

PART 117—DRAWBRIDGE OPERATING REGULATIONS

1. The authority citation for part 117 continues to read as follows.

Authority: 33 U.S.C. 499; 49 CFR 1.46; 33 CFR 1.05-1(g); section 117.255 also issued under the authority of Pub. L. 102-587, 106 Stat. 5039.

2. Section 117.773 is revised to read as follows:

§ 117.773 Buffalo River.

(a) The draw of the Michigan Avenue bridge, mile 1.3, at Buffalo, shall operate as follows:

(1) From March 22 through December 15, the draw shall open within 20 minutes of signal. However, the draw need not open from 7:30 a.m. to 9 a.m., and from 4 p.m. to 5:45 p.m., Monday through Saturday.

(2) From December 16 through March 21, the draw shall open on signal if notice is given at least 4 hours in advance of a vessel's time of intended passage through the draw.

(b) The draw of the Ohio Street bridge, mile 2.1, at Buffalo, shall operate as follows:

(1) From March 22 through December 15, the draw shall open on signal within 20 minutes after a request is made to the Michigan Avenue drawtender. However, the draw need not open from 7:30 a.m. to 9 a.m., and from 4 p.m. to 5:45 p.m., Monday through Saturday.

(2) From December 16 through March 21, the draw shall open on signal if notice is given at least 4 hours in advance of a vessel's time of intended passage through the draw.

(c) The draws of the Conrail railroad bridges, miles 4.02 and 4.39, both at Buffalo, shall open on signal if notice is given at least 4 hours in advance of a vessel's time of intended passage through the draws.

(d) The South Park Avenue, miles 5.3, at Buffalo, shall open on signal if notice is given at least 4 hours in advance of a vessel's time of intended passage through the draw. However, the draw need not open from 7 a.m. to 8:30 p.m. and from 4:30 p.m. to 6 p.m., Monday through Saturday.

(e) The periods when the bridges need not open on signal prescribed in (a)(1), (b)(1), and (d) in this section shall not be effective on Sundays, and on New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, Christmas Day, or days observed in lieu of any of these under State law.

(f) Marine radiotelephones shall be maintained at the Michigan Avenue and Ohio Street bridges. The City of Buffalo shall maintain and monitor a marine radiotelephone for use by the Michigan

Avenue drawtender while enroute between the Michigan Avenue and Ohio Street bridges. The drawtender shall maintain communications with the vessel until the vessel has cleared both the Ohio Street and Michigan Avenue draws.

Dated: October 13, 1995.

Paul J. Pluta,

*Captain, U.S. Coast Guard, Commander,
Ninth Coast Guard District, Acting.*

[FR Doc. 95-26523 Filed 10-25-95; 8:45 am]

BILLING CODE 4910-14-M

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900-AF01

Schedule for Rating Disabilities; Mental Disorders

AGENCY: Department of Veterans Affairs.
ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) is proposing to amend that portion of its Schedule for Rating Disabilities dealing with Mental Disorders. This is part of the first comprehensive review of the rating schedule since 1945. The intended effect of this action is to update the section of the rating schedule on mental disorders to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

DATES: Comments must be received by VA on or before December 26, 1995.

ADDRESSES: Mail written comments to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC 20420 or hand deliver written comments to: Office of Regulations Management, Room 1176, 801 Eye St., NW., Washington, DC 20001. Comments should indicate that they are submitted in response to "RIN 2900-AF01." All written comments received will be available for public inspection in the Office of Regulations Management, Room 1176, 801 Eye St., NW., Washington, DC 20001 between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays).

FOR FURTHER INFORMATION CONTACT: Carol McBrine, M.D., Consultant, Regulations Staff, Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC 20420, (202) 273-7210.

