contemporaneous notification and base any reduction on current medical findings rather than a regulatory assumption that there has been an improvement.

Similarly, we have deleted the two year convalescence period under diagnostic code 7531, kidney transplant. Kidney transplants have become far more common since 1975, when a total evaluation for two years was first specified in the rating schedule, and improved surgical techniques and experience with immuno-suppressive management make it possible to assess residual impairment one year after surgery instead of two. As with malignancies, there will be an indefinite period of convalescence with a mandatory VA examination, in this case one year after hospital discharge following surgery, and any reduction will be based on the findings of this examination, subject to the provisions of 38 CFR 3.105(e). We have retained the 30 percent minimum evaluation. Subsequent to convalescence, the residuals are to be evaluated as renal dysfunction, in order to provide consistent evaluations and objective criteria.

We have eliminated four of the diagnostic categories. Pyelitis, diagnostic code 7503, is not currently used in medical practice and is generally understood to be included under pyelonephritis, which remains as diagnostic code 7504. Intersitial cystitis, diagnostic code 7513 is included under chronic cystitis, diagnostic code 7512, since these are essentially the same disability. Chronic cystitis is amended to include cystitis of all etiologies, infectious and non-infectious. Tuberculosis of the bladder, diagnostic code 7514, is a very uncommon disease and it does not warrant a separate code in this section of the schedule. Ratings for nonpulmonary tuberculosis are prescribed by §§ 4.88b and 4.89. Resection or removal of the prostate gland is included under diagnostic code 7527, prostate gland injuries. Residuals of total prostatectomy are to be evaluated according to the severity of the individual disability instead of assigning a minimum evaluation of 20 percent. A separate diagnostic code is therefore redundant.

Eleven new codes have been added to this section of the rating schedule. Renal tubular dysfunctions, diagnostic code 7532, is given a minimum 20 percent evaluation if symptomatic, with instructions to otherwise rate as renal dysfunction. The following nine conditions are to be rated as renal dysfunction: Cystic disease of the kidneys, code 7533; atherosclerotic renal disease, 7534; toxic neuropathy, 7535; glomerulonephritis, 7536; interstitial nephritis, 7537; papillary necrosis, 7538; renal amyloid disease, 7539; disseminated intravascular coagulation with renal cortical necrosis, 7540; and renal involvement in diabetes mellitus, sickle cell anemia, systemic lupus erythematosus, vasculitis, or other systemic disease processes, 7541. These additional codes have been added in order to reduce reliance on the uncertain practice of rating many kidney disorders by analogy. We have added diagnostic code 7542, neurogenic bladder, with instructions to rate the condition under the criteria for voiding dysfunction. This is a common condition in cases of severe spinal cord injury.

Diagnostic code 7500, removal of one kidney, is changed to instruct the rater to evaluate the condition as renal dysfunction if there is nephritis, infection or pathology of the other kidney. This represents consideration of entire renal dysfunction and is the most consistent means of rating kidney disorders.

Diagnostic code 7508, nephrolithiasis, has been changed to provide a 30 percent evaluation for recurrent stone formation if drug or diet therapy or invasive or non-invasive procedures, more than two

times per year are required. If stone formation is not recurrent to this extent, the condition will be evaluated according to the criteria for hydronephrosis, diagnostic code 7509. Ureterolithiasis, code 7510, and stricture of the ureter, code 7511, have been given the same criteria for evaluation. This provides objective criteria and consistency within this section of the schedule.

We have changed the criteria for the "severe" level of hydronephrosis, diagnostic code 7509, to instruct the rater to use objective evaluation criteria under the general formula for renal dysfunction.

The percentage evaluation for loss of one testicle under diagnostic code 7524 has been reduced from 10 percent to zero percent and the term "other than undecended or congenitally undeveloped" has been deleted from the new zero percent level. No significant employment handicap is anticipated from loss of a single testicle, any retrogressive changes in secondary sex characteristics even following removal of both testes after sexual maturity would occur slowly, if at all, and a solitary testis is adequate to sustain normal endocrine function without hormone replacement.

The title of epididymo-orchitis, tuberculous, active or inactive, diagnostic code 7525, has been changed to epididymo-orchitis, chronic only, with instructions to rate as urinary tract infection. The instructions to rate tubercular infections under §§ 4.88b or 4.89 has been retained. These new instructions allow for evaluation of any type of epididymal infection under this code.

The instructions for evaluation of prostate gland injuries, infections, hypertrophy, or postoperative residuals, diagnostic code 7527, have been changed to evaluate the conditions as voiding dysfunction or urinary tract infection, consistent with other codes in this section and to provide the widest, most objective range of criteria.

The title of diagnostic code 7528, new growths, malignant, any specified part of genitourinary system, has been changed to malignant neoplasms of the genitourinary system because the term neoplasm better connotes the pathological abnormality. Following convalescence, as explained above, the condition will be evaluated as voiding dysfunction or renal dysfunction, whichever is predominant, in order to provide consistent evaluations and objective criteria.

Section 4.115 is revised to clarify that hypertension or heart disease will be separately rated if absence of a kidney is the sole renal disability, if it has progressed to the point where regular dialysis is required.

Section 4.115a is redesignated as section 4.115b, and replaced with the explanation of the three new dysfunction formulas for evaluating a number of genitourinary disabilities.

Section 4.115b is added as the heading for the section containing the rating codes and diagnoses for genitourinary disabilities.

Diagnostic codes Revised	Diagnostic codes Added	Diagnostic codes Removed
7500	7532	7503
7502	7533	7513
7508	7534	7514
7509	7535	7526
7510	7536	
7511	7537	
7524	7538	
7525	7539	
7527	7540	
7528	7541	

7530
7531
7542

REGULATORY AMENDMENT

4-94-2

Regulation affected: 38 CFR 4.150

EFFECTIVE DATE OF REGULATION: February 17, 1994

Date Secretary Approved Regulation: August 19, 1993

Federal Register Citation: 59 FR 2529-2530 (January 18, 1994)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

In December 1988, the General Accounting Office (GAO) recommended that VA prepare a plan for a comprehensive review of the rating schedule and, based on the results, revise the medical criteria accordingly. Based in part on this recommendation, the Compensation and Pension Service initiated a systematic review of the Schedule for Rating Disabilities (38 CFR Part 4) in order to remove outdated medical terminology and ambiguous rating criteria and to introduce recent medical advances.

The schedule of ratings for Dental and Oral Conditions lists five disabilities without diagnostic codes: Carious teeth, treatable; missing teeth, replaceable; dento-alveolar abscess; pyorrhea alveolaris; and Vincent's stomatitis. These conditions are not considered disabling and the issue of service-connection is addressed by raters only for the purpose of determining entitlement to out patient dental treatment under the provisions of 38 CFR 3.382 and 17.123. We have deleted them from § 4.150 and added a new section designated as § 4.149 which states, in more contemporary terms, that these conditions are not compensable conditions, but that they may be considered service-connected solely for the purpose of establishing entitlement to dental examination or outpatient dental treatment.

We have included osteoradionecrosis under diagnostic code 9900, osteomyelitis of the maxilla or mandible, because this condition occurs often enough in the veteran population to warrant inclusion and because its disabling effects are similar to osteomyelitis.

We have denoted categories of both inter-incisal and lateral excursion of the temporomandibular joint, diagnostic code 9905 because this diagnostic code does not specify this type of limitation. We have provided evaluation levels of 10, 20, 30, and 40 percent for precise ranges of inter-incisal motion limitation and a 10 percent evaluation for limited lateral excursion from 0 to 4 millimeters. We have provided a NOTE following the code specifying that ratings for limited inter-incisal movement will not be combined with ratings for limited lateral excursion under this code in accordance with the prohibition against pyramiding (38 CFR 4.14).

We have deleted diagnostic code 9510, maxilla, loss of whole or part of substance of, nonunion of , or malunion of because disabilities of the maxilla are not comparable to those of the mandible, as the instructions to rate the disability imply. We have added three new codes, 9914, 9915 and 9916, each with its own percentage ranges and evaluation criteria in order to provide complete and equitable evaluations for these disabilities.

We have revised the note following diagnostic code 9913, teeth, loss of, due to loss of substance of maxilla or mandible to use the less ambiguous term "periodontal disease" instead of "natural resorption" and to explain why loss of the alveolar process without loss of bone is not compensable.

We have revised the evaluation criteria of diagnostic code 9913 because the current descriptions are confusing and unclear. No substantive change is intended by this revision.

We have substituted the word "prosthesis" for the term "prosthetic appliance under codes 9911 and 9912 for the sake of consistency, since "prosthesis" is used under code 9913 and other diagnostic codes throughout the schedule.

Section 4.149. This section is added to include the non-disabling conditions which are listed for the purpose of determining entitlement to dental examination and dental outpatient treatment and to instruct the rater that these are not compensable conditions.

Section 4.150. This section is amended to:
1) Include osteoradionecrosis under diagnostic code 9900, osteomyelitis of the maxilla or mandible,
2) Provide specific criteria for limitations of ranges of motion of the jaw, diagnostic code 9905, and to add a NOTE cautioning against pyramiding,
3) Add three diagnostic codes: 9914, maxilla, loss of more than half, 9915, maxilla, loss of half or less, and 9916, maxilla, malunion or nonunion, with percentage evaluations for each at levels appropriate to the levels of disability,
4) Amend the note following diagnostic code 9913, tooth loss due to damage of the mandible or maxilla, for clarity and to explain why loss of the alveolar process without bone loss is not compensable,
5) Clarify the descriptions of combinations of loss of teeth in diagnostic code 9913,
6) Substitute the word "prosthesis" for the term "prosthetic appliance" under diagnostic code 9912.

Diagnostic codes Revised	Diagnostic codes Added	Diagnostic codes Removed
9900	9914	NONE
9905	9915	
9912	9916	
9913		

REGULATORY AMENDMENT

4-94-3

Regulation Affected: 38 CFR 4.115b

EFFECTIVE DATE OF REGULATION: September 8, 1994

Date Secretary Approved Regulation: July 28, 1994

Federal Register Citation: 59 FR 46338-9 (September 8, 1994)

The purpose of the following comments on the changes included in these amendments of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

The final revision of the section of the Schedule for Rating Disabilities of the Genitourinary System was published in the Federal Register on January 18, 1994. Taking into account a comment we received after publication of the proposed revision of the genitourinary section of the rating schedule that we should add a n note under DC 7522 (Penis deformity, with loss of erectile power) indicating entitlement to SMC, we have reconsidered the issue of providing guidance to rating specialists in the rating schedule on the issue of special monthly compensation (SMC). We concluded that the combination of the two provisions added by this amendment is the best means of assuring that potential entitlement to SMC is considered.

The amendment adds a note at the beginning of 38 CFR 4.115b requiring rating specialists to refer to 38 CFR 3.350 any time they evaluate a claim involving loss or loss of use of a creative organ, and also adds a footnote at diagnostic codes 7522, 7523, and 7524 directing the rater to review for entitlement to special monthly compensation under § 3.350.

REGULATORY AMENDMENT

4-94-4

Regulation affected: 38 CFR 4.88a and 4.88b

EFFECTIVE DATE OF REGULATION: November 29, 1994

Date Secretary Approved Regulation: August 1, 1994

Federal Register Citation: 59 FR 60901-2 (November 29, 1994)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

We have amended 38 CFR 4.88a and 4.88b and added 4.88c by means of an interim rule with request for comments in order to add a diagnostic code and evaluation criteria for chronic fatigue syndrome to the portion of the rating schedule on systemic diseases. We have provided evaluation levels of 10, 20, 40, 60, and 100 percent. Chronic fatigue syndrome is of unknown etiology and is characterized by non-specific symptoms. Because it has been ill-defined and sometimes confused with other conditions, we have also added a section that provides diagnostic criteria for the syndrome.

We have made this an interim rule with request for comments so that it can be effective immediately, but comments will be received for 60 days, and the rule may be amended based on the comments.

Sections 4.88a and 4.88b are redesignated 4.88b and 4.88c respectively.

Section 4.88a is added to provide diagnostic criteria for chronic fatigue syndrome.

Section 4.88b. New diagnostic code 6354 has been added.

REGULATORY AMENDMENT

4-95-1

Regulation affected: 38 CFR 4.116 and 4.116a

EFFECTIVE DATE OF REGULATION: May 22, 1995

Date Secretary approved regulation: December 22, 1994

Federal Register Citation: 60 FR 19851-6 (April 21, 1995)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended sections 4.116 and 4.116a of 38 CFR, Part 4, the sections of the rating schedule that deal with gynecological conditions and disorders of the breast. The intended effect of this action is to update the gynecological and breast disorders section of the rating schedule to ensure that it uses current medical terminology, unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

We changed the title of this part of the rating schedule from "gynecological conditions" to "gynecological conditions and disorders of the breast" to reflect more accurately the content. We made language changes consistent with current medical usage, such as changing "mammary glands" to "breasts," "new growths" to "neoplasms," and "extirpation," "resection," and "excision" to "removal."

We deleted the introductory section, 4.116, removing some material and putting the material that remained in the form of a note. We removed from the material the statement that excision of uterus, ovaries, etc., prior to the natural menopause is considered disabling because the implied distinction of the effects of the surgery itself before and after the menopause is not warranted.

We also removed from the material in § 4.116 the statement that surgical complications of pregnancy will not be held the result of service except when additional disability resulted from treatment, or they are otherwise attributable to unusual circumstances of service. These remarks were unclear, seemingly restricting service connection in most cases, and such chronic disabilities, if incurred during service, would be subject to service connection, as with other chronic disabilities. For further clarification, we added the statement that chronic residuals of medical or surgical complications of pregnancy may be disabilities for rating purposes.

We added footnotes at diagnostic codes (DC's) 7617 through 7620 and a note at the beginning of § 4.116 to alert the rater to consider special monthly compensation (SMC) because we believe that the combination of the footnotes and note is the best method of assuring that potential entitlement to SMC is considered.

We removed the criteria of "mild," "moderate," and "severe" that had been used to evaluate disease or injury of vulva, vagina, or cervix, and for disease, injury, or adhesions of uterus, Fallopian tube (including PID), or ovary (DC's 7610 through 7615). In their place, we provided a general rating formula using objective evaluation criteria based on the need for continuous treatment and whether symptoms are controlled by treatment. These changes will assure that comparable medical conditions are assigned comparable evaluations. We also revised the titles of DC's 7610 through 7615 to clarify the proper classification of gynecological conditions.

We changed the convalescent period following the removal of uterus and ovaries, or ovaries alone (DC's 7617 and 7619) from 6 months to 3 months, in accord with current medical practice, and taking into account improved surgical techniques, postoperative care, and the practice of early ambulation. We also changed the title of DC 7619 from "ovaries, removal of both" to "ovary, removal of" so that a three-month period of convalescence will apply to the removal of one or both ovaries. The evaluation for removal of one ovary with or without partial removal of the other (DC 7619) has been changed from 10 percent to 0 percent because the loss of one ovary does not compromise endocrine or reproductive function to such an extent that an impairment of earning capacity ordinarily results.

We provided specific criteria for rectovaginal fistula and urethrovaginal fistula (DC's 7624 and 7625, respectively) rather than referring the rater to diagnostic codes in other systems for evaluation criteria. We also removed subjective terminology such as "extensive leakage" and "fairly frequent" from the criteria for rectovaginal fistula (which we had proposed to be the same as the criteria for rectum and anus, impairment of sphincter control, DC 7332), replacing that language with more precise criteria, although with the same basis of evaluation.

We added definitions of the various types of breast surgery for clarity and also provided a compensable evaluation (30%) for less than a total mastectomy when there is significant alteration of size or form (DC 7626). This is a type of breast surgery that may be done for neoplasms and other conditions that is more conservative than a total mastectomy, but which may still be disabling.

We added a new diagnostic code and evaluation criteria for two common conditions that previously required rating by analogy: endometriosis (DC 7628) and benign neoplasms of the gynecological system or breast (DC 7629). In order to assure more consistent evaluations of endometriosis than rating by analogy, we provided evaluation criteria based on the presence of pelvic pain or heavy or irregular bleeding and whether they are controlled by treatment, and on whether there is symptomatic involvement of bladder or bowel. Benign neoplasms are to be evaluated on the basis of impairment of function

We made a minor revision in the language of the evaluation criteria for prolapse of uterus (DC 7621) to be more precise, changing "complete, through vulva" to "complete, through vagina and introitus."

We made changes in the convalescent period following treatment for malignant neoplasm (DC 7627) similar to changes we have made in other body systems, i.e., requiring a mandatory VA examination 6 months following completion of treatment and implementation of § 3.105(e) before any reduction can be made.

Section 4.116 is removed.
Section 4.116a is redesignated as § 4.116.

Diagnostic codes revised	Diagnostic codes added	Diagnostic codes removed
7610	7628	NONE
7611	7629	
7612		
7613		
7614		
7615		
7617		
7618		
7619		
7620		
7621		
7622		
7623		
7624		
7625		
7626		
7627		

REGULATORY AMENDMENT

4-95-2

Regulation affected: 38 CFR 4.117

EFFECTIVE DATE OF REGULATION: October 23, 1995

Date Secretary approved regulation: June 13, 1995

Federal Register Citation: 60 FR 49225-28 (September 22, 1995)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended section 4.117 of 38 CFR, Part 4, the section of the rating schedule that deal with the hemic and lymphatic systems. The intended effect of this action is to update this section of the rating schedule to ensure that it uses current medical terminology, unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

We changed the title of DC 7700 from "pernicious anemia" to "hypochromic-microcytic and megaloblastic anemia" because we have expanded this code to include additional anemias that will be evaluated under the same criteria. The schedule formerly had evaluation levels for 30, 60, 70, and 100 percent. We changed the levels to 0, 10, 30, 70, and 100 percent since the difference between the 60 and 70 percent levels would be so slight as to be meaningless for rating purposes. We added a zero percent level to make it clear that those who are asymptomatic despite a hemoglobin level of 10gm/100ml or less warrant only a zero percent evaluation, and we added a ten percent level for those who are anemic and have mild symptoms such as weakness, easy fatigability, or headaches. We changed the criteria for these anemias to make them more objective, basing them on a certain range of hemoglobin levels plus specific signs and symptoms. Finally, we added a note directing that complications of pernicious anemia be rated separately because such complications occur often enough to warrant instructions in order to ensure consistent ratings.

We deleted DC 7701, secondary anemia, because this represents a symptom of another more specific disease and does not warrant its own diagnostic code.

For acute agranulocytosis, DC 7702, we changed the evaluation levels from 30, 60, 70, and 100 percent to 10, 30, 60, and 100 percent. We removed the 70 percent level because, as stated under DC 7700, the difference between the 60 and 70 percent levels would be so slight as to be meaningless for rating purposes. We added a 10 percent level when the condition requires continuous medication for control. Previously, acute agranulocytosis was rated under the criteria for acute pernicious anemia. However, the course and treatment of agranulocytosis are usually substantially different from those of pernicious anemia, and we have therefore provided new criteria based on the need for a bone marrow transplant or transfusions, the presence of recurrent infections, or the need for continuous medication for control, since these are more appropriate means of evaluating this condition than the criteria we have used for DC 7700. We added a note stating that a 100 percent evaluation will be assigned from the date of hospital admission for a bone marrow transplant, with a mandatory VA examination to be done six months later, and any change in evaluation to be subject to the provisions of § 3.105(e). This will ensure that no evaluation after bone marrow transplant is reduced without current medical evidence, offers veterans prior notice of any proposed action, and provides an opportunity for the veteran to present evidence showing that the action should not be taken.

Under DC 7703, leukemia, we edited the language regarding requirements for a 100 percent evaluation and changed the direction for rating otherwise, directing that it be under either DC 7700 or 7716 (a new code for aplastic anemia), depending on which results in a higher evaluation. This provides a broader range of evaluations, consistent with what may be seen in this condition. For consistency with the method of evaluating malignancies of other body systems, we added a note directing that the total evaluation be continued, with a mandatory VA examination six months following completion of therapy, and any change in evaluation be subject to the provisions of § 3.105(e).

We changed the title of DC 7704, primary polycythemia, to the more current name for this condition, polycythemia vera. This condition was formerly rated as pernicious anemia, but we have provided criteria more specific to this condition, with evaluation levels of 10, 40, and 100 percent, based on the need for phlebotomy or myelosuppressant therapy, and on whether it is stable. We added a note directing that complications be rated separately because they occur often enough that this instruction is needed to assure that veterans are rated consistently.

We changed the title of DC 7705 from purpura hemorrhagica to the more modern term, thrombocytopenia, primary, idiopathic or immune. We made the criteria more objective, basing them primarily on the blood platelet count, requirement for treatment, and whether there is bleeding. As with several other conditions in this section, we changed the evaluation levels from 30, 60, 70, and 100 percent to 0, 30, 70, and 100 percent because the 60 percent level is clinically indistinguishable from the 70 percent level for rating purposes, and we added a zero percent level to indicate that when the platelet count is stable and above 100,000, and there is no bleeding, the condition does not warrant more than a zero percent evaluation.

We changed the evaluation level for splenectomy, DC 7706, from 30 percent to 20 percent because, although antibiotics now available can diminish the consequences of splenectomy (such as increased susceptibility to infection), the spleen also has other functions, and splenectomy is therefore still considered moderately disabling. We added a note under DC 7706 to clarify that complications of splenectomy are to be separately evaluated.

Under DC 7707, spleen, injury of, healed, we changed the direction from "rate as peritoneal adhesions" to "rate for any residuals" to take into account the fact that residuals other than peritoneal adhesions may occur.

We changed the title of DC 7709 from lymphogranulomatosis (Hodgkin's disease) to Hodgkin's disease because this is the modern name for the condition. Rather than continuing evaluation levels of 30, 60, and 100 percent based on specific signs and symptoms, we based the 100 percent evaluation level on the presence of active disease or during a treatment phase and added a note directing the same procedure as for leukemia and other malignancies -- a mandatory VA examination six months following the cessation of treatment, and any change in evaluation to be subject to the provisions of § 3.105(e). In addition to the benefits mentioned above (under the discussion of DC 7702) regarding the use of § 3.105(e), this change will allow the assignment of any level of evaluation based on the findings at examination.

We changed the title of DC 7710 from adenitis, cervical, tuberculous, active or inactive, to adenitis, tuberculous, active or inactive. This consolidates three types of tuberculous adenitis that are now relatively uncommon: cervical, axillary (formerly DC 7711), and inguinal (formerly DC 7712), into a single code. We have deleted DC's 7711 and 7712. We also removed the direction to rate active disease at 100 percent and inactive as §§ 4.88b and 4.89 in favor of a direction to rate as §§ 4.88c or 4.89, which are the sections that direct how to evaluate nonpulmonary tuberculosis.

