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Healthcare Inspection

Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for Traumatic Brain Injury Compensation and Pension Examinations

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Executive Summary

The VA Office of Inspector General (OIG) was required to conduct this review by the Joint Explanatory Statement that accompanied P.L. 113-235, Consolidated and Further Continuing Appropriations Act, 2015.[1] Specifically, we were instructed to (1) review a complaint to the Montana Board of Psychologists (the Board), which resulted in the Board reprimanding a VA psychologist in Ft. Harrison, MT, for practicing outside the scope of his professional qualifications when performing a Compensation and Pension (C&P) examination for traumatic brain injury (TBI), and (2) review the protocols VA uses for examinations for TBI throughout the Veterans Health Administration (VHA) to determine if VA needs to revise its protocols nationwide. We expanded the review at the request of Congressman Tim Walz and Congressman Mike Coffman to include information to assist the House Committee on Veterans' Affairs in understanding if appropriate providers are conducting TBI C&P examinations.

A TBI is a brain injury caused by damage to the brain from an object suddenly hitting the head or an explosive force. TBI from an explosion or blast is a common occurrence among troops in Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom, and as such, has been referred to as the "signature wound" of these wars.[2] Over 80 percent of diagnosed TBIs are mild TBIs (mTBIs), also known as concussions, in both military and civilian populations.

Veterans Benefits Administration (VBA) provides disability compensation to veterans disabled as a result of a service-connected injury. In order to be awarded disability compensation, the service member or veteran must receive a service-connected rating. The degree to which a veteran is disabled determines the percent of service-connection, which in turn governs the amount of benefits. A C&P examination is part of the process for determining the existence and percentage of a service-connection.

The process for determining a veteran's eligibility for disability benefits based on TBI involves several steps, the first of which is a TBI diagnosis. For many veterans, the TBI diagnosis will occur at the time of their injury during active service, and VA policy is to accept that diagnosis for purposes of determining eligibility for disability benefits. If a veteran does not have a diagnosis of TBI as of the application for disability benefits, VA requires a diagnosis by one of the following four physician specialists (referred to in this report as "a required specialist"): neurologist, neurosurgeon, physiatrist (physical medicine and rehabilitation (PM&R)), or psychiatrist.

For veterans with a previous diagnosis made in accordance with VA policy, the C & P examination can be performed by any clinician certified to do so via a program established by Office of Disability and Medical Assessment (DMA), regardless of

[1] https://www.congress.gov/113/plaws/publ235/PLAW-113publ235.pdf. Accessed March 28, 2017.
[2] *Where Soldiers Come From: Traumatic Brain Injury,* November 10, 2011, PBS Documentary, http://www.pbs.org/pov/wheresoldierscomefrom/traumatic-brain-injury/. Accessed December 30, 2015.

specialty. This certification process includes completion of a TBI examination training module, which is a one hour training course. The examination can also be completed by the required specialist who provided the diagnosis for the first part of the examination process.

VBA can also send the TBI disability examination to an outside contractor (the majority of whom are one of the four physician specialists, in the event a diagnosis is needed), or it can send the examination request to VHA. VHA can then choose to have the examination performed by members of its medical staff (which includes physician specialists), or can refer the examination to its contractors. A significant factor in selecting the provider who will perform the examination is a determination by the VBA employee processing the application about which path will be fastest based on available resources and work flow at the time.

As directed by Congress, we reviewed a veteran's case and complaint to the Board. The veteran had a diagnosis of TBI as a result of proximity to an explosion while serving in the military in 2006. The veteran underwent neuropsychological testing in 2006, 2007, and 2009, that demonstrated persistent findings related to the diagnosed TBI. He/she exited the military in 2009; in 2011, the veteran was evaluated by a VA psychologist as part of the C&P process. During claims adjudication, the disability rating was lowered from 100 percent to 90 percent; the veteran subsequently filed a complaint with the Board regarding this examination and its conclusions. The Board determined that the VA psychologist had not provided appropriate testing and assessment, and identified concerns with the training requirements for providers performing TBI C&P examinations. We have reviewed this record and it has informed our findings and recommendations.

We assessed all initial 2015 TBI C&P examinations available in the Corporate Data Warehouse[3] performed by both VHA personnel and VHA/VBA contractors to determine if the examining personnel met VA's qualifications. Specifically, we looked at whether a physician specialist performed the TBI diagnosis or if the diagnosis of TBI was otherwise in accordance with diagnosis requirements. We also determined if all personnel involved in the examination had obtained the proper training and certification as required by DMA.

In addition, to assess the content of the DMA curriculum and training, an OIG physician with expertise in PM&R took the DEMO General Certification Overview Course as well as the DEMO Traumatic Brain Injury (TBI) Examination course. Given the complexity of TBI assessment, a one-hour DEMO TBI training module appeared inadequate to train providers to properly conduct C&P exams unless the provider had prior experience assessing and treating TBI.