SUPPLEMENTARY INFORMATION: Prior to the start of its comprehensive review of the rating schedule, VA contracted with an outside consulting firm to offer suggestions for changes in the rating schedule to help fulfill the goals of revising and updating the medical criteria. This proposed amendment includes many of their suggestions. Some recommendations, however, addressed areas other than evaluation criteria, such as percentage evaluations and frequency of examinations. Since these suggestions are clearly beyond the scope of the contract and deal with issues which would affect the internal consistency of the entire rating schedule rather than one section, we have generally not adopted them. The comments of the consultants are incorporated into the discussions below. VA published an advance notice of proposed rulemaking in the Federal Register on May 2, 1991 (56 FR 20170) in order to solicit comments and suggestions from interested groups and the general public. In response to this notice, we received comments from several employees of VA and one from The American Legion. All of the commenters recommended a change in the rating criteria for mental disorders, urging more clarity and objectivity, and more extensive and definitive guidelines.

In the current rating schedule, §§ 4.125 through 4.131 and the notes in § 4.132 contain general information about mental disorders and guidelines for their evaluation. The material is organized randomly, however, and we propose to reorganize it so that everything dealing with a single topic is grouped together. We also propose to make a number of editorial changes in the material to make the provisions clearer and less ambiguous and to make the terminology more current. We further propose to remove material which is not regulatory, i.e., which neither prescribes VA policy nor limits the action a rating board may take. Additionally, we propose to incorporate regulatory material from the notes in § 4.132 into §§ 4.125 through 4.129, reorganizing and rewording it, and removing repetitious material. This will assure that all of the regulatory provisions are in one area of the schedule, in orderly groupings, rather than spread throughout.

Much of § 4.125 contains general information stating, for example, that there have been rapid advances in modern psychiatry during and since World War II, which have produced a better understanding of the etiology, psychodynamics, and psychopathological changes which

occur in mental diseases and emotional disturbances, and that the field of mental disorders represents the greatest possible variety of etiology, chronicity, and disabling effects and requires differential consideration in these respects. We propose to remove that material because it neither prescribes VA policy nor establishes procedures a rating board must follow and is, therefore, not appropriate in a regulation.

The only information in § 4.125 which is essential is the statement that psychiatric nomenclature in the rating schedule is based on the third edition of the Diagnostic and Statistical Manual (DSM-III), published by the American Psychiatric Association in 1980, and that rating specialists should familiarize themselves thoroughly with that manual. The contract consultants recommended that we make changes in the mental disorders section to assure that it is consistent with the current DSM Manual, and we propose to update the terminology and categories of mental disorders by basing them on the newest revised edition, DSM-IV, which was published in 1994. The DSM Manuals are used in the United States as the basis for the diagnosis and classification of mental disorders. They are referred to by, and their terminology is incorporated into, psychiatry textbooks. They represent the common language of both VA and non-VA health care providers and researchers and, therefore, provide rating specialists with a standard by which examinations from all sources can be compared and assessed. The use of DSM-IV as the basis for terminology and diagnostic classification of mental disorders for VA purposes is, therefore, unquestionably appropriate. We propose to present this material in a note rather than assigning it an entire section of the CFR.

We propose to change the title of § 4.125 from "General considerations" to "Diagnosis of mental disorders" and to divide it into two paragraphs, the first 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 the second 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 propose to place all material about evaluation of mental disorders in § 4.126 and to change the title from

"Substantiation of diagnosis" to "Evaluation of disability from mental disorders." This material is taken 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. We propose to divide this section into four paragraphs dealing with symptoms and remissions, social impairment, organic mental disorders, and conditions diagnosed both as physical and mental disorders.

Paragraph (a) of § 4.126 establishes 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. It further requires that an evaluation be based on all evidence of record bearing on occupational and social impairment. This material is derived from material currently found at § 4.130, Evaluation of psychiatric disability. We have deleted the statement currently found in § 4.130 that the examiner's analysis of the symptomatology is an "essential." Since we propose to revise the evaluation criteria to rely on specific signs and symptoms rather than on a subjective determination as to whether a disorder results in total, severe, considerable, definite, or mild social and industrial impairment, 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 that the rating specialist assigns. We also propose to delete 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) 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 is based on the current regulatory material in § 4.129 and in note (1) following the general rating formula for psychoneurotic disorders, and represents no substantive change. The contract consultants recommended a greater emphasis on social impairment in rating mental disability, but because our statutory authority to establish the rating schedule, 38 U.S.C. 1155, requires that ratings be based, as far as practicable,

upon the average impairments of earning capacity, we do not propose to adopt that recommendation.