We have deleted DC 7713, adenitis, secondary, because it is commonly accepted as a symptom of a specific disease and would be included in the evaluation for that disease.

Under DC 7714, sickle cell anemia, we revised the language of the criteria for the sake of more objectivity by removing the subjective terms "mild," "moderately severe," "severe," and "pronounced"; and we made other editorial, non-substantive changes in the criteria and the note under the code.

There was an instruction under non-Hodgkin's lymphoma, DC 7715, to rate as Hodgkin's disease (DC 7709). For the sake of convenience of those using the schedule, we repeated the criteria used to evaluate Hodgkin's disease under DC 7715.

We added a new condition, aplastic anemia, DC 7716, with the same criteria and evaluation levels we have provided for acute agranulocytosis, DC 7702, because the treatment of these conditions is similar.

Diagnostic codes revised	Diagnostic codes added	Diagnostic codes removed
7700	7716	7701
7702		7711
7703		7712
7704		7713
7705		
7706		
7707		
7709		
7710		
7714		
7715		

REGULATORY AMENDMENT

4-96-1

Regulation affected: 38 CFR 4.71a

EFFECTIVE DATE OF REGULATION: May 7, 1996

Date Secretary Approved Regulation: December 7, 1995

Federal Register Citation: 61 FR 20438-9

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

We have amended 38 CFR 4.71a by means of an interim rule with request for comments in order to add a diagnostic code and evaluation criteria for fibromyalgia to the portion of the rating schedule on musculoskeletal diseases. We have provided evaluation levels of 10, 20, and 40 percent. Fibromyalgia is a syndrome of unknown etiology that is characterized by chronic, widespread musculoskeletal pain associated with multiple tender or "trigger" points, and often with multiple somatic complaints, such as sleep disorders, anxiety, fatigue, headache, and irritable bowel symptoms. Other possible associated complaints include neurologic symptoms such as numbness and weakness without objective neurologic findings, depression, Raynaud's-like syndrome, and weakness.

Classification criteria for fibromyalgia for research and epidemiological purposes were established by the American College of Rheumatology in 1990. The first requirement is a history of widespread pain, which means pain in both the left and right sides of the body, pain both above and below the waist, and pain in both the axial (cervical spine, anterior chest, thoracic spine, or low back) and peripheral (extremity) skeleton. The second requirement is the presence of pain on digital palpation at a minimum of 11 of the following 18 tender point sites: occiput, low cervical, trapezius, supraspinatus, second rib, lateral epicondyle, gluteal, greater trochanter, knee (there is a left site and a right site at each location). In clinical practice, the diagnosis is often made on less stringent criteria, with fewer tender points required.

We are providing three levels of evaluation: 10, 20, and 40 percent, consistent, in our judgment, with the clinical range of impairment of this condition. While patients may have numerous symptoms that may be chronic, it is a benign disease that does not result in loss of musculoskeletal function. For the 40 percent level, the requirements are that the widespread pain and multiple tender points, with or without certain associated complaints, be constant, or nearly so, and refractory to therapy. For the 20 percent level, the requirements are that the pain and tender points, etc., be episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but present more than one-third of the time. For the 10 percent level, the requirement is that the pain and tender points, etc., require continuous medication for control.

We have made this an interim rule with request for comments so that it can be effective immediately, but comments will be received for 60 days, and the rule may be amended based on the comments.

Section 4.71a. New diagnostic code 5025 has been added.

REGULATORY AMENDMENT

4-96-2

Regulation affected: 38 CFR 4.119

EFFECTIVE DATE OF REGULATION: June 6, 1996

Date Secretary approved regulation: December 5, 1995

Federal Register Citation: 61 FR 20440-47

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended section 4.119 of 38 CFR, Part 4, the section of the rating schedule that deals with endocrine system disabilities.

We changed the evaluation criteria for hyperthyroidism (DC 7900) to make them more objective, for example, by removing subjective terms such as "pronounced," "severe," "moderately severe," "marked," and "moderate," because they serve no objective function, and by defining tachycardia as more than 100 beats per minute. The former schedule required "severe" tachycardia at the 100-percent level, but since the medical literature does not define severe tachycardia, we have removed "severe." We added eye involvement to the criteria for a 100-percent evaluation because long-standing hyperthyroidism can lead to significant impairment affecting the eyes. We deleted references to surgery because they are of no value in explaining the qualifying symptoms. We specified that the "nervous symptoms" formerly included in the 100-percent criteria are "sympathetic nervous system" symptoms since this is the part of the nervous system affected. We edited the notes under DC 7900 for clarity.

We removed the zero-percent levels for DC's 7900 and 7903, which required that the condition be "in remission" because they merely restate the general rule found in §4.32. We deleted the criteria that referred to hormone levels for DC's 7900, 7903, and 7904 because although many endocrine conditions require laboratory confirmation of hormone levels for diagnosis, the hormone levels may not correlate with the severity of the clinical findings, and laboratory findings are therefore more useful for diagnosis than for evaluation.

Rather than directing in a note the assignment of a 10-percent evaluation for hyperthyroidism, hypothyroidism (DC 7903), and hypoparathyroidism (DC 7905) when continuous medication is required for control, we have added "continuous medication required for control" to the evaluation criteria themselves at the 10-percent level. For the sake of consistency, we have made "continuous medication required for control" a criterion for a 10-percent evaluation for hyperparathyroidism (DC 7904) as well.

For the convenience of rating specialists, we repeated the criteria for DC 7900 (hyperthyroidism) under DC 7901 (thyroid gland, toxic adenoma of) rather than directing to rate as DC 7900.

We removed "with pressure symptoms" from the criteria (because they are rarely encountered) in favor of a note directing that if there are symptoms due to pressure on adjacent organs, evaluation is to be made under the diagnostic code for disability of the affected organ, if doing so would result in a higher evaluation. We also removed "marked" as a modifier of disfigurement for a 20-percent evaluation because it is our judgment that any adenoma substantial enough to be disfiguring warrants a 20-percent evaluation.

As under DC 7900, we removed the subjective terms "pronounced," "severe," "moderately severe," and "moderate" from the criteria for DC 7903 (hypothyroidism). We also removed the requirement for slow return of reflexes for a 100-percent evaluation and added criteria of cold intolerance, muscular weakness, and cardiovascular involvement because these symptoms are typical of the disease when it is totally disabling. Also at the 100-percent level, we changed "slow pulse" to the more objective

"bradycardia (less than 60 beats per minute)" and removed "sluggish mentality" in favor of "mental disturbance (dementia, slowing of thought, depression)" because these are the common mental disturbances that may be seen in advanced hypothyroidism. We revised the former criteria for the 60-percent level in favor of the more objective criteria: "muscular weakness, mental disturbance, and weight gain". We made "fatigability, constipation, and mental sluggishness," instead of "sluggish mentality and other indications of myxedema," the criteria for the 30-percent level because they are commonly encountered symptoms and are more specific than the former criteria.

We removed "osteitis fibrosa cystica" from the title of DC 7904 (hyperparathyroidism) because that term represents certain bony findings that may be seen in hyperparathyroidism rather than being another term for hyperparathyroidism itself. As under other endocrine criteria, we removed subjective terms such as "pronounced," "severe," and "marked." We removed "high blood and urinary calcium" from the criteria for a 100-percent evaluation and "manifestations of hypercalcemia and urinary calcium" from the 60-percent level for the same reason we deleted criteria related to hormone levels under other endocrine conditions--these laboratory findings are more pertinent to diagnosis than to evaluation of functional impairment. We removed "marked weight loss" in favor of "gastrointestinal symptoms (nausea, vomiting, anorexia, constipation, weight loss, or peptic ulcer) because this is more representative of the variety of gastrointestinal symptoms that may be seen in hyperparathyroidism. We added "kidney stones" as an additional criterion at the 100-percent level because they are indicative of a totally disabling level. For consistency with the 100-percent level criteria, we changed "muscular weakness," one of the former criteria for the 60-percent level, to "weakness." We deleted the indefinite "with symptom combinations less than under 'pronounced' " from the 60-percent level criteria and, as at the 100-percent level, changed "marked weight loss" to "gastrointestinal symptoms. We revised the instructions under DC 7904 regarding post-operative or post-treatment evaluation, deleting the reference to "residual of benign tumor, considering especially bones and kidneys" to a more general direction to evaluate, following surgery or treatment as "digestive, skeletal, renal, or cardiovascular residuals."

We removed the reference to thyroidectomy in the criteria for a 100-percent level of hypoparathyroidism (DC 7905) because, although hypoparathyroidism may follow thyroidectomy if the parathyroid glands are also removed, there are other causes as well. There was a single 100-percent evaluation level based on painful muscular spasms or marked neuromuscular excitability. We revised the 100-percent criteria to "marked neuromuscular excitability," with examples, "plus either cataract or evidence of increased intracranial pressure," with examples. We added the alternative criteria because they are additional objective findings that may be seen at this level of disability. We clarified "marked neuromuscular excitability" by adding in parentheses "convulsions, muscular spasms (tetany), and laryngeal stridor" and eliminated the redundancy of including both "tetany" and "marked neuromuscular excitability" as separate symptoms. We added a 60-percent level based on either marked neuromuscular excitability or a combination of paresthesias (of arms, legs, or circumoral area) plus cataract or evidence of increased intracranial pressure, and a 10-percent level based on the need for continuous medication.

We changed the title of DC 7907 from "hyperpituitarism (pituitary basophilism, Cushing's syndrome)" to "Cushing's syndrome" since this is the medically accepted term for the condition. We removed the requirements at the 100-percent level for pathological fractures and enlargement of the sella turcica, which are rarely encountered, in favor of the more frequently seen findings of hypertension and weakness, and removed the subjective term "marked" modifying loss of muscle strength. We replaced the indefinite criteria of "severe; with symptom combination less than for the 100-percent rating with only partial control by treatment" at the 60-percent level with the more specific requirements of loss of muscle strength and enlargement of pituitary or adrenal gland. We added a 30-percent level for milder cases, especially those that are secondary to steroid treatment, with criteria of striae, obesity, moon face, glucose intolerance, and vascular fragility, which are indicators of milder disease than those criteria named at the 60- and 100-percent levels. We edited the note directing evaluation after recovery or control by expanding the list of possible residuals.

We changed the title of DC 7908 from "hyperpituitarism (acromegaly or gigantism)" to "acromegaly," since this is the most commonly used term for this disability. We removed the phrase "hypofunctional stage of hyperfunction" from the criteria for the 100-percent level because this description does not assist in the evaluation of the condition. We edited and partially revised the list of symptoms for a 100-percent evaluation to "evidence of increased intra-cranial pressure (such as visual field defect),

arthropathy, glucose intolerance, and either hypertension or cardiomegaly because these findings more accurately represent the 100-percent level of severity. We also replaced the former criteria for the 60-percent level with "arthropathy, glucose intolerance, and hypertension" because these are more frequently encountered symptoms. We removed the phrase "X-ray evidence of" modifying enlarged sella turcica at the 30-percent level as unnecessary.

We changed the title of DC 7909 from "hypopituitarism (diabetes insipidus)" to "diabetes insipidus" since this name alone is sufficient to identify this category of disease. We removed the subjective modifiers "pronounced," "severe," "moderately severe," and "moderate" because they did not aid in the evaluation of the condition. As elsewhere in the endocrine system, we removed the laboratory findings, in this case related to serum and urine osmolality from the criteria because they are not necessarily consistent with particular levels of functional impairment. In place of "excessive thirst," "polyuria," and :polydipsia," we added "polyuria with near-continuous thirst" as criteria for all levels. For clarity, we replaced "parenteral replacement therapy" with "episodes of dehydration requiring parenteral hydration" and specified a number of episodes of dehydration per year for the 40-, 60-, and 100-percent level for more objectivity.

Under Addison's disease, DC 7911, the former criteria included references to "episodes" and "crises," but they were not defined. We have added notes under DC 7911 defining them, and specified in the criteria the number of each that warrant each percentage evaluation. We removed the references to laboratory findings of hyponatremia, hyperpotassemia, azotemia, hypoglycemia, and cortisol deficiency for the same reasons as discussed under other endocrine conditions.

We revised the evaluation criteria for diabetes mellitus (DC 7913) to make them more objective and base them on how well the diabetes is controlled. The frequency of insulin injection and medical treatment are valid measures of the severity of diabetes, and we have stipulated a requirement for more than one daily injection of insulin for the 100-percent evaluation level. We also specified the number of hospitalizations per year required because of episodes of ketoacidosis or hypoglycemic reactions and the frequency of visits to a diabetic care provider that warrant a 60- or 100-percent evaluation. We eliminated the requirement for a "large" or "moderate" insulin dosage at the 40- and 20-percent levels respectively because the severity of diabetes is better determined by the degree of control in response to treatment than by the amount of medication required for control.

We deleted from the criteria for the 10- and 20-percent evaluation levels under DC 7913 the requirement "without impairment of health or vigor or limitation of activity" because they do not affirmatively denote required criteria for those evaluation levels. A requirement for regulation of activities was formerly one of the criteria for the 40- and 100-percent levels but not for the 60-percent level. For the sake of consistency, we have made "regulation of activities" one of the required criteria for the 40-. 60-, and 100-percent levels. We clarified the meaning of "severe" complications of diabetes and how to evaluate complications by means of a note and by including a reference to complications that would and would not be separately compensable under the 100- and 60-percent criteria respectively.

Under DC 7914, malignant neoplasms of the endocrine system, we made changes in the convalescent period following treatment that are similar to changes we have made in other body systems, i.e., requiring a mandatory VA examination 6 months following completion of treatment and implementation of § 3.105(e) before any reduction can be made.

We added four commonly occurring endocrine disorders: hyperpituitarism (prolactin secreting pituitary dysfunction) as DC 7916, hyperaldosteronism (benign or malignant) as DC 7917, and pheochromocytoma (benign or malignant) as DC 7918), all to be evaluated as malignant or benign neoplasm as appropriate, and C-cell hyperplasia of the thyroid as DC 7919, to be evaluated as malignant neoplasm.

We removed one condition from this section, hyperadrenia (adrenal genital syndrome), DC 7910, because it is a condition that occurs during infancy and childhood and is rarely encountered in individuals in service.

Diagnostic codes Diagnostic codes Diagnostic codes

revised	added	removed
7900	7916	7910
7901	7917	
7902	7918	
7903	7919	
7904		
7905		
7907		
7908		
7909		
7911		
7912		
7913		
7914		
7915		

REGULATORY AMENDMENT
4-96-3

Regulation affected: 38 CFR 4.88 and 4.88b

EFFECTIVE DATE OF REGULATION: August 30, 1996

Date Secretary approved regulation: March 7, 1996

Federal Register Citation: 61 FR 39873 (July 31, 1996)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended sections 4.88 and 4.88b of 38 CFR, Part 4, the sections of the rating schedule that deal with infectious diseases, immune disorders, and nutritional deficiencies. The intended effect of this action is to update these sections to ensure that they use current medical terminology and unambiguous criteria, and that they reflect medical advances which have occurred since the last review.

We changed the title of this portion of the rating schedule from "Systemic diseases" to "Infectious diseases, immune disorders, and nutritional deficiencies" because the former title did not adequately depict the range of conditions that this section addresses.

We changed the convalescent period for Asiatic cholera (DC 6300) from six months to three months because treatment of this condition is now simple, and the condition is ordinarily self-limited to a few days duration. We also added a note under DC 6300 regarding the rating of residuals to assure that they will be evaluated.

We changed the title of DC 6301 from "kala-azar" to the more modern term for this condition, "visceral leishmaniasis." We also changed the convalescent period for this condition from one year to a requirement for a VA examination six months after the date of inactivity and any reduction in the total evaluation to be made under the provisions of § 3.105(e). This convalescence will allow a period for recuperation and also assure that the extent of residual impairment is documented by examination before any change in evaluation is considered. We added a note under DC 6301 regarding the rating of residuals such as liver damage or lymphadenopathy to assure that they will be evaluated.

Similarly, we changed the period of convalescence for leprosy (DC 6302) from one year to a requirement for a VA examination six months after the date of inactivity and any reduction in the total evaluation to be made under the provisions of § 3.105(e). This change was made for the same reason as for leishmaniasis. We edited the note regarding residuals, removing the instructions regarding contagious and noncontagious cases, because all active disease is regarded as 100 percent disabling; and, following the period of convalescence, the condition is to be evaluated on the basis of residuals such as skin lesions or peripheral neuropathy.

We changed the criteria for the evaluation of malaria (DC 6304) from those based on number of relapses and presence of symptoms such as anemia to a direction to rate active disease at 100 percent, since active infection is normally totally disabling, and there is no need to specify the signs and symptoms. We also provided a note explaining the diagnostic requirements for malaria in current medical practice and directing that residuals be rated under the appropriate system. This information replaces the two former notes that discussed diagnosis and evaluation.

We changed the title of DC 6305 from "filariasis" to "lymphatic filariasis" because the criteria formerly used for the evaluation of filariasis applied only to the lymphatic type. Other types of filariasis are included in DC 6320, Parasitic diseases otherwise not specified. We simplified the evaluation by changing the criteria from those based on recurrences and involvement of extremities and genitalia to a

direction to rate active disease at 100 percent and to rate residuals under the appropriate system, as we have done for a number of infectious diseases, and for the same reasons as discussed under malaria.

We modernized the title of DC 6306 by changing it from Oroya fever to Bartonellosis. We changed the period of convalescence from six months to three months, which is an adequate period of time for recuperation and stabilization of red blood cells in the average individual, according to our consultants. We also added a note regarding evaluation of residuals.

The only change we made under DC 6307, plague, is the addition of a note regarding residuals, and under DC 6308, relapsing fever, we added specific examples of residuals that might occur—liver or spleen damage or central nervous system involvement. We made only minor editorial changes in DC 6309, rheumatic fever. We also made editorial changes under DC 6310, syphilis, expanded the title to "syphilis, and other treponemal infections" to accommodate additional treponemal conditions that can be rated similarly, and listed specific diagnostic codes where complications might be rated. Under DC 6311, miliary tuberculosis, we referred the rater to §§ 4.88c or 4.89, the specific sections that apply to the evaluation of inactive nonpulmonary disease.

For the convenience of the rater, we repeated the criteria for the evaluation of pellagra, DC 6315, under DC 6313, avitaminosis, rather than referring the rater to DC 6315. We provided more objective criteria for beriberi, DC 6314, providing evaluation levels of 30- 60- and 100-percent. We removed the 10-percent level because it was to be assigned for "moderate residuals." By removing this level and adding a note regarding residuals, we provide more latitude in evaluating residuals at any level of disability and also indicate that active beriberi warrants at least a 30 percent evaluation.

We revised the criteria for the evaluation of pellagra, DC 6315, by removing subjective language and otherwise made only minor changes. We removed "Malta or undulant fever," alternative names that are no longer used, from the title of DC 6316, Brucellosis. We revised the criteria by establishing a 100-percent evaluation for active disease. We removed all other criteria and instead stated that residuals such as liver or spleen damage or meningitis are to be rated under the appropriate system.

We changed the period of convalescence for scrub typhus, DC 6317, from six months to three months because with modern therapy, recovery is prompt and uneventful, and convalescence is short. We also updated the note regarding the evaluation of residuals.

For melioidosis, DC 6318, we changed the requirement for 100 percent to active disease, as we have done for several other infectious diseases, rather than requiring specific signs or symptoms, and we modified the note regarding residuals.

We added two new diagnostic codes: 6319 for Lyme disease, which has been identified as a distinct disease and occurs often enough in the veteran population to warrant a separate code, and 6320, parasitic diseases otherwise not specified, to accommodate all parasitic diseases not otherwise listed without the need to rate by analogy. Active disease under both new codes warrants 100 percent, and residuals are to be rated under the appropriate system.

We changed the evaluation percentage levels and the criteria for lupus erythematosus, DC 6350, because the former three highest levels were indistinguishable clinically, and they are now included in the 100-percent evaluation level. Furthermore, two or three exacerbations per year of a week or more were felt to be more consistent with a 60-percent level of evaluation rather than the current 30 percent. We also added two additional potential residuals, adverse effects of medication, and neurological complications, to the note regarding residuals and also revised the note for clarity.

Section 4.88 is removed and reserved.

Diagnostic codes revised	Diagnostic codes added	Diagnostic codes removed
6300	6319	NONE
6301	6320	

6302
6304
6305
6306
6307
6308
6309
6310
6311
6313
6314
6315
6316
6317
6318
6350

REGULATORY AMENDMENT
4-96-4

Regulation affected: 38 CFR 4.96 and 4.97

EFFECTIVE DATE OF REGULATION: October 7, 1996

Date Secretary approved regulation: May 13, 1996

Federal Register Citation: 61 FR 46720-31

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended sections 4.96 and 4.97 of 38 CFR, Part 4, the sections of the rating schedule that deal with the respiratory system. The intended effect of this action is to update this portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

We revised § 4.96 (a) only to reflect changed diagnostic codes in § 4.97. We added paragraph (c), concerning special monthly compensation (SMC), to § 4.96 as an additional reminder to the rating agency to refer to § 3.350 of this chapter to determine whether the veteran may be entitled to SMC. We also retitled § 4.96 to better reflect its content.

We have made one other change to remind the rating agency to consider SMC when there is organic aphonia. We placed footnotes at DC's 6518 (total laryngectomy) and 6519 (complete organic aphonia), conditions that may be associated with complete organic aphonia, directing to review for entitlement to SMC.

We removed chronic atrophic rhinitis (DC 6501) and in its place added three new diagnostic codes for specific types of rhinitis that may result in atrophic rhinitis: DC's 6522, allergic or vasomotor rhinitis, with evaluation levels of 10 and 30 percent; 6523, bacterial rhinitis, with evaluation levels of 10 and 50 percent; and 6524, granulomatous rhinitis, with evaluation levels of 20 and 100 percent. The percentage levels are highest for granulomatous diseases because they are most seriously disabling.

We modernized the title of DC 6502 by changing it from "septum, nasal, deflection of" to "septum, nasal, deviation of" and made the criteria more objective by requiring 50-percent obstruction of the nasal passage on both sides or complete obstruction on one side for a 10-percent evaluation rather than using the indefinite term "marked" for the required degree of interference with the breathing space.

We changed "exposing both nares" to "exposing both nasal passages" under DC 6504 (nose, loss of part of, or scars) for clarity, and added a note regarding alternative evaluation under DC 7800, scars, disfiguring, head, face, or neck.