Paragraph (c) directs the rating board to evaluate delirium, dementia, and amnesic and other cognitive mental disorders under the general rating formula for mental disorders and to combine this evaluation with those for neurological or other physical impairments stemming from the same etiology, e.g., a head injury. This represents no substantive change from material currently contained in notes (1) and (2) under DC 9325.

Paragraph (d) 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. This 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, except that we have deleted "major degree of disability" and substituted "dominant (more disabling) aspect of the condition" for clarity.

We propose to change the title of § 4.127 from "Mental deficiency and personality disorders" to "Mental retardation and personality disorders," since the term "mental deficiency" is obsolete and no longer in common use. This is not a substantive change.

We propose that § 4.127 state that although mental retardation and personality disorders will not be considered as disabilities under the terms of the schedule, a mental disorder that is superimposed upon, but clearly separate from, the mental retardation or personality disorder may be a disability for VA compensation purposes. This represents a revision of the language in the current § 4.127 for the sake of clarity but does not represent a substantive change.

Although the contract consultants suggested that we add a category for psychoactive substance abuse disorders, we have not done so because substance-related disorders are addressed elsewhere in regulations (38 CFR 3.1 (m) and 3.301).

We propose to change the title of § 4.128 from "Change of diagnosis" to "Convalescence ratings following extended hospitalization," and to include in it material from a note under DC 9210 regarding the need to continue a total evaluation following a period of hospitalization lasting six months or more and to schedule a mandatory examination six months after the

veteran is discharged or released to nonbed care. We propose to add 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), which require a 60-day notice before VA can reduce an evaluation and an additional 60-day notice before the reduced evaluation takes effect. While the fact that an individual is no longer hospitalized usually means there has been some improvement, stabilization and return to usual activities in the face of a severe mental disorder is often difficult to achieve. Making changes subject to § 3.105(e) will preclude changes in evaluation unless a stable level of improvement has occurred, and will help to prevent a cycle of changes in evaluations followed by further examinations, further changes in evaluations, etc.

We propose to move the regulatory material on social impairment from § 4.129 to § 4.126, paragraph (b), as discussed above, and to change the title of § 4.129 from "Social inadaptability" to "Mental disorders due to psychic trauma." We propose to include in the revised § 4.129 the regulatory material from § 4.131, which requires 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.

As discussed above, we propose to delete the contents of § 4.130, titled "Evaluation of psychiatric disability" in favor of the proposed paragraph (a) of § 4.126 and the proposed evaluation criteria for mental disorders.

We propose to retain the substance of § 4.131, "Mental disorders due to psychic trauma," in § 4.129 and to delete § 4.131.

There are currently four notes in § 4.132 following the rating formula for psychoneuroses. Notes (1), prohibiting assignment of evaluations based on social impairment only, and (4), concerning evaluation of a single disability which has been diagnosed both as a physical and mental disability, have been incorporated into § 4.126, as discussed above. We propose to delete note (2), which discusses the requirements for a compensable rating from mental disorders; it is redundant since the proposed §§ 4.125 and 4.126 and general rating formula set forth clear diagnostic and evaluation requirements. We also propose to incorporate 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, the section on diagnosis. We propose to delete the part of note (3) that discusses requirements for the diagnosis of conversion disorder, as this is discussed in detail in DSM-IV.

We propose to incorporate the regulatory content of note (2) under DC 9511, about the evaluation of a single condition diagnosed both as a mental and a physical disorder, into § 4.126, the section on evaluation, in order to keep in one place all of the regulatory material on evaluation of mental disorders.