We provided a general rating formula for sinusitis (DC's 6510 through 6514) based on more objective criteria, including signs, symptoms, and frequency of nonincapacitating episodes, and frequency and duration of antibiotic treatment of incapacitating episodes (defined in a note) that warrant a 10- or 30-percent evaluation, and specific findings following surgery that warrant a 50-percent evaluation.

In order to clarify and distinguish the criteria for the given percentages of DC 6516, chronic laryngitis, we have removed the indefinite terms "severe," "marked," and "moderate" and revised the requirements for a ten-percent evaluation to "hoarseness with inflammation of cords or mucous membrane" and for a thirty-percent evaluation to "hoarseness with thickening or nodules of cords, polyps, submucous infiltration, or pre-malignant changes on biopsy." We removed DC 6517, healed injuries of larynx, and combined residuals of laryngeal trauma and stenosis of the larynx under DC 6520, larynx, stenosis of, including residuals of laryngeal trauma, with evaluation based on results of pulmonary function testing or on aphonia (under DC 6519). This provides more flexibility by providing alternative methods of

evaluation. Under laryngectomy, DC 6518, in addition to adding a footnote regarding SMC, we added a direction on the evaluation of partial laryngectomy under DC's 6516, 6519, or 6520. We added more objective criteria for the evaluation of larynx, stenosis of, including residuals of laryngeal trauma (DC 6520) by basing them on pulmonary function tests (FEV-1) and the pattern of the Flow-Volume Loop instead of on subjective indicators such as whether there is dyspnea on "slight," "moderate," or "heavy" exertion.

We added a new diagnostic code, DC 6521, for injuries to the pharynx, with a single evaluation level of 50-percent based on the presence of stricture or obstruction of the pharynx or nasopharynx or on paralysis or absence of the soft palate.

We made the evaluation criteria for chronic bronchitis (DC 6600) more objective by basing them on the results of pulmonary function tests or, for the 100-percent level, the alternative criteria of cor pulmonale, right ventricular hypertrophy, pulmonary hypertension, episode(s) of acute respiratory failure, or a need for outpatient oxygen therapy. We established the similar criteria for conditions with similar functional impairments: pulmonary emphysema (DC 6603), chronic obstructive pulmonary disease (DC 6604), and the restrictive lung diseases--diaphragm paralysis or paresis (DC 6840), spinal cord injury with respiratory insufficiency (DC 6841), kyphoscoliosis, pectus excavatum, pectus carinatum (DC 6842), traumatic chest wall defect (DC 6843), post-surgical residual (DC 6844), and chronic pleural effusion or fibrosis (DC 6845).

We removed indefinite terms such as "pronounced," "severe," "considerable," "occasional," "moderate," etc., from the criteria under DC 6601, bronchiectasis and instead provided more objective, but flexible, criteria based either on the total duration per year of incapacitating episodes of infection, or on symptoms requiring a certain frequency and duration of antibiotic treatment. Using pulmonary impairment as for chronic bronchitis as an alternative was also added. We removed indefinite terms such as "pronounced," "severe," "frequent," and "several" from the criteria for bronchial asthma (DC 6602) and provided objective evaluation criteria based either on the results of selected pulmonary function tests (FEV-1 or FEV-1/FVC) or on treatment requirements.

We made a technical change in Note (1) under the general rating formula for inactive pulmonary tuberculosis by referring to a footnote under 38 U.S.C. 1156 rather than to 38 U.S.C. 356, as in the former schedule, because 38 U.S.C. has been repealed by Public Law 90-493. Because of modern treatment methods of tuberculosis, we have revised the provision under DC 6731 (tuberculosis, pulmonary, chronic, inactive) for a total evaluation for one year after date of attainment of inactivity of tuberculosis to the requirement for a mandatory examination to be requested immediately following notification that active tuberculosis under DC 6730 has become inactive, and with any change in evaluation to be carried out under the provisions of § 3.105(e). We also removed subjective terms such as "pronounced," "severe," "extensive," and "slight" from the former criteria and replaced them with more objective, but flexible, criteria by directing to rate residuals as interstitial lung disease, restrictive lung disease, or, when obstructive lung disease is the major residual, as chronic bronchitis and to rate thoracoplasty as removal of ribs under DC 5297.

We reorganized the nontuberculous diseases that formerly included DC's 6800 through 6821 by grouping most of them into several categories--bacterial infections of the lung, interstitial lung disease, mycotic lung disease, and restrictive lung disease--and by providing a general rating formula for each of these categories of disease. Many conditions were given new diagnostic codes in order to group conditions in the same category together. Bacterial infections of the lung include actinomycosis, DC 6822 (formerly 6803); nocardiosis, DC 6823 (a new condition added because it is one of the common conditions in this category), and chronic lung abscess, DC 6824 (formerly DC 6809). This group is evaluated under a general rating formula with a total evaluation when there is active infection with systemic symptoms, and residuals are evaluated as interstitial or restrictive lung disease, or as chronic bronchitis when obstructive lung disease is the major residual. We deleted streptotrichosis of lung (DC 6804), because this is a term no longer in use.

We deleted DC's 6800 (anthracosis), 6801 (silicosis), and 6802 (pneumoconiosis, unspecified) and included all of these in the newly added DC 6832, titled "pneumoconiosis (silicosis, anthracosis, etc.)" in the category of interstitial lung disease. We also added under this category: diffuse interstitial

fibrosis (DC 6825), desquamative interstitial pneumonitis (DC 6826), pulmonary alveolar proteinosis (DC 6827), eosinophilic granuloma of lung (DC 6828), drug-induced pulmonary pneumonitis and fibrosis (DC 6829), radiation-induced pulmonary pneumonitis and fibrosis (DC 6830), hypersensitivity pneumonitis (DC 6831), and asbestosis (DC 6832). All of these are evaluated under a general rating formula for interstitial lung disease that has 10-, 30-, 60-, and 100-percent evaluation levels based on FVC, DLCO, maximum exercise capacity measured in oxygen consumption, or, at the 100-percent level, alternative criteria of cor pulmonale, pulmonary hypertension, or a requirement for outpatient oxygen therapy.

For mycotic diseases, we removed sporotrichosis (DC 6806) because it usually affects only skin and lymph nodes rather than lung, and mycosis of lung, unspecified (DC 6808), and assigned new diagnostic codes for blastomycosis (changed from DC 6805 to 6836), aspergillosis (changed from DC 6807 to 6838), and coccidioidomycosis (changed from DC 6821 to 6835). We added histoplasmosis of lung (DC 6833), cryptococcosis (DC 6837), and mucormycosis (DC 6838). All of the mycotic diseases are evaluated under a general rating formula with percentage evaluation levels of zero-, 30- 50-, and 100-percent based on symptoms and treatment requirements. We placed the note (edited) about the incubation period of coccidioidomycosis that had been under DC 6821 under the general rating formula.

For restrictive lung diseases, we removed serofibrinous pleurisy (DC 6810), purulent pleurisy (DC 6811), bronchocutaneous or bronchopleural fistula (DC 6812), permanent collapse of the lung (DC 6813), spontaneous pneumothorax (DC 6814), pneumonectomy (DC 6815), lobectomy (DC 6816), and residuals of pleural cavity injuries (DC 6818). We added diaphragm paralysis or paresis (DC 6839); spinal cord injury with respiratory insufficiency (DC 6840); kyphoscoliosis, pectus excavatum, pectus carinatum (DC 6841); traumatic chest wall defect, pneumothorax, hernia, etc. (DC 6842); post-surgical residuals (lobectomy, pneumonectomy, etc.) (DC 6843); and chronic pleural effusion or fibrosis (DC 6844). DC 6813 was removed because collapse therapy for tuberculosis is no longer common. The conditions currently rated as pleurisy will be rated as chronic pleural effusion or fibrosis; fistula, pneumonectomy, and lobectomy will be rated under post-surgical residuals; pleural cavity injuries and pneumothorax will be rated as traumatic chest wall defect. The restrictive lung diseases will be evaluated under a general rating formula with 10-, 30-, 60-, and 100-percent levels based on the same criteria used to evaluate chronic bronchitis, emphysema, etc. Alternatively, the primary disorder may be rated.

We added three notes following the rating formula for restrictive lung diseases. One note stipulates a three-month period of convalescent evaluation from the date of hospital admission for a total spontaneous pneumothorax, a change from the assignment of a 100-percent evaluation for six months for spontaneous pneumothorax under DC 6814. A second note states that pleurisy with empyema will be evaluated at 100 percent until resolved. There was a range of evaluation levels from 10 to 100 percent in the former schedule. The third note discusses the evaluation of gunshot wounds of the pleural cavity, and this represents no substantive change from directions in the former schedule except for an added statement that muscle group XXI (the respiratory muscles) will not be combined with these injuries, a statement added to prevent pyramiding in evaluating these disabilities.

We retitled DC 6817 (lung, chronic passive congestion of) to "pulmonary vascular disease," a more inclusive title to accommodate all types of pulmonary vascular disease. Evaluation under this diagnostic code was formerly done by rating the underlying disease. However, we have provided objective criteria specific to pulmonary vascular disease with evaluation percentage levels of 100-, 60-, 30, and zero-percent.

We changed the method of evaluating respiratory system malignancies in favor of the same system we have used in other revised sections of the rating schedule, namely, a mandatory examination six following cessation of therapy, and implementation of any change in the total evaluation under the provisions of § 3.105(e).

We added a new diagnostic code, 6846, for sarcoidosis, with evaluation levels of zero, 30, 60, and 100 percent based on symptoms, cardiac involvement, treatment requirements, and X-ray findings. Alternatively, sarcoidosis can be evaluated as chronic bronchitis or, with extra-pulmonary involvement, under the specific body system involved. We also added a new diagnostic code, 6847, for sleep apnea,

with evaluation levels of zero, 30, 50, and 100 percent based on symptoms, treatment requirements, and the presence of cor pulmonale or respiratory failure.

Diagnostic codes revised	Diagnostic codes removed	Diagnostic codes added
6502	6501	6521
6504	6517	6522
6510	6800	6523
6511	6801	6524
6512	6802	6604
6513	6803	6822
6514	6804	6823
6515	6805	6824
6516	6806	6825
6518	6807	6826
6519	6808	6827
6520	6809	6828
6600	6810	6829
6601	6811	6830
6602	6812	6831
6603	6813	6832
6730	6814	6833
6731	6815	6834
6732	6816	6835
6817	6818	6836
6819		6837
6820		6838
		6839
		6840
		6841
		6842
		6843
		6844
		6845
		6846
		6847

REGULATORY AMENDMENT

4-96-5

Regulation affected: 38 CFR 4.16 and 4.125 through 4.132

EFFECTIVE DATE OF REGULATION: November 7, 1996

Date Secretary Approved Regulation: September 9, 1996

Federal Register Citation: 61 FR 52695-702

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended sections 4.16 and 4.125 through 4.132 of 38 CFR, Part 4, the sections of the rating schedule that deal with mental disorders. The intended effect of this action is to update the mental disorders section of the rating schedule to ensure that it uses current medical terminology, such as mental retardation instead of mental deficiency, unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

Since DSM-IV is the common language of both VA and non-VA health care providers and researchers, we changed the basis of diagnosis and terminology of mental disorders in the rating schedule from DSM-III to DSM-IV in order to provide rating specialists with a standard by which examinations from all sources can be compared and assessed. This required some reorganization and renaming of the categories of mental disorders as well as changes in the terminology and organization of some of the mental disorders themselves.

In order to conform more closely to the categories in DSM-IV, we have provided eight, instead of four, categories of mental disorders: Schizophrenia and other psychotic disorders; Delirium, dementia, and amnestic and other cognitive disorders; Anxiety disorders; Dissociative disorders; Somatoform disorders; Mood disorders; Chronic adjustment disorder; and Eating disorders. We provided a general rating formula for all categories of mental disorders except eating disorders. The latter are manifested primarily by physical findings and therefore required a separate set of criteria.

We removed 29 diagnostic codes, added 20, revised 10, and did not change 8 codes. The added codes represent conditions not included in the former schedule that are encountered frequently enough in VA claims to warrant their inclusion.

We added a new category of "Schizophrenia and other psychotic disorders." Except for schizoaffective disorder, we did not change the diagnostic codes pertaining to schizophrenia (DC's 9201 through 9205). We deleted DC's 9206, bipolar disorder, manic, depressed, or mixed, and 9207, major depression with psychotic features, since we have provided a category for mood disorders that includes conditions such as these.

We updated the title of DC 9208 from "paranoid disorders (specify type)" to "delusional disorder" and placed it in the category of schizophrenia and other psychotic disorders, in accord with DSM-IV. We deleted DC 9209, major depression with melancholia, another condition that we moved to the category of mood disorders.

We revised the title of DC 9210 from "atypical psychosis" to "psychotic disorder, not otherwise specified (atypical psychosis)," and included it in the psychotic disorders category, in accord with DSM-IV. We also put schizoaffective disorder, formerly part of DC 9205, in this category as DC 9211. Although schizoaffective disorder was linked to schizophrenia in the former schedule, DSM-IV named it as a separate psychotic disorder rather than as a type of schizophrenia.

We changed the name of the category of "Organic mental disorders" to "Delirium, dementia, and amnestic and other cognitive disorders," in accordance with the more current terminology in DSM-IV. The conditions in this category demonstrate a psychological or behavioral abnormality associated with transient or permanent dysfunction of the brain. We consolidated the 16 types of dementia in the former schedule into fewer categories because several of them, e.g., dementia associated with endocrine disorder (DC 9322) and dementia associated with systemic infection (DC 9324), are quite uncommon (only about one-tenth of one percent of VA beneficiaries being compensated for dementia have one of these types of dementia); and a number of others, such as dementia associated with central nervous system syphilis (DC 9301), dementia associated with intracranial infections other than syphilis (DC 9302), and dementia associated with epidemic encephalitis (DC 9315), lend themselves to logical groupings based on etiology (in this case, infection).

DSM-IV uses a more complex classification of dementias than is needed or useful for VA purposes. For example, it has separate categories for dementia due to Huntington's disease, Pick's disease, and Creutzfeldt-Jacob disease, each of which is uncommonly seen for VA rating purposes. We reorganized the dementias into six diagnostic codes, retaining some types because of their frequent occurrence and relevance to veterans, for example, dementia due to head trauma, (DC 9304, dementia associated with brain trauma in the current schedule) and some because they represent clusters of a particular etiology. We propose to retain diagnostic codes for the types of dementia most commonly seen in the general population, vascular dementia (which encompasses the former DC's 9305 and 9306, multi-infarct dementia with cerebral arteriosclerosis and multi-infarct dementia due to causes other than cerebral arteriosclerosis, respectively), and dementia of the Alzheimer's type (formerly DC 9312, primary degenerative dementia). This reorganization will not affect how dementias are evaluated, since all types will be evaluated under the same criteria, but will allow separation of the most common types by etiology.

We deleted DC's 9303 (dementia associated with alcoholism) and 9325 (dementia associated with drug or poison intoxication (other than alcohol)), in favor of including them under DC 9326, as discussed below. We revised DC 9304 (dementia associated with brain trauma) to dementia due to head trauma, because this is more modern terminology, and DC 9301 (dementia associated with central nervous system syphilis) to dementia associated with infection. We included in DC 9301 the conditions formerly under DC's 9301, 9302 (dementia associated with intracranial infections other than syphilis), 9315 (dementia associated with epidemic encephalitis), and 9324 (dementia associated with systemic infection), since the number of cases of dementia due to infection is small, and the specific type of infection has no bearing on the evaluation.

We deleted DC's 9307 (dementia associated with convulsive disorder), 9308 (dementia associated with disturbances of metabolism), 9309 (dementia associated with brain tumor), and 9322 (dementia associated with endocrine disorder), and included these conditions in DC 9326, Dementia due to other neurologic or general medical conditions (endocrine disorders, metabolic disorders, Pick's disease, brain tumors, etc.) or which are substance-induced (drugs, alcohol, poisons). This category encompasses in a single miscellaneous category a number of uncommon conditions that DSM-IV names separately.

We retitled "multi-infarct dementia with cerebral arteriosclerosis" (DC 9305) as "vascular dementia" and included in it the former DC 9306 (multi-infarct dementia due to causes other than cerebral arteriosclerosis) because both types are due to vascular disease, may be difficult to distinguish, and are addressed as a single entity in DSM-IV.

We revised the title of DC 9310 (formerly dementia due to unknown cause) to dementia of unknown etiology and included in it the former DC 9311 (dementia due to undiagnosed cause), now deleted, because, in practice, it may be impossible to differentiate these types. We retitled DC 9312

(formerly dementia, primary, degenerative) to dementia of the Alzheimer's type, in accord with DSM-IV.

We added DC 9327, organic mental disorder, other, to provide a code for conditions such as amnestic disorder, organic personality disorder, and other cognitive disorders that are not dementias.

We established a category for anxiety disorders, in accord with DSM-IV, that includes several conditions formerly in the category of psychoneurotic disorders: "generalized anxiety disorder" (DC 9400), "obsessive compulsive disorder" (DC 9404), "other and unspecified neurosis" (DC 9410), "post-traumatic stress disorder" (DC 9411), and "specific (simple) phobia; social phobia" (DC 9403) (modified from the former "phobic disorder," in accord with terminology in DSM-IV).

We moved some conditions formerly in the category of psychoneurotic disorders to new categories: DC 9401, dissociative amnesia; dissociative fugue; dissociative identity disorder (currently psychogenic amnesia; psychogenic fugue; multiple personality) and DC 9408, depersonalization disorder, to the category of dissociative disorders, as discussed below; DC 9402, conversion disorder; psychogenic pain disorder, and DC 9409, hypochondriasis, to somatoform disorders, as discussed below; and deleted DC 9405, dysthymic disorder; adjustment disorder with depressed mood; major depression without melancholia, also as discussed below. We added to anxiety disorders two conditions that occur frequently enough that diagnostic codes are needed and which are not now included in the rating schedule: "panic disorder and/or agoraphobia" (DC 9412) and "anxiety disorder, not otherwise specified" (DC 9413). While "other and unspecified neurosis" (DC 9410 in the current schedule) is not limited to anxiety disorders, we placed it in this category as a matter of convenience, rather than giving it a separate category.

We added a category for dissociative disorders, conditions, according to DSM-IV, where there is a disturbance in the usually integrated functions of identity, memory, consciousness, or perception of the environment. Included in this category are: "dissociative amnesia; dissociative fugue; dissociative identity disorder (multiple personality disorder)" (DC 9416, which we changed from DC 9401 to keep conditions in this category together) and "depersonalization disorder" (DC 9417, changed from DC 9408 for the same reason).

In accord with DSM-IV, we added a category for somatoform disorders, conditions characterized by the presence of physical symptoms that suggest a general medical condition and are not explained by a general medical condition, by the direct effects of a substance, or by another mental disorder. We moved "conversion disorder; psychogenic pain disorder" (DC 9402) and "hypochondriasis" (DC 9409), formerly under the category of psychoneuroses, to this category and assigned them new diagnostic codes so that the somatoform disorders are grouped together. We split "conversion disorder; psychogenic pain disorder" into "conversion disorder" (DC 9424), and "pain disorder (DC 9422), since the two conditions are distinct, and changed the code for "hypochondriasis" from DC 9409 to DC 9425. (Pain disorder is the current term for "psychogenic pain disorder.") We added two other conditions: "somatization disorder" (DC 9421), a commonly seen somatoform disorder not in the former schedule, and "undifferentiated somatoform disorder" (DC 9423), for somatoform disorders that do not fit elsewhere and for which there was no suitable code in the former schedule.

We established a category for mood disorders and placed in this category: bipolar disorder (DC 9432), dysthymic disorder (DC 9433), and major depressive disorder (DC 9434). Major depressive disorder was formerly under three diagnostic codes: 9207 (major depression with psychotic features), 9209 (major depression with melancholia), and 9405 (dysthymic disorder; adjustment disorder with depressed mood; major depression without melancholia). Since DSM-IV does not recognize three varieties of major depressive disorder, we have used a single diagnostic code, 9434, for major depressive disorder. We changed the diagnostic codes for dysthymic disorder (formerly dysthymia, DC 9405) and bipolar disorder (formerly DC 9206) to DC 9433 and DC 9432, respectively, in order to group the mood disorders together.

For the sake of completeness, we provided diagnostic codes for two additional mood disorders: cyclothymic disorder (DC 9431), which, although related to bipolar disorder, is classified as a separate entity by DSM-IV, and mood disorder, not otherwise specified (DC 9435), which allows the evaluation of conditions with mood symptoms that do not meet the criteria for any specific mood disorder. As part of this reorganization, we removed DC 9405 ("dysthymic disorder; adjustment disorder with depressed mood; major depression without melancholia") since we have provided separate diagnostic codes for both "dysthymic disorder" (DC 9433) and "major depressive disorder" (DC 9434) under the category of mood disorders.

We added a new category and diagnostic code (9440) for chronic adjustment disorder, a condition seen fairly often in the veteran population.

We added a category for eating disorders, a group of mental disorders characterized by gross disturbances in eating behavior. This includes anorexia nervosa (DC 9520) and bulimia nervosa (DC 9521), and we have based their evaluation criteria partly on the extent of weight loss (per DSM-IV) and partly on the extent of incapacitating episodes and needed periods of hospitalization.

We deleted § 4.16 (c), because, in our judgment, it is possible that a veteran may be properly evaluated at a level less than 100 percent based on average impairment, but because of unique aspects of his or her individual situation, might still be unable to secure or follow a substantially gainful occupation. In order to allow rating specialists the flexibility to fairly evaluate such situations, we deleted § 4.16 (c) to allow § 4.16 (a) to apply to mental disorders in the same manner that it does to other disabilities.

We removed DC's 9500 through 9511, the codes for psychological factors affecting physical conditions, for the following reasons. DSM-IV renamed this group of disorders as "psychological factors affecting medical condition" (PFAMC) and placed them in a new category: "Other conditions that may be a focus of clinical attention." It said that PFAMC has two components: a medical condition and psychological factors. If the psychological factors do not constitute a recognized mental disorder, they would not be service-connectable in their own right. If one of the components is a service-connected medical condition or mental disorder, it would be evaluated under the appropriate code. If both components are service-connected, each would be separately evaluated. In either case, an additional separate evaluation for PFAMC would not then be warranted, and in fact would represent pyramiding (see 38 CFR 4.14).