The conditions included under § 4.132 are currently divided into four categories: psychotic disorders (DC's 9201 through 9210), organic mental disorders (DC's 9300 through 9325), psychoneurotic disorders (DC's 9400 through 9411), and psychological factors affecting physical condition (DC's 9500 through 9511). The contract consultants recommended that we reclassify some diseases in accordance with the current version of the DSM, and we propose to do that. We propose to reorganize the conditions into eight categories that conform more closely to the categories in DSM-IV, thus making it easier for rating specialists to correlate the diagnoses given on VA and non-VA exams with the conditions in the rating schedule. This reorganization will require a number of changes in the arrangement and titles of diagnostic codes. We also propose to add diagnostic codes for several conditions that are encountered frequently enough in VA claims to warrant their inclusion in the rating schedule, but which are not currently found there.

We propose a new category of "Schizophrenia and other psychotic disorders." Except for schizoaffective disorder, discussed below, we propose no change in the diagnostic codes pertaining to schizophrenia (DC's 9201 through 9205), which cover conditions with characteristic psychotic symptoms during the active phase, involving delusions, hallucinations, or certain characteristic disturbances in affect and the form of thought. We do, however, propose to change the evaluation criteria for schizophrenia and all other conditions in the section on mental disorders, as will be discussed later in the preamble.

We propose to delete diagnostic codes 9206, bipolar disorder, manic, depressed, or mixed, and 9207, major depression with psychotic features, since we are providing a category for mood disorders that will include conditions such as these, and these changes will be addressed further when mood disorders are discussed.

We propose to update the title of diagnostic code 9208 from "paranoid disorders (specify type)" to "delusional disorder" and place it in the category of schizophrenia and other psychotic disorders, in accord with DSM-IV. This disorder is characterized by a persistent, nonbizarre delusion that is not due to any other mental or physical disorder.

We also propose to delete DC 9209, major depression with melancholia, another condition that will be moved to the category of mood disorders.

We propose to revise the title of DC 9210, "atypical psychosis," to "psychotic disorder, not otherwise specified (atypical psychosis)," and put it in the same category with other psychotic disorders, in accord with DSM-IV. We also propose to put schizoaffective disorder, now part of DC 9205 (schizophrenia, residual type; schizoaffective disorder; other and unspecified types), in this category as diagnostic code 9211. Although schizoaffective disorder is linked to schizophrenia in the current schedule, DSM-IV names it as a separate psychotic disorder rather than as a type of schizophrenia.

We propose to change the title of the current category of "Organic mental disorders" to "Delirium, dementia, and amnestic and other cognitive disorders" in accordance with DSM-IV. The conditions in this section demonstrate a psychological or behavioral abnormality associated with transient or permanent dysfunction of the brain. We also propose to consolidate the 16 types of dementia in the current schedule into fewer categories, since several, such as 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 provides a classification of dementias that is more complex than is needed or useful for VA purposes. For example, it has separate categories for dementia due to Huntington's disease, due to Pick's disease, and due to Creutzfeldt-Jacob disease, all of which are uncommonly seen for VA rating purposes.

We propose a reorganization better suited to VA purposes, and requiring

less revision of the schedule than would be needed to adopt the entire DSM-IV structure. We propose to use six diagnostic codes for specific dementias, many of them the same as are now present. We propose to retain some types because of their frequent occurrence and relevance to veterans, dementia due to head trauma, (DC 9304, dementia associated with brain trauma in the current schedule), for example, and some because they represent clusters of a particular etiology, as discussed above. We propose to retain diagnostic codes for the types of dementia most commonly seen in the general population, vascular dementia (currently 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 (currently 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 propose to delete DC's 9303 (currently dementia associated with alcoholism) and 9325 (currently dementia associated with drug or poison intoxication (other than alcohol)), in accord with DSM-IV, which categorizes them as subtypes of dementia due to general medical conditions, further discussed below. We propose to change 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 propose to include in the revised DC 9301 the conditions now evaluated 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 propose to delete current diagnostic codes 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 to rate these conditions under a single new diagnostic code, 9326, titled dementia due to other neurologic or general medical conditions (including

endocrine disorders, metabolic disorders, drugs, alcohol, poisons, Pick's disease, brain tumors, etc.). This category encompasses in a single miscellaneous category a number of uncommon conditions that DSM-IV names separately.