The former mental disorders section provided separate rating formulas for psychotic disorders, organic mental disorders, and psychoneurotic disorders. There were some specific evaluation criteria at each level for psychoneurotic disorders, but the other formulas used only "mild," "definite," "considerable," or "severe" social and industrial adaptability as criteria for most levels. Because those are non-specific terms, and the formulas offered no objective guidance for the rater, they were subject to interpretation by individual raters and made comparison of one exam with another difficult.

We have therefore provided a general rating formula for mental disorders that contains more objective criteria based on signs and symptoms which characteristically produce a particular level of disability. These criteria are meant to assure more consistent evaluations and offer greater ease in comparing examinations. The symptoms indicated at each level are not intended to be comprehensive (and could not be, because of the multitude of symptoms in mental disorders), but to provide an objective framework for raters to use. The criteria focus on the level of impairment of occupational and social functioning as related to the specific symptoms which are present, whether the symptoms are persistent or transient, their frequency, and their severity. With these more specific and objective criteria, raters can make a determination of the level of severity based on all the evidence of record, including the detailed report of all signs and symptoms, relevant information regarding employment,

report of daily activities, etc., rather than attempting an assessment based on whether the evidence corresponds to the non-specific language in the former schedule.

We reorganized and edited the material in §§ 4.125 through 4.131 and the notes in § 4.132 for clarity, less ambiguity, and to be more current, but the changes are not meant to be substantive. We also removed material which is not regulatory, i.e., which neither prescribes VA policy nor limits the action a rating board may take.

We changed the title of § 4.125 from "General considerations" to "Diagnosis of mental disorders" and divided it into one paragraph requiring that the rating board return an examination report to the examiner if the diagnosis does not conform to DSM-IV or is not supported by the findings in the report, and a second paragraph directing the rating board to determine whether a change in diagnosis of a mental disorder represents progression of a prior diagnosis, correction of an error in a prior diagnosis, or development of a new and separate condition. This material is taken from §§ 4.126 (Substantiation of diagnosis) and 4.128 (Change of diagnosis).

We placed material on the evaluation of mental disorders from §§ 4.129 and 4.130, a statement and notes under DC 9511, notes (1) and (4) under DC 9325, and notes under the general rating formula for psychoneurotic disorders about evaluation of mental disorders in § 4.126 and changed its title from "Substantiation of diagnosis" to "Evaluation of disability from mental disorders." We divided it into four paragraphs, with paragraph (a) establishing the general basis for evaluating mental disorders as the frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the veteran's capacity for adjustment during remissions, with the requirement that evaluation be based on all evidence of record bearing on occupational and social impairment. This is derived from material currently found at § 4.130. We removed from § 4.130 the statement that the examiner's analysis of the symptomatology is an "essential" because it is the signs and symptoms that the examiner documents rather than his or her assessment of their level of severity that will determine the evaluation. We also deleted the statement that describes time lost from gainful work and decrease in work efficiency as "two of the most important determinants of disability." Since the proposed evaluation criteria are structured around the nature and extent of occupational and social impairment, including decreased reliability, productivity, and work efficiency, that statement is no longer necessary.

Paragraph (b), which is based on § 4.129 and note (1) following the general rating formula for psychoneurotic disorders, directs the rating board to consider the extent of social impairment, but not to assign an evaluation solely on the basis of social impairment. This does not represent a substantive change.

Paragraph (c) discusses the evaluation of delirium, dementia, and amnestic and other cognitive mental disorders and represents no substantive change from material currently contained in notes (1) and (2) under DC 9325.

Paragraph (d), which represents no substantive change from information in notes (4) and (2) at the end of the rating schedules for psychoneurotic disorders and psychological factors affecting physical condition, respectively, directs the rating board to evaluate a single disability that has been diagnosed both as a physical condition and as a mental disorder under the diagnostic code which represents the dominant (more disabling) aspect of the condition. We substituted "dominant (more disabling) aspect of the condition" for "major degree of disability" for clarity.

Section 4.127 represents a revision of the former § 4.127 and states that mental retardation and personality disorders will not be considered as diseases or injuries for compensation purposes, but a mental disorder that is superimposed upon the mental retardation or personality disorder may be a disability for VA compensation purposes.

We retitled § 4.128 "Convalescence ratings following extended hospitalization," and included material from a note under DC 9210 regarding a total evaluation following a period of hospitalization lasting six months or more and a mandatory examination six months after the veteran is discharged or released to nonbed care. We added a requirement that a change in evaluation based on that or any subsequent examination shall be subject to the provisions of 38 CFR 3.105(e) because stabilization and return to usual activities in the face of a severe mental disorder is often difficult to achieve. This change will help to prevent a cycle of changes in evaluations followed by further examinations, further changes in evaluations, etc.

We modernized the title of § 4.129 to "Mental disorders due to traumatic stress," and it includes the requirement from the former § 4.131 to assign an evaluation of not less than 50 percent when a mental disorder that develops in service as a result of a highly stressful event is severe enough to cause the veteran's release from active service.

We retained the substance of the former § 4.131, "Mental disorders due to psychic trauma," in § 4.129 and deleted § 4.131.

There were four notes in § 4.132 following the rating formula for psychoneuroses. We deleted note (2) as redundant, since §§ 4.125 and 4.126 and the general rating formula set forth clear diagnostic and evaluation requirements. We incorporated the regulatory content of note (3) (regarding the return of an inadequate examination report to the examiner), and note (1) under DC 9511 (concerning the diagnosis of psychological disorders) into § 4.125 and deleted the part of note (3) that discussed the diagnosis of conversion disorder as unnecessary, since this is discussed in detail in DSM-IV.

We incorporated the regulatory content of note (2) under DC 9511, regarding a single condition diagnosed both as a mental and a physical disorder, into § 4.126 in order to keep in one place all of the regulatory material on evaluation of mental disorders.

We retitled § 4.130 "Schedule of ratings--mental disorders."

Section 4.16(c), § 4.131, and § 4.132 are removed.

Diagnostic codes revised	Diagnostic codes added	Diagnostic codes removed
9205	9211	9206
9208	9326	9207
9210	9327	9209
9300	9412	9302
9301	9413	9303
9304	9416	9306
9305	9417	9307
9310	9421	9308
9312	9422	9309
9403	9423	9311
	9424	9315
	9425	9322
	9431	9324
	9432	9325
	9433	9401
	9434	9402
	9435	9405
	9520	9408
	9521	9409
	9440	9500

		9501 9502 9505 9506
Diagnostic codes revised	Diagnostic codes added	Diagnostic codes removed
		9507 9508 9509 9510 9511

REGULATORY AMENDMENT
4-97-1

Regulation affected: 38 CFR 4.47 through 4.56, 4.69, 4.72, and 4.73

EFFECTIVE DATE OF REGULATION: July 3, 1997

Date Secretary approved regulation: March 5, 1997

Federal Register Citation: 62 FR 30235-30240 (June 3, 1997)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended §§ 4.47 through 4.56, 4.69, 4.72, and 4.73 of 38 CFR, Part 4, the sections of the rating schedule that address muscle injuries.

Section 4.47 was, in effect, a discussion of the results of missile wounds on muscles, pointing out that residual muscle fusion and scarring interfere with coordination and strength, and that fatigue and pain result from prolonged exertion of the injured muscles. Since this is common medical fact readily available in more complete form elsewhere, we deleted § 4.47 from the schedule. Similarly, § 4.48 was a discussion of scars resulting from wounds, emphasizing the importance of a complete examination to assess any disability arising from the scars. It was redundant because there was a regulatory requirement elsewhere that evaluations be based on a complete examination, and we deleted it.

Section 4.49 discussed residuals of wounds in deeper structures and the importance of reviewing the complete history of injury, which is also required by 38 CFR 4.1. Residuals of wounds and evaluation of evidence are discussed in Part VI of the VBA Manual and Chapter 2 of the Physician's Guide, and we deleted § 4.49 as unnecessary.

Section 4.50 recited the symptoms of missile wounds, emphasizing that it is the deeper scarring of muscles that is disabling. This information is not regulatory in nature, and we deleted it. The final three sentences of § 4.50, however, were regulatory; they specifically prohibited the evaluation of injured muscle groups which act upon ankylosed joints, with the two exceptions of the shoulder or knee joints. We incorporated all of the instructions concerning ankylosed joints into § 4.55 and deleted § 4.50 altogether.

Section 4.51 discussed muscle weakness due to injury, and the testing of muscles to evaluate occupational efficiency. Since symptoms of muscle injury are detailed in the section concerning factors for evaluating muscle disabilities (§ 4.56), we deleted § 4.51.

The section titled Muscle damage, § 4.52, discussed the anatomical structure of muscles and the effects of missile wounds, also discussing the symptoms of muscle injury. Since this subject is addressed in § 4.56, we deleted § 4.52.
Muscle patterns and the interaction of individual muscles in producing movement were discussed in § 4.53, with a list of the cardinal symptoms of muscle disability. These cardinal symptoms are an important factor in the evaluation of muscle injuries, and we moved them to § 4.56, the section dealing with evaluation of muscle injuries. Since the remaining material dealing with muscle patterns and the mechanics of movement in § 4.53 was medical in nature and not regulatory, we deleted it.

Section 4.54 listed the muscle groups and anatomical regions, repeated the cardinal symptoms of muscle disability, and listed the cardinal signs of muscle injuries. For the sake of clarity, we deleted § 4.54 and incorporated the portion dealing with muscle groups and anatomical regions into § 4.55, and the portion addressing cardinal signs and symptoms of muscle injury into § 4.56.

The scheme for rating muscle injuries placed individual muscles into 23 muscle groups, each with its own diagnostic code. Each muscle group was assigned to one of five anatomical regions: (1) the

shoulder girdle and arm, (2) the forearm and hand, (3) the foot and leg, (4) the pelvic girdle and thigh, or (5) the torso and neck. The former schedule had interchangeable references to anatomical "regions" and "segments." For the sake of consistency, we used only anatomical regions.

In § 4.55, in addition to the revisions of paragraphs (a) through (f) described above, we removed paragraph (g), which stated that muscle injury ratings will not be combined with peripheral nerve paralysis for the same part, unless affecting entirely different functions because we have made § 4.55 deal exclusively with the principles of rating muscle injuries. We revised paragraph (d) to require that the combined evaluation of muscle groups acting upon a single unankylosed joint must be lower than the evaluation for unfavorable ankylosis of that joint.
Section 4.56 defined the four levels of muscle disability and the type of injury, history and complaint of the injury, and objective findings for each. We revised the descriptions of the various levels of muscle injury for clarity. The descriptions of objective findings within the categories of moderate and moderately severe injuries used the subjective adjectives "moderate" and "moderately severe." We deleted these words since they caused confusion within the categories by using the same words to describe the terms they were defining, and we deleted the word "marked" as ambiguous.

In part, § 4.72 described the significance of fractures and wounds. Since fractures are now classified in medical practice as either open or closed, we changed the term "compound" comminuted fracture, which is currently used in this section, to "open" comminuted fracture. Two regulatory instructions were stated in § 4.72, the first concerning evaluation of open comminuted fractures and the second concerning evaluation of through and through missile wounds. For ease of reference, we put these instructions under § 4.56 with the other factors relating to evaluation of muscle disabilities. We deleted the phrase "from the missile," since muscle wounds may also be due to other causes. With the rearranging of these regulatory instructions into § 4.56, we deleted § 4.72.

We listed the functions of the muscle group under each diagnostic code ahead of the specific muscles which comprise the group and perform those movements to simplify the rating process by identifying the muscle group by functional disability rather than by the names of the individual muscles involved.

The preferred medical terms describing handedness are "dominant" and "nondominant," and we substituted these designations for "major" and "minor," and changed the heading of § 4.69 to avoid confusion. We also amended § 4.69 to indicate that in an ambidextrous individual, the injured hand, or the most severely injured, will be considered the dominant hand for rating purposes.

The 50 percent level under diagnostic code 5317 (gluteus muscles) included a footnote directing that entitlement to special monthly compensation be considered when bilateral function of the buttocks is severely impaired. We retained the footnote and also added a note under § 4.73, preceding the coded evaluations of disabilities, instructing raters to refer to § 3.350 whenever they rate a muscle injury which has resulted in loss of use of any extremity or loss of use of both buttocks. We believe that this combination of note and footnote will be the most effective way to ensure complete review for special monthly compensation.

Since the word "neoplasm" connotes a pathological abnormality better than the term "new growth," we substituted that word under diagnostic codes 5327 and 5328, which pertain to malignant and benign muscle conditions, respectively.

Diagnostic codes 5327 (malignancies of muscles) and 5329 (soft tissue sarcomas) provided a 100 percent evaluation for six months following surgery or the cessation of antineoplastic therapy. We revised these codes to continue the total evaluation indefinitely after treatment is discontinued, and to examine the veteran six months thereafter. If the results of this or any subsequent examination warrant a reduction in evaluation, the reduction will be implemented under the provisions of 38 CFR 3.105(e). This method is the same as that used in other revised body systems.
We changed the heading of § 4.56 to "Evaluation of muscle disabilities" and of § 4.69 to "Dominant hand."
In DC 5325, "Muscle injury, facial muscles," we revised the evaluation instructions by directing that functional impairment due to injury to facial muscles be evaluated as seventh (facial) cranial nerve neuropathy (DC 8207), disfiguring scar (DC 7800), etc.

We added a the note at the beginning of § 4.73, referring to § 3.350, to clearly remind rating specialists that there is potential entitlement to special monthly compensation when evaluating any muscle injuries resulting in loss of use of any extremity or of both buttocks.

We also corrected the list of the plantar group of intrinsic muscles of the foot under Group X (DC 5310) by removing "opponens digiti V" (a hand muscle), moving "dorsal interossei" from the dorsal group (the plantar and dorsal interossei are both considered plantar muscles in standard anatomy textbooks), changing "flexor hallucis" to "flexor hallucis brevis," its more complete name, in order to distinguish it from "flexor hallucis longus," a muscle in another group, and changing "abductor hallucis" to "adductor hallucis." We changed "V" to the current designation "minimi" wherever "V" was used to indicate the fifth digit. We added "peroneus brevis" and "plantaris" to the list of posterior and lateral crural muscles and muscles of the calf in Group XI (DC 5311) because standard anatomy textbooks place them in this group. We changed "long extensors of toes" in Group XII (DC 5312) to "extensor digitorum longus" and "extensor hallucis longus," the specific names of these muscles.

We made several other nonsubstantive, editorial changes to the proposed rule based on our own review of the proposed regulation.

REGULATORY AMENDMENT
4-97-2

Regulation affected: 38 CFR 4.100, 4.101, 4.102, and 4.104

EFFECTIVE DATE OF REGULATION: January 12, 1998

Date Secretary approved regulation: August 7, 1997

Federal Register Citation: 62 FR 65207-65224 (December 11, 1997)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended sections 4.100, 4.101, 4.102, and 4.104 of CFR, Part 4, the sections of the rating schedule that address the cardiovascular system. The intended effect of this action is to update this portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

We removed introductory sections 4.100, 4.101, and 4.102 for several reasons. Some of the material in them pertained to issues of service connection, which belong in the regulations beginning at 38 CFR 3.303, rather than in the rating schedule, which is intended as a guide to evaluation. Some material in the removed sections was general medical information about the types and course of heart disease, some of it now obsolete, and it did not bear on evaluation. Some material discussed issues related to the diagnosis of heart disease, but diagnosis is the responsibility of the examiner. The information about varicose veins in former § 4.102 became unnecessary in view of the revised evaluation criteria for varicose veins. The material about determining the separate effects of coexisting heart diseases was moved to a note in § 4.104.

We changed the title of DC 7000 from "rheumatic heart disease" to "valvular heart disease (including rheumatic heart disease)" to include all types of valvular heart disease, including traumatic. We changed the period of convalescence evaluation following active infection with valvular heart damage from six months to three months, in view of current medical information about the course of the condition. We provided a new set of more objective evaluation criteria for valvular heart disease and most other types of heart disease, based on such clinical or laboratory findings as the level of METs (metabolic equivalents) at which cardiac symptoms develop; the presence of chronic or recurrent congestive heart failure, the extent of ventricular dysfunction, as assessed by the ventricular ejection fraction; objective evidence of cardiac hypertrophy or dilatation; and whether a requirement for continuous medication. These remove the necessity of interpreting the meaning of "moderate exertion" or whether "more than light manual labor is not feasible."

One MET is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. The calculation of work activities in multiples of METs is a useful measurement for assessing disability. METs are measured by means of a treadmill exercise test, which is the most widely used test for diagnosing coronary artery disease and for assessing the ability of the coronary circulation to deliver oxygen according to the metabolic needs of the myocardium. Because administering a treadmill exercise test may not be feasible in some instances, we indicated in a note at the beginning of § 4.104 that when a treadmill test cannot be done for medical reasons, the examiner's estimation of the level of activity, expressed in METs and supported by examples of specific activities, such as slow stair climbing, or shoveling snow, that results in dyspnea, fatigue, angina, dizziness, or syncope, is acceptable as an alternative. The alternative objective evaluation criteria, such as cardiac hypertrophy or dilatation, decreased left ventricular ejection fraction, and congestive heart failure, may also be used in those cases.

A 100-percent evaluation is warranted if a workload of three METs or less produces dyspnea, fatigue, angina, dizziness, or syncope. A workload of three METs represents such activities as level walking,

driving, and very light calisthenics. A 60-percent evaluation is warranted if a workload of greater than three METs but not greater than five METs results in cardiac symptoms. Activities that fall into this range include walking two and a half miles per hour, social dancing, light carpentry, etc. A 30-percent evaluation is warranted if a workload of greater than five METs but not greater than seven METs produces symptoms. Activities that fall into this range include slow stair climbing, gardening, shoveling light earth, skating, bicycling at a speed of nine to ten miles per hour, carpentry, and swimming. Some conditions also include a 10-percent evaluation, that is warranted if symptoms develop at a workload of greater than 7 METs but not greater than 10 METs. Activities that fall into this range include jogging, playing basketball, digging ditches, and sawing hardwood. When symptoms develop only during such activities, there may be some impairment of earning capacity, but it is likely to be slight. The alternative of the need for continuous medication warrants a 10-percent evaluation for some conditions.

We provided the same METs-based and other objective criteria for the evaluation of endocarditis (DC 7001), pericarditis (DC 7002), pericardial adhesions (DC 7003), syphilitic heart disease (DC 7004), arteriosclerotic heart disease (DC 7005), myocardial infarction (DC 7006), hypertensive heart disease (DC 7007), ventricular arrhythmias (DC 7011), atrioventricular block (DC 7015), heart valve replacement (DC 7016), coronary bypass surgery (DC 7017), and two newly added conditions—cardiac transplantation (DC 7019), and cardiomyopathy (DC 7020). They are also provided as alternative criteria for implantable cardiac pacemakers (DC 7018), another newly added condition. DC 7018 will otherwise be evaluated the same as supraventricular arrhythmias (DC 7010). We provided more objective criteria for the evaluation of supraventricular arrhythmias, based on the number of episodes per year of supraventricular arrhythmias or whether there is permanent atrial fibrillation. We removed the former evaluation criteria for hyperthyroid heart disease (DC 7008) and instead directed several possible ways of evaluation, depending on the specific findings, including under hyperthyroidism (DC 7900) or under supraventricular arrhythmias (DC 7010).

We removed permanent auricular fibrillation (DC 7012), paroxysmal tachycardia (DC 7013), and sinus tachycardia (DC 7014) in favor of using two codes for all arrhythmias—DC 7010 for supraventricular arrhythmias and DC 7011 for ventricular arrhythmias. These two codes distinguish between the ordinarily milder supraventricular arrhythmias, with evaluations of ten or 30 percent, and the more potentially disabling ventricular arrhythmias, with a range of evaluation from ten to 100 percent. We eliminated the need for a distinction between complete and incomplete heart block in the assessment of atrioventricular block (DC 7015) because the symptoms and severity of heart block of each type vary from individual to individual, and an assessment on the actual disabling symptoms that are present is more equitable than an evaluation based solely on the type of heart block. An evaluation of 100 percent under DC 7011 is also warranted if an Automatic Implantable Cardioverter-Defibrillator (AICD), a device used to treat supraventricular arrhythmias that has the potential for serious complications, is present.

We added several new conditions, based on the fact that they occur commonly enough in veterans to warrant inclusion in the schedule: implantable cardiac pacemakers (DC 7018), cardiac transplantation (DC 7019), and cardiomyopathy (DC 7020). Pacemakers were formerly included under auriculoventricular block (DC 7015), but we provided a separate code because pacemakers are used for conditions other than heart blocks. Cardiac transplantation was formerly rated analogous to renal transplantation, but was not listed in the schedule. We provided evaluation criteria for cardiac transplantation identical to those for most other heart diseases, based on a METs assessment or other objective findings, except that we stipulated a minimum evaluation of 30 percent, because of the ongoing need for immunosuppressive therapy in this condition. Cardiomyopathy has similar criteria but no minimum evaluation.

We removed "general arteriosclerosis" (DC 7100) because it was too broad a category for appropriate evaluation, and the effects of widespread arteriosclerosis can be better evaluated under the specific disabilities in various body systems as cerebrovascular disease, renal disease, etc.

We revised the convalescence evaluations for several conditions. The previous schedule provided convalescence evaluations for six months for the following conditions: rheumatic heart disease (DC 7000); arteriosclerotic heart disease, following coronary occlusion (DC 7005); myocardial infarction (DC 7006); and soft tissue sarcoma (of vascular origin) (DC 7123). It provided convalescence

evaluations for one year for the following conditions: auriculoventricular block, with implantation of a pacemaker (DC 7015); heart valve replacement (DC 7016); coronary artery bypass (DC 7017); and aortic aneurysm, following surgical correction (DC 7110). We changed the duration of convalescence evaluations for DC's 7000, 7005, and 7006 to three months; for DC 7018 (pacemaker implantation, formerly DC 7015) to two months; and for DC 7017 to three months. We proposed an indefinite period of convalescence evaluation with an examination at six months for DC's 7016, 7110, 7011 (now ventricular arrhythmias), 7111 (aneurysm of any large artery), and 7123 (soft-tissue sarcoma). We also provided an indefinite period of convalescence evaluation, but with an examination at one year, for cardiac transplantation (DC 7019). The new periods of convalescence evaluation reflect, according to medical sources we consulted, the average periods of recovery needed by the average person following certain procedures and illnesses. They can, of course, be extended, when medically warranted, under the authority of 38 CFR 4.29 and 4.30. The indefinite periods of convalescence require application of the notice and effective date provisions of 38 CFR 3.105(e) before a change in evaluation can be made.

In response to comments that it was needed to assure consistency, we added a note under hypertensive vascular disease (DC 7101) stating what the term hypertension means, and also added what the term "isolated systolic hypertension" means, for purposes of evaluation under § 4.104. We also specified the number of readings required (two or more times on at least three different days) to confirm the diagnosis of hypertension, because the former schedule gave an indefinite recommendation. We moved the provision for a ten-percent evaluation when hypertension is controlled by continuous medication and there is a history of diastolic blood pressure predominantly 100 or more from a note to the criteria for a ten-percent evaluation. We also added "systolic blood pressure predominantly 160 or more" to the criteria for a ten-percent evaluation to indicate the appropriate evaluation for isolated systolic hypertension of this extent.

We edited and made more objective the criteria for evaluating aortic aneurysm (DC 7110) by providing a 100-percent evaluation if the aneurysm is 5 cm. or greater in diameter or if it is symptomatic. Under DC 7111, aneurysm of any large artery is evaluated at 100 percent if it is symptomatic. Since the aorta is the largest artery in the body, it would be inconsistent and inequitable not to allow the same evaluation that the schedule provides for symptomatic aneurysms of other large arteries.

The previous schedule established a minimum evaluation of 20 percent following surgical correction of an aortic aneurysm (DC 7110). Because there is a wide range of possible complications and residual disability following surgical correction of an aortic aneurysm, depending on such factors as the location of the aneurysm, its type (dissecting or not), etc., with some warranting a higher, and some a lower, evaluation than 20 percent, we removed the minimum evaluation in favor of a direction to evaluate the actual residuals.

For the sake of consistency, we also provided objective criteria for aneurysm of any large artery (DC 7111), in place of the former subjective requirement that the lower extremities be "symptomatic" (for 60 percent) or the upper extremities be "symptomatic" (for 40 percent). As with aortic aneurysm, a 100-percent evaluation is required if symptomatic, or for an indefinite period from the date of hospital admission for correction. There is a range of evaluation levels for the postoperative state based on the objective criteria of severity of claudication, the ankle/brachial index, and the presence of trophic changes, ulcers, rest pain, and whether the extremity is cold. The same criteria apply to arteriosclerosis obliterans (DC 7114) and thrombo-angiitis obliterans (DC 7115). Those two conditions, plus intermittent claudication (DC 7166), which we removed because it is a symptom and not a disease, were all formerly evaluated under the same set of criteria, which were based on findings similar to, but more subjective than, the new criteria. We added three notes under DC 7111, the first explaining the ankle/brachial index, the second explaining the method of evaluation when more than one extremity is affected, and the third describing the method of postoperative convalescence evaluation.

The previous schedule provided a 10-percent evaluation for aneurysm of any small artery (DC 7112). We changed the evaluation for asymptomatic aneurysm of a small artery to zero percent, since asymptomatic small artery aneurysms are found in about five percent of the population and are not considered disabling. Symptomatic aneurysms can be evaluated under the appropriate body system, depending on the actual findings, and we added a note directing how to evaluate them.

We changed the title of DC 7113 from "arteriovenous aneurysm, traumatic," to the currently accepted term for the condition, "arteriovenous fistula, traumatic," because the condition represents a direct communication between an artery and a vein rather than an aneurysm of a blood vessel. For the sake of more objectivity, we revised the criteria under DC 7113 to include such findings as enlarged heart, wide pulse pressure, tachycardia, edema, stasis dermatitis, ulceration, and cellulitis, in place of the former indefinite criteria, such as "with marked vascular symptoms." In addition, because the most serious cardiac consequence of arteriovenous aneurysm is high output congestive heart failure, we added a 100-percent evaluation level for that condition.

As described above, we provided evaluation criteria for arteriosclerosis obliterans (DC 7114) and thrombo-angiitis obliterans (DC 7115) that are identical to those of the postoperative criteria for aneurysm of any large artery (DC 7111). The notes regarding the ankle/brachial index and explaining the method of evaluation when more than one extremity is affected are the same as those following DC 7111. However, we also provided another note directing that the residuals of aortic and large arterial bypass surgery or arterial graft be evaluated as arteriosclerosis obliterans, since there had been no direction on how to rate those conditions. Under DC 7115, we provided only the notes about the ankle/brachial index and the evaluation when more than one extremity is affected.

The new method of evaluation when more than one extremity is affected by peripheral arterial disease requires a separate evaluation of each affected extremity, with use of the bilateral factor when applicable. These evaluations are to be combined, as other multiple disabilities of the extremities are. These instructions replace the former notes following DC 7117, which were complex, open to misinterpretation, and could result in an evaluation for involvement of multiple extremities no higher than that for involvement of a single extremity.

The former criteria for Raynaud’s syndrome (DC 7117) required subjective assessments of the meaning of "severe form," "multiple areas," "frequent vasomotor attacks," and "occasional attacks." In addition to adding a note defining "characteristic attacks" of Raynaud's disease, for VA purposes, we provided more objective criteria for evaluation using the specific frequency of characteristic attacks, the number of digital ulcers, and whether there is autoamputation of one or more digits, in order to ensure more consistent evaluations.

The former criteria for angioneurotic edema (DC 7118) were also subjective, e.g., "severe, frequent attacks with severe manifestations." We established more objective criteria based on the typical duration of attacks, their frequency, and on whether there is laryngeal involvement. In our judgment, angioneurotic edema affecting the larynx warrants separate consideration because laryngeal edema commonly causes respiratory distress due to airway obstruction and requires emergency treatment. Laryngeal edema is serious enough that if it occurs once or twice a year, it warrants a 20-percent evaluation; if it occurs more than twice a year, it warrants a 40-percent evaluation. We also added a 10-percent evaluation level for attacks without laryngeal involvement that occur two to four times a year. These criteria will foster more consistent evaluations.

The former criteria for erythromelalgia (DC 7119) were subjective—"severe," "moderate," or "mild." We provided a note that defines "characteristic attacks" of erythromelalgia, for purposes of § 4.104, and provided evaluation criteria based on the frequency and duration of attacks and their response to treatment.

As with the peripheral arterial diseases, we revised the method of evaluating multiple extremity involvement by venous diseases. Under the previous schedule, a variety of methods were used to evaluate vascular diseases affecting the extremities, particularly when more than one extremity was affected. For example, the criteria for thrombophlebitis (DC 7121) applied to a single extremity, and if other extremities were affected, they were separately evaluated. For varicose veins (DC 7120), the criteria for a 10-percent evaluation applied to either unilateral or bilateral involvement, but at other evaluation levels, different percentages were assigned for unilateral and bilateral involvement. There was no direction for evaluation if one extremity was more severely affected than the other. We therefore revised the method of evaluating varicose veins (DC 71720) to have the criteria apply to a single extremity, as for DC 7121, as well as arteriosclerosis obliterans (DC 7114), thrombo-angiitis obliterans (DC 7115), and postoperative aneurysm of any large artery (DC 7111).

We revised the evaluation criteria for varicose veins (DC 7120) and post-phlebitic syndrome of any etiology (DC 7121) in order to adopt the more consistent method of separately evaluating each extremity and to assure that venous conditions with similar findings receive consistent evaluations,. Varicose veins are ordinarily asymptomatic or mildly symptomatic, but may produce prolonged venous insufficiency and progress to thrombophlebitis and postphlebitic syndrome. Signs of venous insufficiency, such as edema, stasis pigmentation, ulceration, eczema, and induration, and symptoms such as aching and fatigue, are the major disabling effects of varicose veins. The size, location, extent, etc., of varicose veins, do not correlate with symptoms, and we removed those criteria as factors in evaluation. The presence or absence of impairment of the deep circulation is more an indicator of the feasibility of surgical repair than of functional impairment, and we therefore also removed references to the deep circulation and replaced them with criteria based on symptoms (such as aching and fatigue after prolonged standing or walking) or objective physical findings (such as edema, stasis pigmentation, eczema, or ulceration). These changes will allow accurate and consistent evaluations when more than one extremity is affected by varicose veins, but to different degrees.

The effects of chronic venous insufficiency are the same, whether from varicosities, thrombophlebitis, or some other cause. The postphlebitic syndrome may itself lead to the development of varicosities because of chronic venous insufficiency, and the possible manifestations and disabling effects of varicose veins and postphlebitic syndrome are very similar. We therefore used the same criteria to evaluate both conditions, with evaluation levels of 0, 10, 20, 40, 60, and 100 percent for involvement of a single extremity. We added under DC 7120: "With the following findings attributed to the effects of varicose veins," and under DC 7121: "With the following findings attributed to venous disease" in order to assure that the examiner has determined that the abnormal findings are attributed to venous disease. We changed the title of DC 7121 from "phlebitis or thrombophlebitis" to "post-phlebitic syndrome of any etiology" because both superficial and deep acute thrombophlebitis are transient conditions, but it is the chronic form of thrombophlebitis with venous insufficiency, known as "postphlebitic leg," "postphlebitic sequelae of chronic venous insufficiency," "postphlebitic syndrome," or "stasis syndrome," that is the disabling residual of thrombophlebitis.

We revised the title of DC 7122 from "frozen feet, residuals of" to "cold injury residuals" to indicate that this code may be used to evaluate any cold injury. Because cold injury produces similar tissue changes wherever it occurs, a single diagnostic code and set of evaluation criteria are adequate. However, we revised the criteria to more accurately reflect the range of effects that cold injury may produce, such as arthralgia, tissue loss, nail abnormalities, and color changes. We also deleted the bilateral evaluations in favor of evaluating each affected part separately and combining them for the overall evaluation for cold injury, similar to changes we made in the method of evaluating peripheral arterial and venous diseases of the extremities, and for the same reasons. In the case of paired extremities, the evaluations will be combined, if appropriate, in accordance with §§ 4.25 and 4.26 (as described in Note (2), following DC 7122). Note (1) has been amended to include more information about the evaluation of complications that may occur following cold injury, such as peripheral neuropathy, or squamous cell carcinoma of the skin at the site of a scar.

The former schedule provided six-months of convalescence evaluation for soft tissue sarcoma of vascular origin (DC 7123). The change to an indefinite period of a 100-percent evaluation is described earlier.

Diagnostic codes revised	Diagnostic codes removed	Diagnostic codes added
7000	7012	7018
7001	7013	7019
7002	7014	7020
7003	7100	
7004	7116	
7005		
7006		
7007		
7008		

7010
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7101
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7111
7112
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7114
7115
7117
7118
7119
7120
7121
7122
7123

For the reasons set out in the preamble, 38 CFR part 4, subpart B, is amended as set forth below:

PART 4--SCHEDULE FOR RATING DISABILITIES

1. The authority citation for part 4 continues to read as follows:

AUTHORITY: 38 U.S.C. 1155, unless otherwise noted.

Subpart B--Disability Ratings

§§ 4.100 through 4.102 [Removed and Reserved]

2. Sections 4.100, 4.101, 4.102 are removed and reserved.

3. Section 4.104 is revised to read as follows:

§ 4.104 Schedule of ratings—cardiovascular system.

DISEASES OF THE HEART

NOTE (1): Evaluate cor pulmonale, which is a form of secondary heart disease, as part of the pulmonary condition that causes it.

NOTE (2): One MET (metabolic equivalent) is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. When the level of METs at which dyspnea, fatigue, angina, dizziness, or syncope develops is required for evaluation, and a laboratory determination of METs by exercise testing cannot be done for medical reasons, an estimation by a medical examiner of the level of activity (expressed in METs and supported by specific examples, such as slow stair climbing or shoveling snow) that results in dyspnea, fatigue, angina, dizziness, or syncope may be used.

_____ Rating

7000 Valvular heart disease (including rheumatic heart disease):

During active infection with valvular heart damage and for three months following cessation of therapy for the active infection.....100

Thereafter, with valvular heart disease (documented by findings on physical examination and either echocardiogram, Doppler echocardiogram, or cardiac catheterization) resulting in:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent 60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electro-cardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7001 Endocarditis:

For three months following cessation of therapy for active infection with cardiac involvement.....100

Thereafter, with endocarditis (documented by findings on physical examination and either echocardiogram, Doppler echocardiogram, or cardiac catheterization) resulting in:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7002 Pericarditis:

For three months following cessation of therapy for active infection with cardiac involvement.....100

Thereafter, with documented pericarditis resulting in:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater

than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent 60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7003 Pericardial adhesions:

Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7004 Syphilitic heart disease:

Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of than 30 percent.....100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

NOTE: Evaluate syphilitic aortic aneurysms under DC 7110 (aortic aneurysm).

7005 Arteriosclerotic heart disease (Coronary artery disease):

With documented coronary artery disease resulting in:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100

More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

NOTE: If nonservice-connected arteriosclerotic heart disease is superimposed on service-connected valvular or other non-arteriosclerotic heart disease, request a medical opinion as to which condition is causing the current signs and symptoms.

7006 Myocardial infarction.

During and for three months following myocardial infarction, documented by laboratory tests.....100

Thereafter:
With history of documented myocardial infarction, resulting in:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7007 Hypertensive heart disease:

Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7008 Hyperthyroid heart disease:

Include as part of the overall evaluation for hyperthyroidism under DC 7900. However, when atrial fibrillation is present, hyperthyroidism may evaluated either under DC 7900 or under DC 7010 (supraventricular arrhythmia), whichever results in a higher evaluation.

7010 Supraventricular arrhythmias:

Paroxysmal atrial fibrillation or other supraventricular tachycardia, with more than four episodes per year documented by ECG or Holter monitor.....30
Permanent atrial fibrillation (lone atrial fibrillation), or; one to four episodes per year of paroxysmal atrial fibrillation or other supraventricular tachycardia documented by ECG or Holter monitor.....10

7011 Ventricular arrhythmias (sustained):

For indefinite period from date of hospital admission for initial evaluation and medical therapy for a sustained ventricular arrhythmia, or; for indefinite period from date of hospital admission for ventricular aneurysmectomy, or; with an automatic implantable Cardioverter-Defibrillator (AICD) in place.....100

Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent 100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent 60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

NOTE: A rating of 100 percent shall be assigned from the date of hospital admission for initial evaluation and medical therapy for a sustained ventricular arrhythmia or for ventricular aneurysmectomy. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

7015 Atrioventricular block:

Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent 100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left

ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication or a pacemaker required.....10

NOTE: Unusual cases of arrhythmia such as atrioventricular block associated with a supraventricular arrhythmia or pathological bradycardia should be submitted to the Director, Compensation and Pension Service. Simple delayed P-R conduction time, in the absence of other evidence of cardiac disease, is not a disability.

7016 Heart valve replacement (prosthesis):

For indefinite period following date of hospital admission for valve replacement.....100

Thereafter:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent 100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

NOTE: A rating of 100 percent shall be assigned as of the date of hospital admission for valve replacement. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

7017 Coronary bypass surgery:

For three months following hospital admission for surgery.....100

Thereafter:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent 100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent 60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram,

echocardiogram, or X-ray.....30
Workload greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7018 Implantable cardiac pacemakers.

For two months following hospital admission for implantation or reimplantation.....100

Thereafter:
Evaluate as supraventricular arrhythmias (DC 7010), ventricular arrhythmias (DC 7011), or atrioventricular block (DC 7015). Minimum.....10

NOTE: Evaluate implantable Cardioverter-Defibrillators (AICD's) under DC 7011.

7019 Cardiac transplantation:

For an indefinite period from date of hospital admission for cardiac transplantation.....100

Thereafter:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Minimum.....30

NOTE: A rating of 100 percent shall be assigned as of the date of hospital admission for cardiac transplantation. One year following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

7020 Cardiomyopathy:

Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent 100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

DISEASES OF THE ARTERIES AND VEINS

7101 Hypertensive vascular disease (hypertension and isolated systolic hypertension).

Diastolic pressure predominantly 130 or more.....60
Diastolic pressure predominantly 120 or more.....40
Diastolic pressure predominantly 110 or more, or; systolic pressure predominantly 200 or more... 20
Diastolic pressure predominantly 100 or more, or; systolic pressure predominantly 160 or more, or; minimum evaluation for an individual with a history of diastolic pressure predominantly 100 or more who requires continuous medication for control.……....….....10

NOTE (1): Hypertension or isolated systolic hypertension must be confirmed by readings taken two or more times on at least three different days. For purposes of this section, the term hypertension means that the diastolic blood pressure is predominantly 90mm. or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm. or greater with a diastolic blood pressure of less than 90mm.

NOTE (2): Evaluate hypertension due to aortic insufficiency or hyperthyroidism, which is usually the isolated systolic type, as part of the condition causing it rather than by a separate evaluation.

7110 Aortic aneurysm:

If five centimeters or larger in diameter, or; if symptomatic, or; for indefinite period from date of hospital admission for surgical correction (including any type of graft insertion).....100
Precluding exertion.....60
Evaluate residuals of surgical correction according to organ systems affected.

NOTE: A rating of 100 percent shall be assigned as of the date of admission for surgical correction. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

7111 Aneurysm, any large artery:

If symptomatic, or; for indefinite period from date of hospital admission for surgical correction.....100

Following surgery:
Ischemic limb pain at rest, and; either deep ischemic ulcers or ankle/brachial index of 0.4 or less.....100
Claudication on walking less than 25 yards on a level grade at 2 miles per hour, and; persistent coldness of the extremity, one or more deep ischemic ulcers, or ankle/brachial index of 0.5 or less.....60
Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour, and; trophic changes (thin skin, absence of hair, dystrophic nails) or ankle/brachial index of 0.7 or less.....40
Claudication on walking more than 100 yards, and; diminished peripheral pulses or ankle/brachial index of 0.9 or less.....20

NOTE (1): The ankle/brachial index is the ratio of the systolic blood

pressure at the ankle (determined by Doppler study) divided by the simultaneous brachial artery systolic blood pressure. The normal index is 1.0 or greater.

NOTE (2): These evaluations are for involvement of a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor, if applicable.

NOTE (3): A rating of 100 percent shall be assigned as of the date hospital admission for surgical correction. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

7112 Aneurysm, any small artery:

Asymptomatic.....0

NOTE: If symptomatic, evaluate according to body system affected. Following surgery, evaluate residuals under the body system affected.

7113 Arteriovenous fistula, traumatic:

With high output heart failure.....100
Without heart failure but with enlarged heart, wide pulse pressure, and tachycardia.....60
Without cardiac involvement but with edema, stasis dermatitis, and either ulceration or cellulitis:
Lower extremity.....50
Upper extremity.....40
With edema or stasis dermatitis:
Lower extremity.....30
Upper extremity.....20

7114 Arteriosclerosis obliterans:

Ischemic limb pain at rest, and; either deep ischemic ulcers or ankle/brachial index of 0.4 or less.....100
Claudication on walking less than 25 yards on a level grade at 2 miles per hour, and; either persistent coldness of the extremity or ankle/brachial index of 0.5 or less.....60
Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour, and; trophic changes (thin skin, absence of hair, dystrophic nails) or ankle/brachial index of 0.7 or less.....40
Claudication on walking more than 100 yards, and; diminished peripheral pulses or ankle/brachial index of 0.9 or less.....20

NOTE (1): The ankle/brachial index is the ratio of the systolic blood pressure at the ankle (determined by Doppler study) divided by the simultaneous brachial artery systolic blood pressure. The normal index is 1.0 or greater.

NOTE (2): Evaluate residuals of aortic and large arterial bypass surgery or arterial graft as arteriosclerosis obliterans.

NOTE (3): These evaluations are for involvement of a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor

(§ 4.26), if applicable.

7115 Thrombo-angiitis obliterans (Buerger's Disease):

Ischemic limb pain at rest, and; either deep ischemic ulcers or ankle/brachial index of 0.4 or less.....100
Claudication on walking less than 25 yards on a level grade at 2 miles per hour, and; either persistent coldness of the extremity or ankle/brachial index of 0.5 or less.....60
Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour, and; trophic changes (thin skin, absence of hair, dystrophic nails) or ankle/brachial index of 0.7 or less.....40
Claudication on walking more than 100 yards, and; diminished peripheral pulses or ankle/brachial index of 0.9 or less.....20

NOTE (1): The ankle/brachial index is the ratio of the systolic blood pressure at the ankle (determined by Doppler study) divided by the simultaneous brachial artery systolic blood pressure. The normal index is 1.0 or greater.

NOTE (2): These evaluations are for involvement of a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.

7117 Raynaud's syndrome:

With two or more digital ulcers plus autoamputation of one or more digits and history of characteristic attacks.....100
With two or more digital ulcers and history of characteristic attacks.....60
Characteristic attacks occurring at least daily.....40
Characteristic attacks occurring four to six times a week.....20
Characteristic attacks occurring one to three times a week.....10

NOTE: For purposes of this section, characteristic attacks consist of sequential color changes of the digits of one or more extremities lasting minutes to hours, sometimes with pain and paresthesias, and precipitated by exposure to cold or by emotional upsets. These evaluations are for the disease as a whole, regardless of the number of extremities involved or whether the nose and ears are involved.

7118 Angioneurotic edema:

Attacks without laryngeal involvement lasting one to seven days or longer and occurring more than eight times a year, or; attacks with laryngeal involvement of any duration occurring more than twice a year.....40
Attacks without laryngeal involvement lasting one to seven days and occurring five to eight times a year, or; attacks with laryngeal involvement of any duration occurring once or twice a year.....20
Attacks without laryngeal involvement lasting one to seven days and occurring two to four times a year.....10

7119 Erythromelalgia:

Characteristic attacks that occur more than once a day, last an average of more than two hours each, respond poorly to treatment, and that restrict most routine daily activities.....100
Characteristic attacks that occur more than once a day, last an average

of more than two hours each, and respond poorly to treatment, but that do not restrict most routine daily activities.....60
Characteristic attacks that occur daily or more often but that respond to treatment.....30
Characteristic attacks that occur less than daily but at least three times a week and that respond to treatment.....10

NOTE: For purposes of this section, a characteristic attack of erythromelalgia consists of burning pain in the hands, feet, or both, usually bilateral and symmetrical, with increased skin temperature and redness, occurring at warm ambient temperatures. These evaluations are for the disease as a whole, regardless of the number of extremities involved.

7120 Varicose veins:

With the following findings attributed to the effects of varicose veins:
Massive board-like edema with constant pain at rest.....100
Persistent edema or subcutaneous induration, stasis pigmentation or eczema, and persistent ulceration 60
Persistent edema and stasis pigmentation or eczema, with or without intermittent ulceration.....40
Persistent edema, incompletely relieved by elevation of extremity, with or without beginning stasis pigmentation or eczema.....20
Intermittent edema of extremity or aching and fatigue in leg after prolonged standing or walking, with symptoms relieved by elevation of extremity or compression hosiery.....10
Asymptomatic palpable or visible varicose veins.....0

NOTE: These evaluations are for involvement of a single extremity. If more than one extremity is involved, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.