We propose to change the title of DC 9305 from multi-infarct dementia with cerebral arteriosclerosis to vascular dementia and to have it encompass multi-infarct dementia due to causes other than cerebral arteriosclerosis (DC 9306), which we propose to delete, since both are due to vascular disease and may be difficult to distinguish. They are addressed as a single entity in DSM-IV.

In practice, it may be impossible to determine whether a dementia fits into DC 9310 (dementia due to unknown cause) or DC 9311 (dementia due to undiagnosed cause). We therefore propose to delete DC 9311 and revise DC 9310 to encompass both as dementia of unknown etiology. We propose to retain DC 9312 but to alter the title from dementia, primary, degenerative, to dementia of the Alzheimer's type, in accord with DSM-IV.

We also propose to add diagnostic code 9327, organic mental disorder, other, to provide a code for conditions such as amnesic disorder, organic personality disorder, and other cognitive disorders that are not dementias.

We propose to create a new category for anxiety disorders, in accord with DSM-IV. This category will include several of the conditions currently listed under 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 current "phobic disorder," in accord with terminology in DSM-IV).

We propose to move some of the conditions now listed under 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 to delete DC 9405, dysthymic disorder; adjustment disorder with depressed mood; major depression without melancholia, also as

discussed below. We also propose to add 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 propose to place it in this category as a matter of convenience, rather than giving it a separate category.

We propose to create 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 will be: "dissociative amnesia; dissociative fugue; dissociative identity disorder (multiple personality disorder)", (DC 9416, changed from 9401 to keep conditions in this category together) and "depersonalization disorder" (DC 9417, changed from 9408 for the same reason).

In accord with DSM-IV, we propose to add 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 propose to move two disorders, "conversion disorder; psychogenic pain disorder" (DC 9402) and "hypochondriasis" (DC 9409), that are currently listed under the category of psychoneuroses to this category and give them new diagnostic codes (DC's 9424, 9422, and 9425) so that the somatoform disorders can be grouped together. We propose to split "conversion disorder; psychogenic pain disorder" into "conversion disorder," DC 9424, and "pain disorder" (the current term for psychogenic pain disorder), DC 9422, since the two conditions are distinct, and to change the diagnostic code for "hypochondriasis" from DC 9409 to DC 9425. We also propose to add two other conditions: "somatization disorder" (DC 9421), a commonly seen somatoform disorder not included in the present schedule, and "undifferentiated somatoform disorder" (DC 9423), for somatoform disorders that do not fit elsewhere and for which there is no suitable code in the current schedule.

We propose to establish a new category in the rating schedule for mood disorders, which are characterized, according to DSM-IV, by a disturbance in mood as the predominant feature. We

propose to place in this category: bipolar disorder (DC 9432), dysthymic disorder (DC 9433), and major depressive disorder (DC 9434). Major depressive disorder is currently included 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 propose to evaluate it under a single diagnostic code, 9434 (major depressive disorder). We also propose to change the diagnostic codes for dysthymic disorder (currently dysthymia, DC 9405) and bipolar disorder (DC 9206) to DC's 9433 and 9432, respectively, in order to group the mood disorders together.

For the sake of completeness, we propose to provide diagnostic codes for two additional mood disorders not currently included in the rating schedule: 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 propose to remove DC 9405 ("dysthymic disorder; adjustment disorder with depressed mood; major depression without melancholia") since we are providing separate diagnostic codes for both "dysthymic disorder" (DC 9433) and "major depressive disorder" (DC 9434) under the category of mood disorders.