7121 Post-phlebitic syndrome of any etiology:

With the following findings attributed to venous disease:
Massive board-like edema with constant pain at rest.....100
Persistent edema or subcutaneous induration, stasis pigmentation or eczema, and persistent ulceration.....60
Persistent edema and stasis pigmentation or eczema, with or without intermittent ulceration.....40
Persistent edema, incompletely relieved by elevation of extremity, with or without beginning stasis pigmentation or eczema.....20
Intermittent edema of extremity or aching and fatigue in leg after prolonged standing or walking, with symptoms relieved by elevation of extremity or compression hosiery.....10
Asymptomatic palpable or visible varicose veins.....0

NOTE: These evaluations are for involvement of a single extremity. If more than one extremity is involved, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.

7122 Cold injury residuals:

With pain, numbness, cold sensitivity, or arthralgia plus two or more of the following: tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, X-ray abnormalities (osteoporosis, subarticular punched out lesions, or osteoarthritis) of affected parts.....30
With pain, numbness, cold sensitivity, or arthralgia plus tissue loss, nail

abnormalities, color changes, locally impaired sensation, hyperhidrosis, or X-ray abnormalities (osteoporosis, subarticular punched out lesions, or osteoarthritis) of affected parts.....20
With pain, numbness, cold sensitivity, or arthralgia.....10

NOTE (1): Amputations of fingers or toes, and complications such as squamous cell carcinoma at the site of a cold injury scar or peripheral neuropathy should be separately evaluated under other diagnostic codes.

NOTE (2): Evaluate each affected part (hand, foot, ear, nose) separately and combine the ratings, if appropriate, in accordance with §§ 4.25 and 4.26.

7123 Soft tissue sarcoma (of vascular origin).....100

NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.

(Authority: 38 U.S.C. 1155)

REGULATORY AMENDMENT
4-98-1

Regulation affected: 38 CFR 4.104

EFFECTIVE DATE OF REGULATION: August 13, 1998

Date Secretary approved regulation: June 30, 1998

Federal Register Citation: 63 FR 37778-79 (July 14, 1998)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

In the Federal Register of March 28, 1997 (62 FR 14832) we published a proposal to revise the provisions of VA's rating schedule (38 CFR part 4) governing evaluations for frozen feet (38 CFR 4.104, diagnostic code 7122). As part of a final rule published in the Federal Register on December 11, 1997, revising the cardiovascular portion of the rating schedule, we adopted the revision proposed on March 28, 1997, with only minor changes. This final rule responds to comments received in response to the proposed rule and makes additional nonsubstantive technical changes. It also expands the discussion of possible residual effects in note (1).

In the evaluation criteria, we changed "pain" to "arthralgia or other pain" to emphasize the relatively new concept that arthralgia may result from cold injury, and we added a direction in note (1) to separately evaluate other disabilities that are determined to be residuals of cold injury, such as Raynaud's phenomenon and muscle atrophy, unless they are used to support an evaluation under diagnostic code 7122, in response to a comment.

For the reasons set out in the preamble, 38 CFR part 4, subpart B, is amended as set forth below:

Part 4--SCHEDULE FOR RATING DISABILITIES

Subpart B—Disability Ratings

1. The authority citation for part 4 continues to read as follows:

AUTHORITY: 38 U.S.C. 1155 unless otherwise noted.

2. Section 4.104 is amended by revising diagnostic code 7122 to read as follows:

§ 4.104 Schedule of ratings—cardiovascular system.

* * * * *

7122 Cold injury residuals.

With the following in affected parts:
Arthralgia or other pain, numbness, or cold sensitivity plus two or more of the following: tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, X-ray abnormalities (osteoporosis, subarticular punched out lesions, or osteoarthritis) ……..30
Arthralgia or other pain, numbness, or cold sensitivity plus tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, or X-ray abnormalities (osteoporosis, subarticular punched out lesions, or osteoarthritis) ……..20
Arthralgia or other pain, numbness, or cold sensitivity…… 10

NOTE (1): Separately evaluate amputations of fingers or toes, and complications such as squamous cell carcinoma at the site of a cold injury scar or peripheral neuropathy, under other diagnostic codes.

Separately evaluate other disabilities that have been diagnosed as the residual effects of cold injury, such as Raynaud's phenomenon, muscle atrophy, etc., unless they are used to support an evaluation under diagnostic code 7122.

NOTE (2): Evaluate each affected part (e.g., hand, foot, ear, nose) separately and combine the ratings in accordance with §§ 4.25 and 4.26.

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(Authority: 38 U.S.C. 1155)

REGULATORY AMENDMENT
4-99-1

Regulation affected: 38 CFR 4.85, 4.86, 4.87, 4.87a, and 4.87b

EFFECTIVE DATE OF REGULATION: June 10, 1999

Date Secretary approved regulation: January 8, 1999

Federal Register Citation: 64 FR 25202 (May 11, 1999)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended sections 4.85 through 4.87b of 38 CFR, Part 4, the sections of the rating schedule that address the ear and other sense organs. The intended effect of this action is to update this portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

We revised introductory section 4.85 to indicate that an examination for hearing impairment must be conducted by a state-licensed audiologist, to state what puretone frequencies are averaged to obtain the puretone threshold average and to state that it is the Maryland CNC speech discrimination test that must be used, to direct that if only one ear is service-connected, the NSC ear will be assigned a hearing impairment level of I, and to refer the rater to 38 CFR 3.383 for consideration of SMC in any claim for impaired hearing. Section 4.86 was revised to provide directions on evaluating veterans with either of two exceptional patterns of hearing impairment. This change is based on a VHA study indicating that without these special provisions, these small groups of veterans would be underrated. We removed § 4.86a and revised 4.87 by providing more objective criteria for peripheral vestibular disorders, DC 6204, (formerly chronic labyrinthitis) and Meniere's syndrome, DC 6205. We removed DC 6206, mastoiditis, and included mastoiditis with chronic suppurative otitis media and cholesteatoma in DC 6200, since these are closely related and often co-existent. We removed DC 6203, otitis interna, as an obsolete term. The condition is included in DC 6204. More detailed explanations for some of these changes are included in the "Supplementary Information" section of both the final revision, which is enclosed, and the proposed revision, which was published in the Federal Register on April 12, 1994 (59 FR 17295).

Diagnostic codes revised	Diagnostic codes removed	Diagnostic codes added
6200	6203	
6201	6206	
6204	6101	
6205	6102	
6207	6103	
6208	6104	
6209	6105	
6210	6106	
6260	6107	
6275	6108	
6276	6109	
	6110	

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900-AF22

Schedule for Rating Disabilities; Diseases of the Ear and Other Sense Organs

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends that portion of the Department of Veterans Affairs (VA) Schedule for Rating Disabilities that addresses the ear and other sense organs. The intended effect of this action is to update this portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances that have occurred since the last review.

DATES: Effective Dates: This amendment is effective June 10, 1999.

FOR FURTHER INFORMATION CONTACT: Caroll McBrine, M.D., Consultant, Regulations Staff (211B), Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Ave., NW, Washington DC 20420, (202) 273-7230.

SUPPLEMENTARY INFORMATION: As part of its review of the Schedule for Rating Disabilities, VA published a proposal to amend that portion of the Schedule pertaining to the ear and other sense organs in the Federal Register of April 12, 1994 (59 FR 17295-17301). Interested persons were invited to submit written comments on or before June 13, 1994. We received comments from the Veterans of Foreign Wars, Disabled American Veterans, and three individuals.

The evaluation of hearing impairment in the previous rating schedule was based on two criteria: the results of a puretone audiometry test and the results of a controlled speech discrimination test. Based on the results of these tests, one of two tables was used to determine a Roman numeral designation for hearing impairment: Table VI, where the number is determined by combining the percent of speech discrimination with the average puretone decibel (dB) loss, and Table VIa, which is based solely on average puretone dB loss, and was used only if language difficulties or inconsistent speech audiometric scores made use of Table VI inappropriate. The Roman numeral designations determined for each ear using Table VI or VIa were then combined using Table VII, in order to determine the percentage evaluation for hearing

impairment. We proposed no change in this method of evaluation and included information about it in Sec. 4.85, ``Evaluation of hearing impairment'' and Sec. 4.86, ``Auditory acuity, hearing aids, and evidence other than puretone audiometry and controlled speech.'' In response to several comments we received about the method of evaluation, and requesting more specific details, we have reorganized Secs. 4.85 and 4.86 for the sake of clarity, as explained in detail below.

One commenter stated that nowhere is VA's authority to use the specific hearing tests it uses spelled out in the regulations. We agree that the tests required were not specified in the rating schedule and have therefore stated in Sec. 4.85(a) that the Maryland CNC speech discrimination test and the puretone audiometry test are to be used for evaluating hearing impairment. The use of the Maryland CNC speech discrimination test and the puretone threshold average determined by an audiometry test was established by a regulation on the evaluation of hearing loss published in the Federal Register on November 18, 1987 (52 FR 44117). That regulation changed the method of evaluating hearing loss based on a VA study on hearing loss testing methods and assistive hearing devices that had been requested by Congress in 1984. The results of the study were published in a VA report titled ``Report on Hearing Loss Study'' that was issued on January 6, 1986. Although the regulation revised the rating schedule to incorporate rating tables based on the new method of evaluation, it did not add to the schedule specific details about the new testing methods.

One commenter stated that if only VA examinations or authorized audiological clinic examinations are to be used, this should be stated in the proposed regulation. Based on this comment, we have stated in Sec. 4.85(a) that an examination for hearing impairment for VA purposes must be conducted by a state-licensed audiologist. This will help to assure that examinations of veterans will be accurate and consistent because state licensing agencies require that audiologists meet specific educational and training requirements and pass a national competency examination.

Two commenters noted that the meaning of average puretone decibel loss is not explained in the rating schedule. We agree that this information should be included in the rating schedule and have added an explanation in Sec. 4.85(d). For VA purposes, the average puretone decibel loss means a four-frequency puretone threshold average obtained by adding the puretone thresholds at four specified frequencies 1000, 2000, 3000, and 4000 Hertz and dividing by four. This method and the reasons for its selection were explained in the 1987 regulation referred to above. Current terminology is ``puretone threshold average'' rather than ``average puretone decibel loss,'' and we have used this language in Sec. 4.85 and have revised the labels in Tables VI and VIa. For clarity, we have also titled Table VIa, untitled in the proposed rule, ``Numeric Designation of Hearing Impairment Based Only on Puretone Threshold Average'' and retitled Table VI, titled ``Numeric Designation of Hearing Impairment'' in the proposed rule, ``Numeric Designation of Hearing Impairment Based on Puretone Threshold Average and Speech Discrimination.'' In the proposed rule we inadvertently placed the numeric tables in Sec. 4.86, we have moved them to Sec. 4.85(h) as the more appropriate location. We removed the examples from Sec. 4.85 because the directions for using the tables are clear enough without them.

We also proposed to add two new provisions for evaluating veterans with certain patterns of hearing impairment that cannot always be accurately assessed under Sec. 4.85, because the speech discrimination test may not reflect the severity of communicative functioning these veterans experience. These veterans were identified in review studies carried out by the Veterans Health Administration's (VHA's) Audiology and Speech Pathology Service in 1991. One of the new provisions, proposed as Sec. 4.85(d), stated that if puretone thresholds in any four of the five frequencies of 500, 1000, 2000, 3000, and 4000 Hertz are 55 dB's or more, an evaluation could be based either on Table VI or Table VIa, whichever results in a higher evaluation. (This provision has been redesignated Sec. 4.86(a), as discussed below.)

One commenter, although offering no rationale for the comment, suggested that the level of hearing loss for this provision should be 50 dB instead of 55.

To conduct a speech discrimination test in someone with hearing impairment, the sounds must be amplified sufficiently for the individual to hear the words. The greater the dB threshold level, the higher the level of amplification that is needed. Up to a 50 dB threshold level, amplification sufficient to conduct a speech discrimination test is feasible. However, with a 55 dB threshold level--the level at which speech becomes essentially inaudible--the high level of amplification needed to attempt to conduct a speech discrimination test would be painful to most people, and speech discrimination tests may therefore not be possible or reliable. The new provision will allow evaluation of hearing impairment in such individuals on the basis of puretone threshold average only, if that results in a higher evaluation than one based on a combination of speech discrimination and puretone threshold average.

The same commenter suggested applying proposed Sec. 4.85(d) if three of the five specified frequencies have a threshold of 55 dB or more because the frequencies of 2000 and above are the most important frequencies for speech discrimination, and precipitous hearing impairment in the high frequencies is extremely handicapping in the work environment.

The frequencies selected and the dB threshold were chosen because VHA, through their clinical studies, found that speech discrimination studies are quite variable in veterans with a 55 dB threshold in four or more frequencies and may not accurately reflect the true extent of disability. Also based on the results of their studies, they did not extend the recommendation for an alternative method of evaluation to those with that extent of hearing impairment at only three frequencies. In view of VHA's recommendations, based on tests conducted on 1565 individuals, we make no change based on this comment.

The second provision we proposed to add (as Sec. 4.85(e)) was to direct the rating agency to choose the Roman numeral designation derived from either table VI or VIa, whichever is higher, when puretone thresholds are 30 dB or less at frequencies of 1000 Hertz and below, and are 70 dB or more at 2000 Hertz. It also directed the rating agency to elevate that Roman numeral designation one level. This provision was meant to compensate for a pattern of hearing impairment that is an extreme handicap in the presence of any environmental noise. VHA found

that when this pattern of impairment is present, a speech discrimination test conducted in a quiet room with amplification of the sounds does not always reflect the extent of impairment experienced in the ordinary environment. This provision allows evaluation of hearing impairment in these individuals on puretone average only, if that results in a higher evaluation. (This provision has been redesignated Sec. 4.86(b), as discussed below.)

One commenter said it appears in proposed Sec. 4.85(d) and (e) that 500 Hertz is one of the frequencies to be used in the puretone average, although when Sec. 4.85 was revised in 1987, the supplementary information stated that puretone frequencies at 1000, 2000, 3000, and 4000 Hertz were to be used to determine the puretone threshold average. The commenter also said that the use of four frequencies in some circumstances and of five or more in others requires an explanation of why such a methodology does not give rise to disparate treatment.

In the proposed rule, the four frequency puretone threshold average was the basis of the evaluation for hearing impairment in all cases, and the 500 Hertz frequency was to be used only to help select the veterans to whom the special provisions would be applied. However, in order to remove any suggestion of disparate treatment, and after consultation with VHA, we removed the 500 Hertz stipulations from the two proposed special provisions. VHA assured us that this change would not affect the need for the special provisions and would not affect the disability ratings of any group of veterans.

One commenter suggested that the language for evaluation parallel the language of 38 CFR 3.385.

The purpose of Sec. 3.385, ``Disability due to impaired hearing,'' is to explain the basis for determining whether impaired hearing is a disability, which is different from the purpose of Sec. 4.85, which is to explain how to evaluate hearing impairment, once it has been determined to be a disability, for purposes of disability compensation. Since these regulations serve different purposes, and different frequencies are involved, the use of parallel language is neither necessary nor feasible.

When the puretone threshold average is 105 dB or more, tables VI and VIa require a numeric designation of XI, the highest level of evaluation. This is unchanged from the previous schedule. One commenter stated that a loss of greater than 92 dB, rather than 105 dB, would result in total impairment in everyone, according to the American Academy of Otolaryngology and Otolaryngology Guide for the Evaluation of Hearing Impairment.

Methods of measuring hearing impairment and assessing disability based on the results vary from one organization to another, making direct comparisons infeasible. Not all organizations use the same range of frequencies, for example, to determine a puretone threshold average. While VA uses 1000, 2000, 3000, and 4000 Hertz for evaluation, based on the results of the VA study referred to above, the American Medical Association (AMA), in its ``Guides to the Evaluation of Permanent Impairment'' 4th ed., 1993, uses 500, 1000, 2000, and 3000 Hertz. The National Institute for Occupational Safety and Health proposed using puretone thresholds at 1000, 2000, 3000, and 4000 Hertz, as has the American Speech and Hearing Association Task Force, and their rationale

is that these frequencies are most sensitive to discrimination ability in quiet and in noise. Not all organizations use a speech discrimination test in evaluating hearing impairment; the AMA, for example, does not. The guide referred to by the commenter is no longer in existence, but the AMA Guides states that the criteria it uses are adapted from the 1979 Academy of Otolaryngology-Head and Neck Surgery Guide. The AMA Guides considers impairment of hearing to be total if the average of the four puretone frequencies they use is over 91.7 dB. However, total impairment of hearing under their system does not mean that a 100-percent disability evaluation is assigned. Under the AMA disability evaluation system, each disability is considered in terms of its effect on the whole person. The evaluation they would assign for a bilateral puretone threshold of 91.7 dB (in workers' compensation claims, for example) is 35 percent, not 100 percent. With a unilateral puretone threshold of 91.7 dB (with the other ear normal), the AMA system would evaluate monaural hearing impairment at 100 percent, and binaural hearing impairment at approximately 17 percent, but the actual evaluation they would assign is six percent. Thus, direct comparisons of different systems of evaluating disability due to hearing loss are not possible, and we make no change based on this comment.

One commenter pointed out that Sec. 4.86 in the previous schedule stated that evaluations are intended to make proper allowance for improvement by hearing aids and that examination to determine the improvement is not necessary. The commenter further stated that because Table VI appears to be unchanged in the proposed regulations, it would appear that Table VI continues to be built on the assumption of improvement with hearing aids and that performing audiology tests with hearing aids or adjusting the rating values based on an assumption of improvement with hearing aids violates the policy of determining impairment of body function without the use of any prosthetic device.

We are unaware of any general policy which prohibits consideration of the effect of a prosthetic device in determining the degree of impairment. In fact, there is a standard method for measuring best corrected vision, and the rating schedule requires that examinations for visual impairment include corrected, as well as uncorrected, visual acuity. However, there is no standard procedure for measuring best corrected hearing, and the amended instruction (Sec. 4.85(a)) states that examinations for hearing impairment will be conducted without the use of hearing aids. Section 4.85(a) is clear enough that, in order to avoid confusion, we have removed the language in proposed Sec. 4.86(b) stating that the evaluations are designed to measure the best residual uncorrected hearing and that examinations comparing hearing with and without hearing aids are unnecessary. VHA consultants indicated that it is well accepted in the audiological literature that the better the speech discrimination score, the better the overall result with hearing aids, but they also stated that the language in the former rating schedule about anticipated improvement by a hearing aid did not in any way affect the method of evaluation or disability ratings themselves, and that removal of that language would also have no effect on the method of evaluation or on disability ratings.

The previous Sec. 4.87 and proposed Sec. 4.86(a) defined ``impairment of auditory acuity,'' for VA purposes. However, that term is not used elsewhere in the rating schedule, although the terms ``hearing impairment,'' ``hearing loss,'' and ``deafness'' are used. We have therefore removed Sec. 4.86(a) as unnecessary and have, for the

sake of clarity, used ``hearing impairment'' in all other parts of the rating schedule to designate a loss of hearing except where the statutory terms ``deafness'' or ``hearing loss'' are required (by 38 U.S.C. 1114(k)).

Former section 4.86a, ``Evidence other than puretone audiometry and controlled speech,'' explained that where claims contain evidence which predates the use of puretone audiometry and controlled speech, determination of service connection will be evaluated under the regulations in effect on December 17, 1987. We proposed to retain this instruction in Sec. 4.86(c). One commenter suggested that this is not a rating regulation and that it properly belongs in Part 3 of 38 CFR.

We agree that regulations regarding service connection are not appropriate in the rating schedule, which is used for the evaluation of disabilities, and we have removed Sec. 4.86(c). This completes the removal of the contents of proposed Sec. 4.86. We have, however, retained Sec. 4.86, retitled it ``Exceptional patterns of hearing impairment,'' and added paragraphs (a) and (b) for the two provisions that were proposed as Sec. 4.85(d) and (e). This change better highlights the unusual aspects of evaluating these uncommon patterns of hearing impairment.

The previous schedule did not provide specific instructions on evaluating bilateral hearing impairment when hearing impairment is service-connected in only one ear. One commenter suggested that we add a note indicating that a non-service-connected ear is to be treated as having normal hearing.

We concur and have added Sec. 4.85(f) to specify that a non-service-connected ear will be assigned a Roman numeral designation of I, subject to the provisions of Sec. 3.383, ``Special consideration for paired organs and extremities.'' This is consistent with the manner in which we evaluate other paired organs, where only one of the pair is service-connected (38 CFR 4.73 (muscle injuries) and 38 CFR 4.124a (diseases of the cranial and peripheral nerves)).

One commenter stated that the regulation should include a specific effective date and should state whether the regulatory change constitutes a liberalizing law or issue.

The effective date of the regulation will be 30 days after publication of this final rule in the Federal Register. The revisions of the sections addressing ear and other sense organs are part of the overall revision of the rating schedule based on medical advances, etc., rather than representing liberalizing interpretations of regulations. We have explained above the reasons for the provisions of Sec. 4.86. The preamble erred in discussing these provisions as liberalizations. Rather, they are an attempt to assure more equitable evaluations in a small number of veterans with unusual patterns of hearing impairment.

Special monthly compensation (SMC) is a benefit authorized by 38 U.S.C. 1114 that is payable in addition to the compensation payable for specific disabilities, or combinations of disabilities, based upon the extent of impairment under the Schedule for Rating Disabilities. We proposed removing the footnote regarding SMC in Table VII in favor of a single note at the end of Sec. 4.85 directing the rating agency to

refer to Sec. 3.350 (``Special monthly compensation ratings'') to determine whether a claimant is entitled to SMC. One commenter suggested that we retain this footnote.

In response to the comment, and for the sake of consistency with references to SMC that we have made in other revised sections of the rating schedule, we have added this information as Sec. 4.85(g) and also restored a footnote to Table VII, Percentage Evaluations for Hearing Impairment, indicating that the rating agency is to review for entitlement to special monthly compensation under Sec. 3.350. (We proposed to put the information now in Sec. 4.85(g) in a footnote following Sec. 4.86, but moved it to Sec. 4.85 instead to remove ambiguity about whether it referred only to the provisions of Sec. 4.86 or to all hearing evaluations.) A single footnote to Table VII is adequate because we have deleted all but one diagnostic code (DC), 6100, for hearing impairment, since it is unnecessary for any practical purpose to have multiple diagnostic codes to indicate various evaluation levels of the same disability. SMC may be warranted not only when hearing impairment is evaluated at 100 percent, but also for various levels of deafness (or hearing impairment) when they occur in combination with blindness, and the single footnote will assure that SMC is always considered when there is hearing impairment. We believe that the combination of the footnote and Sec. 4.85(g) is the most effective method for ensuring complete review for special monthly compensation.

38 U.S.C. 1114(k) authorizes payment of SMC if there is absence of air and bone conduction in both ears. The implementing regulation, 38 CFR 3.350(a)(5), states that deafness of both ears, having absence of air and bone conduction, will be held to exist when bilateral hearing loss is equal to or greater than the minimum bilateral hearing loss required for a maximum rating (100 percent) under the schedule. One commenter suggested that we add a footnote to the 80- and 90-percent levels indicating entitlement to special monthly compensation, because these evaluations constitute deafness, for all practical purposes.

We do not concur. Complete loss of air and bone conduction would result in no response on audiometry, even at 105 dB, according to VHA consultants, and would therefore warrant a 100-percent evaluation. If there is a response on audiometry, which would necessarily be the case to establish an 80- or 90-percent evaluation for hearing impairment, there is not complete absence of air and bone conduction, and the hearing impairment in those cases would not meet the requirements of 38 U.S.C. 1114(k). Such a footnote would therefore be contrary to statutory requirements.

The previous schedule listed mastoiditis under its own diagnostic code (6206), with evaluation based on suppuration and impairment of hearing. We proposed to combine it with suppurative otitis media under DC 6200. The previous schedule provided neither diagnostic code nor evaluation criteria for cholesteatoma; raters have generally evaluated it analogous to otitis media. We also proposed to include cholesteatoma under DC 6200, because the three conditions are closely related, and their manifestations may be essentially the same. One commenter suggested that we assign separate diagnostic codes for cholesteatoma and mastoiditis because the proposed rule is ambiguous as to whether one of these conditions must accompany otitis media to assign a 10-percent evaluation and because mastoiditis and cholesteatoma can exist

without forming pus (suppuration).

Chronic otitis media, mastoiditis, and cholesteatoma may exist with or without suppuration. However, two or more of these conditions, all of which are interrelated, commonly coexist, and their manifestations may be very similar. For example, chronic mastoiditis may develop simultaneously with otitis media or may occur as a later complication. Therefore, a single diagnostic code and set of evaluation criteria for all three conditions is appropriate, and we have revised the title of DC 6200 to clarify that it can apply to any of these conditions. We have also added aural polyps to the criteria for a 10-percent evaluation because they are a possible consequence of chronic otitis media. We have also expanded the note directing that hearing impairment be evaluated separately to include a list of other possible complications--labyrinthitis, tinnitus, facial nerve paralysis, and bone loss of skull--that would also warrant separate evaluations. These criteria better encompass the usual range of impairments that may develop in this group of conditions. Placing these related conditions under a single diagnostic code will help assure that the same impairment is not evaluated twice when more than one of these conditions is present in an individual.

The previous schedule addressed otitis interna under DC 6203 and evaluated it based on the extent of hearing loss. We proposed to eliminate this diagnostic code because otitis interna is an archaic name for a general ear infection condition which is more accurately classified as a peripheral vestibular disorder, DC 6204. One commenter suggested that we provide instructions under peripheral vestibular disorders explaining how to evaluate otitis interna. We do not concur. Otitis interna is an obsolete term, and conditions which it formerly encompassed are best evaluated under the criteria for peripheral vestibular disorders.

The previous rating schedule provided three evaluation levels for Meniere's syndrome, DC 6205, based on the severity and frequency of attacks. Among other things, we proposed to provide objective measures for the frequency of the attacks. One commenter stated that the prodromal signs, the duration of the episode, and the recovery period for an attack may last as long as ten days, and therefore suggested that the frequency of attacks proposed for the 100-percent evaluation (more than once weekly) and 60-percent evaluation (once a week or less) was too stringent. The commenter also said that ``attacks occurring once a week or less'' should be better defined.

Attacks of vertigo in Meniere's syndrome appear suddenly and last from a few to 24 hours (Boies Fundamentals of Otolaryngology, Sixth Edition, W.B. Saunders Company, 1989, p.139, and The Merck Manual of Diagnosis and Therapy, Merck Research Laboratories, 1992, p. 2336). Since the attacks of vertigo (often accompanied by nausea, vomiting, hearing impairment, and tinnitus) generally subside within 24 hours, requiring attacks more than once weekly for a 100-percent level, and one to four times a month for a 60-percent level, are reasonable requirements, in our judgment, that are equivalent to, but more objective than, the requirements of ``frequent and typical,'' and ``less frequent'' in the previous schedule. In response to the comment, however, we better defined the criteria by changing the requirements for a 60-percent evaluation from ``deafness with attacks of vertigo and cerebellar gait occurring once a week or less'' to ``hearing impairment

with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus," and by changing the requirements for a 30-percent evaluation from ``deafness with occasional vertigo'' to ``hearing impairment with vertigo less than once a month, with or without tinnitus." Tinnitus is commonly, but not universally, present in Meniere's syndrome. We included the phrase ``with or without tinnitus'' in these criteria to emphasize that the overall evaluation of Meniere's syndrome is the same whether or not tinnitus is present. This will avoid the assignment of a separate evaluation for tinnitus when evaluating the syndrome under DC 6205, and at the same time, indicate that the absence of tinnitus in certain cases has no effect on the evaluation to be assigned under DC 6205.

We proposed to retain ``deafness'' as one of the criteria at the 100-percent evaluation level of Meniere's syndrome (DC 6205). One commenter suggested that there be a footnote appended to the 100-percent level, signaling that entitlement to Special Monthly Compensation is payable.

We do not concur. A particular level of impaired hearing is not a requirement for the 100-percent level for Meniere's syndrome. The term ``deafness'' was meant to indicate any level of hearing impairment, and we have changed ``deafness'' to ``hearing impairment'' in the criteria for Meniere's syndrome to make that clear. The requirements for a 100-percent evaluation of Meniere's syndrome are met if there is any level of hearing impairment, and vertigo and cerebellar gait occur more than once weekly. 38 CFR 3.350(a)(5), on the other hand, requires an absence of air and bone conduction and hearing loss equal to or greater than the minimum bilateral hearing loss required for a 100-percent rating, for entitlement to SMC on the basis of hearing impairment. For this reason, a footnote referring to entitlement to SMC is not appropriate here, and Sec. 4.85(g) and the footnote to Table VII will assure consideration of SMC in any case of hearing impairment.

Another commenter suggested that we add a note under Meniere's syndrome instructing the rating agency that hearing impairment will be rated separately and combined. We did not adopt this suggestion because the evaluation criteria and percentages are based on all of the manifestations of Meniere's syndrome, with attacks often consisting of hearing impairment, vertigo, tinnitus, and staggering gait. Any of the symptoms may be intermittent. It would be contrary to 38 CFR 4.14 (Avoidance of pyramiding), which prohibits the evaluation of the same manifestation under different diagnoses, to evaluate hearing impairment separately, and also use it to support an evaluation under DC 6205. However, we have added a note stating that Meniere's syndrome may be evaluated either under DC 6205 or by separately evaluating vertigo (as a peripheral vestibular disorder), hearing impairment, and tinnitus, whichever method results in a higher overall evaluation. The note also prohibits combining an evaluation for hearing impairment, tinnitus, or vertigo with an evaluation under DC 6205.

The previous schedule provided a minimum 10-percent evaluation for malignant neoplasms of the ear, DC 6208. We proposed to delete the minimum evaluation. One commenter suggested that we reinstate the minimum 10-percent evaluation because it was meant to compensate for skull loss.

In our judgment, loss of function is the most accurate and

equitable basis for evaluating the residuals of this condition. If a malignant neoplasm results in skull loss, the skull loss would be separately evaluated under the skeletal system (DC 5296).

The previous rating schedule provided a 10-percent evaluation for tinnitus, DC 6260, with the criteria being: ``persistent as a symptom of head injury, concussion or acoustic trauma.'' We proposed to remove the requirement that tinnitus be a symptom of head injury, concussion or acoustic trauma and that it be persistent and instead provide a 10-percent evaluation for recurrent tinnitus. One commenter suggested that we add a note following tinnitus instructing that the evaluation for tinnitus be combined with ratings for hearing impairment, suppurative otitis media, and peripheral vestibular disorder.

We agree and have added a note under DC 6260 stating that a separate evaluation for tinnitus under DC 6260 may be combined with an evaluation under DC's 6100, 6200, 6204, or other diagnostic code except when tinnitus supports an evaluation under one of those diagnostic codes.

We added the word ``nonsuppurative'' to the proposed title of DC 6201, ``chronic nonsuppurative otitis media with effusion (serous otitis media),'' to better distinguish it from DC 6200, ``chronic suppurative otitis media, mastoiditis, or cholesteatoma.'' We also made additional nonsubstantive changes throughout this final rule for the sake of clarity and succinctness.

The Secretary hereby certifies that this regulatory amendment will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. The reason for this certification is that this amendment would not directly affect any small entities. Only VA beneficiaries could be directly affected. Therefore, pursuant to 5 U.S.C. 605 (b), this amendment is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

This regulatory action has been reviewed by the Office of Management and Budget under Executive Order 12866.

The Catalog of Federal Domestic Assistance numbers are 64.104 and 64.109.

List of Subjects in 38 CFR Part 4

Disability benefits, Individuals with disabilities, Pensions, Veterans.

For the reasons set out in the preamble, 38 CFR part 4 is amended as set forth below:

PART 4--SCHEDULE FOR RATING DISABILITIES

1. The authority citation for part 4 continues to read as follows:

Authority: 38 U.S.C. 1155.

Subpart B--Disability Ratings

2. Section 4.85 is revised to read as follows:

Sec. 4.85 Evaluation of hearing impairment.

(a) An examination for hearing impairment for VA purposes must be conducted by a state-licensed audiologist and must include a controlled speech discrimination test (Maryland CNC) and a puretone audiometry test. Examinations will be conducted without the use of hearing aids.

(b) Table VI, ``Numeric Designation of Hearing Impairment Based on Puretone Threshold Average and Speech Discrimination,'' is used to determine a Roman numeral designation (I through XI) for hearing impairment based on a combination of the percent of speech discrimination (horizontal rows) and the puretone threshold average (vertical columns). The Roman numeral designation is located at the point where the percentage of speech discrimination and puretone threshold average intersect.

(c) Table VIa, ``Numeric Designation of Hearing Impairment Based Only on Puretone Threshold Average,'' is used to determine a Roman numeral designation (I through XI) for hearing impairment based only on the puretone threshold average. Table VIa will be used when the examiner certifies that use of the speech discrimination test is not appropriate because of language difficulties, inconsistent speech discrimination scores, etc., or when indicated under the provisions of Sec. 4.86.

(d) ``Puretone threshold average,'' as used in Tables VI and VIa, is the sum of the puretone thresholds at 1000, 2000, 3000 and 4000 Hertz, divided by four. This average is used in all cases (including those in Sec. 4.86) to determine the Roman numeral designation for hearing impairment from Table VI or VIa.

(e) Table VII, ``Percentage Evaluations for Hearing Impairment,'' is used to determine the percentage evaluation by combining the Roman numeral designations for hearing impairment of each ear. The horizontal rows represent the ear having the better hearing and the vertical columns the ear having the poorer hearing. The percentage evaluation is located at the point where the row and column intersect.

(f) If impaired hearing is service-connected in only one ear, in order to determine the percentage evaluation from Table VII, the non-service-connected ear will be assigned a Roman Numeral designation for hearing impairment of I, subject to the provisions of Sec. 3.383 of this chapter.

(g) When evaluating any claim for impaired hearing, refer to Sec. 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation due either to deafness, or to deafness in combination with other specified disabilities.

(h) Numeric tables VI, VIA*, and VII.

3. Section 4.86 is revised to read as follows:

Sec. 4.86 Exceptional patterns of hearing impairment.

(a) When the puretone threshold at each of the four specified frequencies (1000, 2000, 3000, and 4000 Hertz) is 55 decibels or more,

the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. Each ear will be evaluated separately.

(b) When the puretone threshold is 30 decibels or less at 1000 Hertz, and 70 decibels or more at 2000 Hertz, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. That numeral will then be elevated to the next higher Roman numeral. Each ear will be evaluated separately.

(Authority: 38 U.S.C. 1155)

Sec. 4.86a [Removed]

4. Section 4.86a is removed.

5. Section 4.87 is revised to read as follows:

Sec. 4.87 Schedule of ratings--ear.

	Rating
DISEASES OF THE EAR	
6200 Chronic suppurative otitis media, mastoiditis, or cholesteatoma (or any combination):	
During suppuration, or with aural polyps.....	10
Note: Evaluate hearing impairment, and complications such as labyrinthitis, tinnitus, facial nerve paralysis, or bone loss of skull, separately.	
6201 Chronic nonsuppurative otitis media with effusion (serous otitis media):	
Rate hearing impairment	
6202 Otosclerosis:	
Rate hearing impairment	
6204 Peripheral vestibular disorders:	
Dizziness and occasional staggering.....	30
Occasional dizziness.....……	10
Note: Objective findings supporting the diagnosis of vestibular disequilibrium are required before a compensable evaluation can be assigned under this code. Hearing impairment or suppuration shall be separately rated and combined.	
6205 Meniere's syndrome (endolymphatic hydrops):	
Hearing impairment with attacks of vertigo and cerebellar gait occurring more than once weekly, with or without tinnitus.....	100
Hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus.....	60
Hearing impairment with vertigo less than once a month, with or without tinnitus.....	30

Note: Evaluate Meniere's syndrome either under these criteria or by separately evaluating vertigo (as a peripheral vestibular disorder), hearing impairment, and tinnitus, whichever method results in a higher overall evaluation. But do not combine an evaluation for hearing impairment, tinnitus, or vertigo with an evaluation under diagnostic code 6205.

6207 Loss of auricle:
Complete loss of both..... 50
Complete loss of one..... 30
Deformity of one, with loss of one-third or more of the substance.....……..... 10

6208 Malignant neoplasm of the ear (other than skin only)..... 100

Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation treatment, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based on that or any subsequent examination shall be subject to the provisions of Sec. 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.

6209 Benign neoplasms of the ear (other than skin only):
Rate on impairment of function.

6210 Chronic otitis externa:
Swelling, dry and scaly or serous discharge, and itching requiring frequent and prolonged treatment..... 10

6211 Tympanic membrane, perforation of..... 0

6260 Tinnitus, recurrent..... 10

Note: A separate evaluation for tinnitus may be combined with an evaluation under diagnostic codes 6100, 6200, 6204, or other diagnostic code, except when tinnitus supports an evaluation under one of those diagnostic codes.

(Authority: 38 U.S.C. 1155)

6. Section 4.87a is revised to read as follows:

Sec. 4.87a Schedule of ratings--other sense organs.

_____Rating

6275 Sense of smell, complete loss..... 10

6276 Sense of taste, complete loss..... 10

Note: Evaluation will be assigned under diagnostic codes 6275 or 6276 only if there is an anatomical or pathological basis

for the condition.

(Authority: 38 U.S.C. 1155)

Sec. 4.87b [Removed]

7. Section 4.87b is removed.

TABLE VI
NUMERIC DESIGNATION OF HEARING IMPAIRMENT BASED ON PURETONE THRESHOLD AVERAGE AND SPEECH DISCRIMINATION

	Puretone Threshold Average								
% of discrim-ination	0-41	42-49	50-57	58-65	66-73	74-81	82-89	90-97	98+
92-100	I	I	I	II	II	II	III	III	IV
84-90	II	II	II	III	III	III	IV	IV	IV
76-82	III	III	IV	IV	IV	V	V	V	V
68-74	IV	IV	V	V	VI	VI	VII	VII	VII
60-66	V	V	VI	VI	VII	VII	VIII	VIII	VIII
52-58	VI	VI	VII	VII	VIII	VIII	VIII	VIII	IX
44-50	VII	VII	VIII	VIII	VIII	IX	IX	IX	X
36-42	VIII	VIII	VIII	IX	IX	IX	X	X	X
0-34	IX	X	XI	XI	XI	XI	XI	XI	XI

TABLE VIA*
NUMERIC DESIGNATION OF HEARING IMPAIRMENT BASED ONLY ON PURETONE THRESHOLD AVERAGE

Puretone Threshold Average										
0-41	42-48	49-55	56-62	63-69	70-76	77-83	84-90	91-97	98-104	105+
I	II	III	IV	V	VI	VII	VIII	IX	X	XI

* This table is for use only as specified in §§ 4.85 and 4.86.

TABLE VII
PERCENTAGE EVALUATION FOR HEARING IMPAIRMENT
(DIAGNOSTIC CODE 6100)

	Poorer Ear										
XI	100*										
X	90	80									
IX	80	70	60								
VIII	70	60	50	50							
VII	60	60	50	40	40						
VI	50	50	40	40	30	30					
V	40	40	40	30	30	20	20				
IV	30	30	30	20	20	20	10	10			
III	20	20	20	20	20	10	10	10	0		
II	10	10	10	10	10	10	10	0	0	0	
I	10	10	0	0	0	0	0	0	0	0	0
	XI	X	IX	VIII	VII	VI	V	IV	III	II	I

* Review for entitlement to special monthly compensation under §3.350 of this chapter.

REGULATORY AMENDMENT
3-99-2

Regulations Affected: 38 C.F.R. §3.381 and §3.382; 38 C.F.R. §4.149

Effective Date of the Regulation: June 8, 1999

Date Secretary Approved Regulation: April 21, 1999

Federal Register Citation: 64 FR 30392-93 (June 8, 1999)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

38 CFR Part 4, the Schedule for Rating Disabilities, provides evaluations for dental conditions considered disabling in nature. There are, however, other dental conditions which are not considered disabling and consequently do not fall under the purview of the rating schedule. The issue of service connection for these conditions arises only for the purpose of determining eligibility to outpatient dental treatment. These conditions include carious teeth, replaceable missing teeth, dental or alveolar abscesses, periodontal disease, and Vincent's stomatitis (also referred to as Vincent's disease, Vincent's infection, or acute necrotizing gingivitis). These conditions were listed in the former 38 CFR §4.149, in the Schedule for Rating Disabilities. Because these conditions are not evaluated for compensation, but only to determine eligibility for treatment, it is more appropriate to list them in 38 CFR Part 3, which contains general rules for determining service connection. Therefore, §4.149 has been deleted.

Prior to the current revision, §3.381 provided that service connection will be granted for certain dental conditions shown after a "reasonable period of service"; however, this subjective term was not defined. The new rule replaces this subjective term with the objective requirement of 180 days or more of active service in decisions pertaining to service connection for dental conditions that develop over a period of time. Such conditions include dental caries, periodontal disease, and disease of pathology of third molars or teeth in which an existing filling requires replacement. Because these conditions take time to develop, (often a year or two in permanent teeth), it is more likely than not that caries or pathology that become apparent within the first 180 days of service pre-existed that service.

The new rule also eliminates overlapping provisions in 38 CFR §§ 3.381 and 3.382 which did not clearly state requirements for service connection or which appeared to be possibly conflicting. Section 3.381(d) now includes specific rules for determining whether dental conditions that are noted at entry into service and treated during active duty are service connected for treatment purposes. These provisions provide concrete guidelines for decisions related to tooth extractions and restorations, as well as for missing teeth.

Former §3.381(c) which addressed the principle of secondary service connection for dental diseases and injuries was deleted because it was superfluous given the provisions governing secondary service connection already contained in §3.310. Likewise, paragraphs (a) and (b) of §3.382 were deleted because its statements related to the types of evidence needed to establish service connection were redundant of provisions contained elsewhere in the regulations which adequately describe evidence requirements for establishing service connection. (*See* 38 CFR §3.303, §3.304)

Former §3.381(d) specifically stated that the presumption of soundness does not apply to non-compensable dental conditions. While no longer explicitly stated in the revised regulation, the presumption of soundness is clearly inapplicable based on 38 U.S.C. §1110 and §1111. Section 1111 requires VA to consider every veteran
to have been in sound condition at the time of entry except as to defects noted at that time. It specifically references §1110 of Title 38 which applies only to payment of compensation for disability. Section 1111 is therefore not applicable to determining eligibility to outpatient dental treatment under 38 U.S.C. §1712. In addition, §1153 of Title 38 U.S.C. applies only to disabilities. Because non-compensable dental conditions are not considered to be disabilities, §1153 is also not applicable to 38 U.S.C. §1712 determinations.

The revised rule retains the general principle contained in former §3.381(b) which stated that treatment during service is not considered *per se* aggravation of a dental condition noted as present at the time of entry because such treatment is considered ameliorative. However, the phrase "*per se"* has been deleted and is replaced with a statement that treatment in service is not evidence that a condition noted at entry has been aggravated unless additional pathology developed after 180 days or more of service. This is consistent with the change reflected in §3.381(d) requiring 180 days of active duty service as a prerequisite to considering specified dental conditions as service connected for purposes of treatment.

Paragraph 3.381(e) lists conditions that will not be service connected for treatment purposes, replacing former §3.382(c). Current medical terminology has been used to describe these conditions with "calculus" replacing "salivary deposits," and "periodontal disease" replacing "gingivitis," "Vincent's disease," and "pyorrhea." Impacted or malposed teeth are considered developmental defects as is the presence of third molars (wisdom teeth). These conditions are not service connected unless separate pathology develops after 180 days of active service. The use of the 180-day time period has been explained above. Periodontal disease is related to dental hygiene and can be affected by other factors such as diet, abnormal stress, other disease processes, and reaction to certain drugs or chemicals. With proper treatment, most periodontal disease resolves with no residuals. Therefore, service connection for acute periodontal disease is not subject to service condition in the former rule and remains not subject to service connection in the present rule. However, chronic periodontal disease (formerly described as "Pyorrhea"), which may result in tooth extraction, will warrant service connection for the lost teeth.

For the reasons set forth in the preamble, 38 CFR Part 3 is amended as follows:

1. The Authority citation for part 3 continues to read as follows:

AUTHORITY: 38 U.S. C. 501 (a), unless otherwise noted.

2. Section 3.381 is amended by revising the heading and text to read as follows:

§ 3.381 Service connection of dental conditions for treatment purposes.

(a) Treatable carious teeth, replaceable missing teeth, dental or alveolar abscesses, and periodontal disease will be considered service-connected solely for the purpose of establishing eligibility for
outpatient dental treatment as provided in section 17.161 of this chapter.