A category of mental disorders that the current rating schedule does not specifically address, but that is seen fairly often in the veteran population, is adjustment disorder. The essential feature of an adjustment disorder is the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors. We propose to add a new category and diagnostic code (9440) for chronic adjustment disorder.

The current rating schedule provides separate rating formulas for psychotic disorders, organic mental disorders, and psychoneurotic disorders. The formula for psychoneurotic disorders provides some specific criteria at each evaluation level, but also uses "mild," "definite," "considerable," and "severe" industrial impairment at certain levels. Formulas for the other two provide specific criteria only at the 100 percent level and assign less than total evaluations based on whether there is "mild," "definite,"

"considerable," or "severe" impairment of social and industrial adaptability at the other levels. Because those are non-specific terms, they are subject to interpretation by individual rating boards, and it is possible that they may not be applied consistently. For example, the current criterion for the 50 percent level of evaluation for psychotic disorders is: "considerable impairment of social and industrial adaptability." This offers no objective guidance for the rating board and makes comparison of one exam with another difficult. We propose to provide more objective criteria that will in turn result in more consistent evaluations.

The contract consultants recommended that we base the evaluation of mental disorders on more extensive objective descriptions of their possible effects and with examples of signs and symptoms at various levels. In keeping with that recommendation, we propose to evaluate all mental disorders except eating disorders under a single formula, providing objective criteria based on signs and symptoms which characteristically produce a particular level of disability. For example, we propose criteria for the 50 percent level to be: "moderately severe impairment in social and occupational functioning with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short—and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective relationships at work and socially." These criteria are clearly more objective than the present rating formulas, and providing such objective criteria at each level of evaluation will result in more consistent evaluations and will 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 that will enable rating boards to assign consistent evaluations for mental disorders based on signs and symptoms. The proposed criteria are more objective than the current ones because they 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 (e.g., of panic

attacks), and their severity (e.g., degrees of memory loss are given at different levels). With more specific and objective criteria, the rating board 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., and will not have to attempt an assessment based on whether the evidence corresponds to the non-specific language in the current schedule.

In the current rating schedule, DC's 9500 through 9511 represent psychological factors affecting physical conditions in various body systems, and they are in their own category. Evaluation is directed to be made under the general rating formula for psychoneurotic disorders. In DSM-IV, the condition of "psychological factors affecting physical condition" has been renamed "psychological factors affecting medical condition" (PFAMC) and placed in a new category, "Other conditions that may be a focus of clinical attention." DSM-IV states that PFAMC refers to the presence of one or more specific psychological or behavioral factors that adversely affect a general medical condition. There are therefore two components in PFAMC: a medical condition and psychological factors. There is no need for a separate code and evaluation criteria for this condition, and we propose to delete DC's 9500 through 9511. Psychological factors that do not constitute a recognized mental disorder would not be service-connectable in their own right. A separate evaluation for each service-connected component would be made as usual under the appropriate diagnostic code(s). An additional separate evaluation for PFAMC would not be warranted, and in fact would represent pyramiding (see 38 CFR 4.14).

We propose to add one other category, "eating disorders," a group of mental disorders characterized by gross disturbances in eating behavior. This category will include anorexia nervosa (DC 9520) and bulimia nervosa (DC 9521), conditions which are commonly diagnosed but cannot be appropriately rated under the proposed general rating criteria for mental disorders because their more disabling aspects are manifested primarily by physical findings rather than by psychological symptoms. We propose that the criteria be based partly on the extent of weight loss (per DSM-IV) and partly on the extent of incapacitating episodes and needed periods of hospitalization.