(b) The rating activity will consider each defective or missing tooth and each disease of the teeth and periodontal tissues separately to determine whether the condition was incurred or aggravated in line of duty during active service. When applicable, the rating activity will determine whether the condition is due to combat or other in-service trauma, or whether the veteran was interned as a prisoner of war.

(c) In determining service connection, the condition of teeth and periodontal tissues at the time of entry into active duty will be considered. Treatment during service, including filling or extraction of a tooth, or placement
of a prosthesis, will not be considered evidence of aggravation of a condition that was noted at entry, unless additional pathology developed after 180 days or more of active service.

(d) The following principles apply to dental conditions noted at entry and treated during service:

(1) Teeth noted as normal at entry will be service-connected if they were filled or extracted after 180 days or more of active service.

(2) Teeth noted as filled at entry will be service-connected if they were extracted, or if the existing filling was replaced, after 180 days or more of active service.

(3) Teeth noted as carious but restorable at entry will not be service connected on the basis that they were filled during service. However, new caries that developed 180 days or more after such a tooth was filled will be service-connected.

(4) Teeth noted as carious but restorable at entry, whether or not filled, will be service-connected if extraction was required after 1 80 days or more of active service.

(5) Teeth noted at entry as non-restorable will not be service-connected, regardless of treatment during service.

(6) Teeth noted as missing at entry will not be service connected, regardless of treatment during service.

(e) The following will not be considered service-connected for treatment purposes:

(1) calculus;

(2) acute periodontal disease;

(3) third molars, unless disease or pathology of the tooth developed after 180 days or more of active service, or was due to combat or in-service trauma;

(4) impacted or malposed teeth, and other developmental defects, unless disease or pathology of these teeth developed after 180 days or more of active service.

(f) Chronic periodontal disease. Teeth extracted because of chronic periodontal disease will be service-connected only if they were extracted after 180 days or more of active service.

(Authority: 38 U.S.C. 1712)

§ 3.382 Evidence to establish service connection for dental disabilities. [Removed]

3. Section 3.382 is removed and reserved.

PART 4 SCHEDULE FOR RATING DISABILITIES

Dental and Oral Conditions

4. The Authority citation for part 4 continues to read as follows:

AUTHORITY: 38 U.S.C. 11 55.

§ 4.149 Rating diseases of the teeth and gums. [Removed]

5. Section 4.149 is removed and reserved.

REGULATORY AMENDMENT
4-99-2

Regulation affected: 38 CFR 4.71a.

Effective Date of Regulation: June 17, 1999

Date Secretary approved regulation: March 24, 1999

Federal Register Citation: 64 FR 32410 (June 17, 1999)

In the Federal Register of May 7, 1996 (61 FR 20438), we published an interim final rule adding a new diagnostic code, 5025, and evaluation criteria for fibromyalgia to § 4.71a of 38 CFR part 4, the rating schedule. This final rule responds to comments received in response to the interim final rule and adopts the interim final rule without change. The Federal Register document follows.
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DEPARTMENT OF VETERANS AFFAIRS
38 CFR Part 4

RIN 2900-AH05

Schedule for Rating Disabilities; Fibromyalgia

AGENCY: Department of Veterans Affairs

ACTION: Final rule

SUMMARY: This document adopts as a final rule without change an interim final rule adding a diagnostic code and evaluation criteria for fibromyalgia to the Department of Veterans Affairs' (VA's) Schedule for Rating Disabilities. The intended effect of this rule is to insure that veterans diagnosed with this condition meet uniform criteria and receive consistent evaluations.

DATES: Effective Date: This final rule is effective June 17, 1999. The interim rule adopted as final by this document was effective May 7, 1996.

FOR FURTHER INFORMATION CONTACT: Caroll McBrine, M.D., Consultant, Policy and Regulations Staff (211B), Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420, (202) 273-7230.

SUPPLEMENTARY INFORMATION: On May 7, 1996, VA published in the Federal Register an interim final rule with request for comments (61 FR 20438). The rule added a diagnostic code, 5025, and evaluation criteria for fibromyalgia to the section of the VA Schedule for Rating Disabilities (38 CFR part 4) that addresses the musculoskeletal system (38 CFR 4.71a). A 60-day comment period ended July 8, 1996, and we received three comments, one from two physicians in the Department of Medicine at The Oregon Health Sciences University, and two from VA employees.

The evaluation criteria for fibromyalgia under diagnostic code 5025 have one requisite that applies to all levels: ``[w]ith widespread musculoskeletal pain and tender points, with or without associated fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud's-like symptoms.'' The 40-, 20-, and 10-percent evaluation levels are additionally based on whether these findings are constant, or nearly so, and refractory to therapy; are episodic, but present more than one-third of the time; or require continuous medication for control. One commenter felt that the use of the phrase ``with or without'' as used in diagnostic code 5025 is confusing and might be interpreted as rendering the symptoms that follow the phrase as superfluous and unnecessary in the evaluation of fibromyalgia.

Some individuals with fibromyalgia have only pain and tender points; others have pain and tender points plus stiffness; still others have pain and tender points plus stiffness and sleep disturbance; etc. As a shorter way of stating this, we have used the phrase ``with or without,'' followed by a list of symptoms, to indicate that any or all of these symptoms may be part of fibromyalgia, but none of them is necessarily present in a particular case. When symptoms in addition to pain and tenderness are present, they may be used as part of the assessment of whether fibromyalgia symptoms are episodic or constant. When none of the symptoms on the list is present, the determination of whether the condition is episodic or constant must be based solely on musculoskeletal pain and tender points. The term ``with or without'' is also used in Sec. 4.116 (Schedule of ratings--gynecological conditions and disorders of the breast) of the rating schedule under diagnostic code 7619, ``Ovary, removal of,'' where the criterion for a zero-percent evaluation is ``removal of one with or without partial removal of the other.'' We believe that in both cases the phrase ``with or without,'' rather than adding confusion, better defines the potential scope of the condition under evaluation. We therefore make no change based on this comment.

The same commenter questioned whether the intent is to place a ceiling of 40 percent on the evaluation of fibromyalgia despite the presence of one or more of the symptoms following the phrase ``with or without.''
As the evaluation criteria indicate, there may be multi-system complaints in fibromyalgia. If signs and symptoms due to fibromyalgia are present that are not sufficient to warrant the diagnosis of a separate condition, they are evaluated together with the musculoskeletal pain and tender points under the criteria in diagnostic code 5025 to determine the overall evaluation. The maximum schedular evaluation for fibromyalgia in such cases is 40 percent. If, however, a separate disability is diagnosed, e.g., dysthymic disorder, that is determined to be secondary to fibromyalgia, the secondary condition can be separately evaluated (see 38 CFR 3.310(a)), as long as the same signs and symptoms are not used to evaluate both the primary and the secondary condition (see 38 CFR 4.14 (Avoidance of pyramiding)). In such cases, fibromyalgia and its complications may warrant a combined evaluation greater than 40 percent. Since these rules are for general application, they need not be specifically referred to under diagnostic code 5025.

Another commenter referred to a statement in the supplementary information to the interim final rule that indicated that fibromyalgia is a benign disease that does not result in loss of musculoskeletal function. The commenter said that while it is not a malignant disease which leads to anatomic crippling, the result of persistent chronic pain is often musculoskeletal dysfunction.

The statement regarding the lack of loss of musculoskeletal function is supported by medical texts which state, for example, that objective musculoskeletal function is not impaired in fibromyalgia (``The Manual of Rheumatology and Outpatient Orthopedic Disorders'' 349 (Stephen Padgett, Paul Pellicci, John F. Beary, III, eds., 3rd ed. 1993)); that the syndrome is not accompanied by abnormalities that are visible, palpable, or measurable in any traditional sense; and that the patient must recognize the physical benignity of the problem (``Clinical Rheumatology'' 315 (Gene V. Ball, M.D. and William J. Koopman, M.D., 1986)). These medical texts confirm that fibromyalgia does not result in objective musculoskeletal pathology. The criteria we have established to evaluate disability due to fibromyalgia are therefore based on the symptoms of[[Page 32411]]fibromyalgia rather than on objective loss of musculoskeletal function.

The same commenter said that more could have been said about the wide clinical spectrum of fibromyalgia and the associated stress response which may lead to clinical problems of psychopathology, inappropriate behavior, deconditioning, hormonal imbalance, and sleep disorder.

The evaluation criteria do include a broad spectrum of possible symptoms, and sleep disturbance is one of them. As discussed above, any disability, including a mental disorder, that is medically determined to be secondary to fibromyalgia, can be separately evaluated. The rating schedule is, however, a guide to the evaluation of disability for compensation, not treatment (see 38 CFR 4.1), and it is unnecessary for that purpose to include a broad discussion of the clinical aspects of fibromyalgia. We therefore make no change based on this comment.

The same commenter said that it is important to stress that fibromyalgia may co-exist with other rheumatic disorders and have an additive effect on disability. If two conditions affecting similar

functions or anatomic areas are present, and one is service-connected and one is not (a situation that is not unique to rheumatic disorders), the effects of each are separately evaluated, if feasible.

When it is not possible to separate the effects of the conditions, VA regulations at 38 CFR 3.102, which require that reasonable doubt on any issue be resolved in the claimant's favor, dictate that the effects be attributed to the service-connected condition. Since there is an established method of evaluating co-existing conditions, there is no need to stress the point that other diseases may co-exist with fibromyalgia, resulting in additive effects, and we make no change based on this comment.

The commenter also stated that the correct diagnosis of fibromyalgia and the exclusion of other rheumatic conditions are of paramount importance in ensuring a successful treatment program.

The diagnosis of fibromyalgia and exclusion of other rheumatic disorders are functions of the examiner and outside the scope of the rating schedule, which, as noted earlier, is a guide for the evaluation of disability for purposes of compensation, not treatment. We therefore make no change based on this comment.

One commenter stated that claimants with fibromyalgia will present with limitation of motion of various joints of the body, and the rating agency will have to take into consideration pain on movement and functional loss due to pain (see 38 CFR 4.40 and 4.45). The commenter felt that the proposed scheme invites separate ratings for limitation of motion of each joint.

Fibromyalgia is a ``nonarticular'' rheumatic disease (``The Merck Manual'' (1369, 16th ed. 1992)), and objective impairment of musculoskeletal function, including limitation of motion of the joints, is not present, in contrast to the usual findings in ``articular'' rheumatic diseases. Joint examinations in fibromyalgia are necessary only to exclude other rheumatic diseases because physical signs other than tender points at specific locations are lacking. The pain of fibromyalgia is not joint pain, but a deep aching, or sometimes burning pain, primarily in muscles, but sometimes in fascia, ligaments, areas of tendon insertions, and other areas of connective tissue (Ball and Koopman, 315). The evaluation criteria require that the pain be widespread, and that the symptoms be assessed based on whether they are constant or episodic, or require continuous medication, but they are not based on evaluations of individual joints or other specific parts of the musculoskeletal system. We believe the evaluation criteria make clear the basis of evaluation, and we therefore make no change based on this comment.

Based on the rationale set forth in the interim final rule document and this document, we are adopting the provisions of the interim final rule as a final rule without change. We also affirm the information in the interim final rule document concerning the Regulatory Flexibility Act.

List of Subjects in 38 CFR Part 4

Disability benefits, Individuals with disabilities, Pensions, Veterans.

Accordingly, the interim final rule amending 38 CFR part 4 which was published at 61 FR 20438 on May 7, 1996, is adopted as a final rule without change.

Approved: March 24, 1999.

Togo D. West, Jr.,
Secretary of Veterans Affairs.

REGULATORY AMENDMENT
4-01-1

Regulation affected: 38 CFR 4.112 and 4.114

Effective Date of Regulation: July 2, 2001

Date Secretary approved regulation: March 5, 2001

Federal Register Citation: 66 FR 29486-89

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

This document amends 38 CFR 4.112 and certain diagnostic codes in 38 CFR 4.114, in order to address hepatitis C and its sequelae, and to update evaluation criteria for other liver disabilities.

We have made the information in § 4.112 more specific by stating that the term "substantial weight loss," for purposes of evaluating conditions in § 4.114, means a loss of greater than 20 percent of the individual's baseline weight, sustained for three months or longer; that the term "minor weight loss" means a loss of 10 to 20 percent of the individual's baseline weight, sustained for three months or longer; and that the term “inability to gain weight” means “substantial” (rather than the current term “significant”) weight loss with inability to regain it despite appropriate therapy. We have also defined "baseline weight" as the average weight for the two-year-period preceding onset of the disease.

We revised the evaluation criteria for Injury of the liver (diagnostic code 7311) to have them include not only adhesions of peritoneum (diagnostic code 7301), but also cirrhosis of liver (diagnostic code 7312) or chronic liver disease without cirrhosis (diagnostic code 7345) as options for evaluation.

We broadened the scope of diagnostic code 7312 so that the criteria apply not only to cirrhosis of the liver but also to primary biliary cirrhosis and the cirrhotic phase of sclerosing cholangitis, two conditions that are not in the current rating schedule but that have disabling effects similar to cirrhosis. We deleted the subjective and outdated terms in the evaluation criteria for diagnostic code 7312, but retained the same evaluation levels, except for adding a 10-percent level to provide an appropriate evaluation level for individuals who have symptoms due to cirrhosis but do not meet the criteria for a 30-percent evaluation, as might occur in the early stages of the disease. We have provided evaluation criteria that are similar to those formerly in the schedule, but updated. They include the presence or history of ascites, hemorrhage from varices or portal gastropathy, hepatic encephalopathy, portal hypertension, splenomegaly, jaundice, and substantial weight loss, as well as symptoms of generalized weakness, anorexia, abdominal pain, and malaise. We have also added a add a note stating that evaluation under this diagnostic code requires documentation of cirrhosis (by biopsy or imaging) and abnormal liver function tests.

We deleted diagnostic code 7313 because abscesses of the liver now ordinarily resolve without residual disability.

We updated the titles of diagnostics 7343 and 7344 and made changes in the evaluation of malignant neoplasms similar to those we have made in other sections of the rating schedule.

We changed the title of diagnostic code 7345, formerly infectious hepatitis, to chronic liver disease without cirrhosis (including hepatitis B, chronic active hepatitis, autoimmune hepatitis, hemochromatosis, drug induced hepatitis, etc., but excluding bile duct disorders and hepatitis C). This code will now encompass many chronic liver diseases that were not named in the former schedule, most importantly hepatitis B, and will exclude hepatitis A (formerly called infectious hepatitis), which is an acute disease that heals without long-term residuals. We added new diagnostic code 7354 for hepatitis C (or non-A, non-B hepatitis), a disease of rising importance in veterans.

We provided the same evaluation criteria for diagnostic codes 7345 and 7354. The evaluation of both is based either on the signs and symptoms of chronic liver disease, such as fatigue, malaise, and anorexia, or on the total duration of incapacitating episodes (defined as a period of acute signs and symptoms severe enough to require bed rest and treatment by a physician). We changed the evaluation levels under 7345 from 100, 60, 30, 10, and zero percent to

100, 60, 40, 20, 10, and zero percent. This change was made in order to maintain internal consistency in the rating schedule, because they correspond to the levels that we proposed for the evaluation of intervertebral disc syndrome, another condition for which we proposed to use the total duration of periods of incapacitation as an alternative means of evaluation. Because chronic liver disease may in some cases be nonsymptomatic even when not healed, and would still not be disabling and therefore warrant no more than a zero-percent evaluation, we changed the evaluation criteria for the zero-percent level from "healed, nonsymptomatic" to "nonsymptomatic". This will assure that all nonsymptomatic veterans who have serologic evidence of having had a hepatitis B or C virus will be service-connected at 0% in order to assure appropriate handling of later-developing sequelae of hepatitis B and C. We removed ”depression” and “anxiety” as criteria under diagnostic code 7345 because they are not prominent symptoms of chronic liver disease, and, if a mental disorder is medically determined to be secondary to liver disease, it would be separately evaluated under the mental disorders portion of the rating schedule. We added a note under diagnostic codes 7345 and 7354 directing that sequelae of these conditions, such as cirrhosis or malignancy of the liver, be evaluated under an appropriate diagnostic code, as long as the same signs and symptoms are not used as the basis for evaluation under both 7345 or 7354 and under another diagnostic code. We added another note under 7345 to indicate that the diagnosis of hepatitis B infection must be confirmed by serologic testing. The hepatitis C criteria indicate that it too requires serologic evidence of infection.

We added new diagnostic code 7351 for liver transplants, which requires a 100-percent evaluation for an indefinite period from the date of hospital admission for transplant surgery, with a mandatory VA examination one year following hospital discharge. We also provided a minimum evaluation of 30 percent following transplant, because of the need for long-term immunosuppressive medication and its associated problems.

Diagnostic codes revised	Diagnostic codes removed	Diagnostic codes added
7311	7313	7354
7312		7351
7343		
7344		
7345		

PART 4--SCHEDULE FOR RATING DISABILITIES

1. The authority citation for part 4 continues to read as follows: Authority: 38 U.S.C. 1155, unless otherwise noted.

2. Section 4.112 is revised to read as follows:

Sec. 4.112 Weight Loss.

For purposes of evaluating conditions in Sec. 4.114, the term ``substantial weight loss" means a loss of greater than 20 percent of the individual's baseline weight, sustained for three months or longer; and the term ``minor weight loss" means a weight loss of 10 to 20 percent of the individual's baseline weight, sustained for three months or longer. The term ``inability to gain weight" means that there has been substantial weight loss with inability to regain it despite appropriate therapy. ``Baseline weight" means the average weight for the two-year-period preceding onset of the disease. (Authority: 38 U.S.C. 1155)

3. Section 4.114 is amended by:

   A. Revising diagnostic codes 7311, 7312, 7343, 7344, and 7345.

   B. Removing diagnostic code 7313.

   C. Adding diagnostic codes 7351 and 7354.

   D. Adding a new authority citation at the end of the section.

The revisions and additions read as follows:

Sec. 4.114 Schedule of ratings-digestive system.

* * * *

---------- Rating

7311 Residuals of injury of the liver:

Depending on the specific residuals, separately evaluate as adhesions of peritoneum (diagnostic code 7301), cirrhosis of liver (diagnostic code 7312), and chronic liver disease without cirrhosis (diagnostic code 7345).

7312 Cirrhosis of the liver, primary biliary cirrhosis, or cirrhotic phase of sclerosing cholangitis:

Generalized weakness, substantial weight loss, and persistent jaundice, or; with one of the following refractory to treatment: ascites, hepatic encephalopathy, hemorrhage from varices or portal gastropathy (erosive gastritis)..... 100

History of two or more episodes of ascites, hepatic encephalopathy, or hemorrhage from varices or portal gastropathy (erosive gastritis), but with periods of remission between attacks . ….… 70

History of one episode of ascites, hepatic encephalopathy, or hemorrhage from varices or portal gastropathy (erosive gastritis)..... 50

Portal hypertension and splenomegaly, with weakness, anorexia, abdominal pain, malaise, and at least minor weight loss..... 30

Symptoms such as weakness, anorexia, abdominal pain, and malaise ……. 10

Note: For evaluation under diagnostic code 7312, documentation of cirrhosis (by biopsy or imaging) and abnormal liver function tests must be present.

* * * * *

7343 Malignant neoplasms of the digestive system, exclusive of skin growths.....
……..... 100

Note: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of Sec. 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.

7344 Benign neoplasms, exclusive of skin growths:

Evaluate under an appropriate diagnostic code, depending on the predominant disability or the specific residuals after treatment

7345 Chronic liver disease without cirrhosis (including hepatitis B, chronic active hepatitis, autoimmune hepatitis, hemochromatosis, drug-induced hepatitis, etc., but excluding bile duct disorders and hepatitis C):

Near-constant debilitating symptoms (such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain)..... 100

Daily fatigue, malaise, and anorexia, with substantial weight loss (or other indication of malnutrition), and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least six weeks during the past 12- month period, but not occurring constantly ……..… 60

Daily fatigue, malaise, and anorexia, with minor weight loss and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least four weeks, but less than six weeks, during the past 12-month period……..…… 40

Daily fatigue, malaise, and anorexia (without weight loss or hepatomegaly), requiring dietary restriction or continuous medication, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a

total duration of at least two weeks, but less than four weeks, during the past 12-month period..... 20
Intermittent fatigue, malaise, and anorexia, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least one week, but less than two weeks, during the past 12-month period..... 10
Nonsymptomatic..... 0

Note (1): Evaluate sequelae, such as cirrhosis or malignancy of the liver, under an appropriate diagnostic code, but do not use the same signs and symptoms as the basis for evaluation under DC 7354 and under a diagnostic code for sequelae. (See Sec. 4.14.).

Note (2): For purposes of evaluating conditions under diagnostic code 7345, ``incapacitating episode'' means a period of acute signs and symptoms severe enough to require bed rest and treatment by a physician.

Note (3): Hepatitis B infection must be confirmed by serologic testing in order to evaluate it under diagnostic code 7345.

* * * * *

7351 Liver transplant:
For an indefinite period from the date of hospital admission for transplant surgery..... 100
Minimum..... 30

Note: A rating of 100 percent shall be assigned as of the date of hospital admission for transplant surgery and shall continue. One year following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of Sec. 3.105(e) of this chapter.

7354 Hepatitis C (or non-A, non-B hepatitis):
With serologic evidence of hepatitis C infection and the following signs and symptoms due to hepatitis C infection:
Near-constant debilitating symptoms (such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain)..... 100
Daily fatigue, malaise, and anorexia, with substantial weight loss (or other indication of malnutrition), and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least six weeks during the past 12- month period, but not occurring constantly 60
Daily fatigue, malaise, and anorexia, with minor weight loss and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least four weeks, but less than six weeks, during the past 12-month period..... 40
Daily fatigue, malaise, and anorexia (without weight loss or hepatomegaly), requiring dietary restriction or continuous medication, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least two weeks, but less than four weeks, during the past 12-month period..... 20
Intermittent fatigue, malaise, and anorexia, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least one week, but less than two weeks, during the past 12-month period..... 10
Nonsymptomatic..... 0

Note (1): Evaluate sequelae, such as cirrhosis or malignancy of the liver, under an appropriate diagnostic code, but do not use the same signs and symptoms as the basis for evaluation under DC 7354 and under a diagnostic code for sequelae. (See Sec. 4.14.).

Note (2): For purposes of evaluating conditions under diagnostic code 7354, ``incapacitating episode'' means a period of acute signs and symptoms severe enough to require bed rest and treatment by a physician.

(Authority: 38 U.S.C. 1155)