The contract consultants suggested we include the categories of sexual

disorders and sleep disorders in the revised schedule. Sexual disorders, which include sexual dysfunctions such as sexual desire disorders and orgasmic disorders, paraphilias such as fetishism and sexual sadism, and gender identity disorders, do not have any inherent effect on employability, and we do not propose to include them in the schedule. Sleep disorders are often manifested by significant physical manifestations, and narcolepsy is currently addressed in the rating schedule under neurologic disorders (as DC 8108). We published a proposed revision of the respiratory disorders section of the rating schedule (58 FR 4962-69) that will include sleep apnea (as DC 6846). We therefore do not propose to add a separate category for sleep disorders to the mental disorders section of the schedule.

Section 4.16 of 38 CFR was established to assure that any veteran unable to secure or follow a substantially gainful occupation because of service-connected disabilities will be awarded a total evaluation even though the schedular evaluation does not reach that level. Section 4.16(c) provides that where the only service-connected disability is a mental disorder assigned a 70 percent schedular evaluation, but which nonetheless precludes the veteran from securing or following a substantially gainful occupation, the mental disorder will be assigned a 100 percent schedular evaluation rather than an extra-schedular total evaluation. We propose to delete § 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 propose to have § 4.16(a) apply to mental disorders in the same manner that it does to other disabilities.

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 (RFA), 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 rule has been reviewed under Executive Order 12866 by the Office of Management and Budget.

The Catalog of Federal Domestic Assistance program numbers are 64.104 and 64.109.

List of Subjects in 38 CFR Part 4

Disability benefits, Individuals with disabilities, Pensions, Veterans.

Approved: July 19, 1995.

Jesse Brown,
Secretary of Veterans Affairs.

For the reasons set out in the preamble, 38 CFR part 4 is proposed to be 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.

§ 4.16 [Amended]

2. In § 4.16, paragraph (c) is removed.

Subpart B—Disability Ratings

3. Section 4.125 is revised to read as follows:

§ 4.125 Diagnosis of mental disorders.

(a) If the diagnosis of a mental disorder does not conform to DSM-IV or is not supported by the findings on the examination report, the rating board shall return the report to the examiner to substantiate the diagnosis.

(b) If the diagnosis of a mental disorder is changed, the rating board shall determine whether the new diagnosis represents progression of the prior diagnosis, correction of an error in the prior diagnosis, or development of a new and separate condition. If it is not clear from the available records what the change of diagnosis represents, the rating board shall return the report to the examiner for a determination.

4. Section 4.126 is revised to read as follows:

§ 4.126 Evaluation of disability from mental disorders.

(a) When evaluating a mental disorder, the rating board shall consider the frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the veteran's capacity for adjustment during periods of remission. The rating board shall assign an evaluation based on all the evidence of record that bears on occupational and social impairment rather than on the examiner's assessment of the level of disability at the moment of the examination.

(b) When evaluating the level of disability from a mental disorder, the

rating board will consider the extent of social impairment, but shall not assign an evaluation solely on the basis of social impairment.

(c) Delirium, dementia, and amnesic and other cognitive disorders shall be evaluated under the general rating formula for mental disorders; neurologic deficits or other impairments stemming from the same etiology (e.g., a head injury) shall be evaluated separately and combined with the evaluation for delirium, dementia, or amnesic or other cognitive disorder (see § 4.25 of this part).

(d) When a single disability has been diagnosed both as a physical condition and as a mental disorder, the rating board shall evaluate it using a diagnostic code which represents the dominant (more disabling) aspect of the condition (see § 4.14 of this part).

5. Section 4.127 is revised to read as follows:

§ 4.127 Mental retardation and personality disorders.

Mental retardation and personality disorders will not be considered as disabilities under the terms of the schedule, but a mental disorder that is superimposed upon, but clearly separate from, the mental retardation or personality disorder may be a disability for VA compensation purposes.

6. Section 4.128 is revised to read as follows:

§ 4.128 Convalescence ratings following extended hospitalization.

If a mental disorder has been assigned a total evaluation due to a continuous period of hospitalization lasting six months or more, the rating board shall continue the total evaluation indefinitely and schedule a mandatory examination six months after the veteran is discharged or released to nonbed care. A change in evaluation based on that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

7. Section 4.129 is revised to read as follows:

§ 4.129 Mental disorders due to psychic trauma.

When a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veteran's release from active military service, the rating board shall assign an evaluation of not less than 50 percent and schedule an examination within the six month period following the veteran's discharge.

8. Section 4.130 is revised to read as follows:

§ 4.130 Schedule of ratings—mental disorders.

Note: The nomenclature employed in this portion of the rating schedule is based upon the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, of the American Psychiatric Association (DSM-IV). Rating boards must be thoroughly familiar with this manual to properly implement the directives in § 4.125 through § 4.129 and to apply the general rating formula for mental disorders in § 4.130.

Schizophrenia and Other Psychotic Disorders

- 9201 Schizophrenia, disorganized type
- 9202 Schizophrenia, catatonic type
- 9203 Schizophrenia, paranoid type
- 9204 Schizophrenia, undifferentiated type
- 9205 Schizophrenia, residual type; other and unspecified types
- 9208 Delusional disorder
- 9210 Psychotic disorder, not otherwise specified (atypical psychosis)
- 9211 Schizoaffective disorder

Delirium, Dementia, and Amnestic and Other Cognitive Disorders

- 9300 Delirium
- 9301 Dementia due to infection (HIV infection, syphilis, or other systemic or intracranial infections)
- 9304 Dementia due to head trauma
- 9305 Vascular dementia
- 9310 Dementia of unknown etiology
- 9312 Dementia of the Alzheimer's type
- 9326 Dementia due to other neurologic or general medical conditions (endocrine disorders, metabolic disorders, drugs, alcohol, poisons, Pick's disease, brain tumors, etc.)
- 9327 Organic mental disorder, other

Anxiety Disorders

- 9400 Generalized anxiety disorder
- 9403 Specific (simple) phobia; social phobia
- 9404 Obsessive compulsive disorder
- 9410 Other and unspecified neurosis
- 9411 Post-traumatic stress disorder
- 9412 Panic disorder and/or agoraphobia
- 9413 Anxiety disorder, not otherwise specified

Dissociative Disorders

- 9416 Dissociative amnesia; dissociative fugue; dissociative identity disorder (multiple personality disorder)
- 9417 Depersonalization disorder

Somatoform Disorders

- 9421 Somatization disorder
- 9422 Pain disorder
- 9423 Undifferentiated somatoform disorder
- 9424 Conversion disorder
- 9425 Hypochondriasis

Mood Disorders

- 9431 Cyclothymic disorder
- 9432 Bipolar disorder
- 9433 Dysthymic disorder
- 9434 Major depressive disorder
- 9435 Mood disorder, not otherwise specified

Chronic Adjustment Disorder

- 9440 Chronic adjustment disorder

General Rating Formula for Mental Disorders

Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name—100.

Severe occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: Suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships—70.

Occupational and social impairment with reduced reliability and productivity due to such symptoms as: Flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships—50.

Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due

to such symptoms as: Depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events)—30.

Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by continuous medication—10.

A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication—0.

Eating Disorders

- 9520 Anorexia nervosa
- 9521 Bulimia nervosa

Rating Formula for Eating Disorders

Self-induced weight loss to less than 80 percent of expected minimum weight, with incapacitating episodes of at least six weeks total duration, and requiring hospitalization more than twice a year for parenteral nutrition or tube feeding—100.

Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of six or more weeks total duration per year—60.

Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of more than two but less than six weeks total duration per year—30.

Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder and incapacitating episodes of up to two weeks total duration per year—10.

Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder but without incapacitating episodes—0.

Note: An incapacitating episode is a period during which bed rest and treatment by a physician are required.

§§ 4.131 and 4.132 [Removed]

9. § 4.131 and § 4.132 are removed.
[FR Doc. 95-26567 Filed 10-25-95; 8:45 am]
BILLING CODE 8320-01-P