Generally, we found evidence that VA practice is consistent with requirements with regard to the specialty and training of the provider conducting the TBI C&P examination.

[3] The Corporate Data Warehouse is VA's centralized data repository.

In cases where the TBI examination was not performed by a C&P examiner who was a required physician specialist, we found that the diagnosis of TBI in almost all of these examinations was made either while the veteran was in the military or based on a diagnosis by a required specialist. We also found that even when TBI C&P examinations were not done in accordance with VHA's TBI certification policy, the non-compliant exams were generally performed in a clinically appropriate manner.

Examinations by VHA Staff

Specifically, the majority of TBI C&P examinations during 2015 was performed by VHA staff. We found that 17,778 veterans had an initial TBI C&P examination performed by VHA staff in 2015. Of these, we were able to identify that 10,596 of 17,778 veterans (59.6 percent) had an examination performed by a required physician specialist in 2015. From our review of the remaining 7,182 veterans, we estimated that 95.9 percent[4] of the TBI examinations done by VHA employees were compliant with VHA policy regarding TBI certification.

Examinations by VHA and VBA Contractors

The remainder of the examinations were performed by VHA and VBA contractors. We determined that 5,626 of 5,651 (99.6 percent) initial TBI C&P examinations were performed by VHA contractors of the appropriate specialty and with proper certification, and similarly, 7,648 of 7,650 (99.97 percent) of examinations performed by VBA contractors were completed by personnel of the appropriate specialty and certification.

TBI C&P examinations are complex and rely significantly on the clinical experience and judgment of the examiner. Because TBI C&P examinations are so reliant on the clinical skills and judgment of the providers performing them, it is important that these skills and judgment be equalized to the extent possible via thorough training that imparts as many objective criteria as possible, recognizing that each veteran is unique and must be individually assessed. Given the complexity of evaluating TBI, we determined the training requirements in the curriculum were insufficiently rigorous. The required DEMO training module explicitly recommended additional training to further the provider's competency in TBI examination, and noted in particular that determination of causation is a complex issue. Because additional training was not required by VA policy, a provider's only TBI training and experience may be the one-hour DEMO module. We recommended that VA strengthen its training requirements for TBI C&P examinations.

Another significant challenge to TBI assessment is the requirement that the examiner assess the presence of neurobehavioral symptoms which may also be a result of conditions such as post-traumatic stress disorder (PTSD), depression, and other mood or anxiety disorders. Under the current system of assigning disability ratings, the assignment of causation of symptoms by the TBI examiner may significantly impact a veteran's rating. VBA converts the clinical findings on examination into a percentage

[4] The 95 percent confidence interval is 94.3 – 97.0 percent.

rating depending upon the diagnosis causing the findings. Veterans with identical symptoms and functional limitations might end up with different ratings based on how causation was determined and assigned by the examiner. For example, the rules for converting TBI findings base the rating on the highest score in any domain in contrast to PTSD where a more global assessment is used.

Assigning disability ratings based on symptoms and clinical findings without regard to diagnosis would avoid such disparities in ratings. The emphasis should be placed upon the determination of the impact of these disabilities upon the veteran, without regard to the cause. An evaluation that determines the impact of similar or identical cognitive symptoms for disability purposes should not rely upon one rating pathway for TBI and a different pathway for PTSD. Using two distinct pathways may result in different disability ratings for a veteran with cognitive symptoms that could be caused by either or both conditions.

We also found that documentation of examination findings in TBI C&P examinations was insufficient to determine the basis of the assessment of cognitive impairment or residuals of TBI. Transparency in the basis for disability determinations is critical to ensuring that the veteran receives an appropriate decision and in creating an appropriate record in the event the determination is appealed. Appropriate documentation of the TBI examination process is in the best interests of the veteran and the VA.

We recommended that the Executive in Charge, Office of the Under Secretary for Health, and the Acting Under Secretary for Benefits convene experts to develop a plan to:

1) Ensure that personnel performing the TBI C&P examination have comprehensive training on the evaluation of TBI, including the assessment and evaluation of cognitive disorders.
2) Develop requirements for documentation of the TBI C&P examination process, including the basis for determinations of cognitive impairment and other residuals of TBI.
3) Consider whether to provide disability ratings to veterans with claims arising from cognitive issues based upon their clinical signs and symptoms, not primarily based upon the diagnosis or cause of their cognitive deficits (that is, TBI or PTSD).

Comments

The Executive in Charge, Office of the Under Secretary for Health, concurred with our recommendation and the Acting Under Secretary for Benefits concurred with our recommendation in principle. The Offices of the Under Secretary for Health and Under Secretary for Benefits provided acceptable action plans (see Appendixes C and D, pages 25–40). We will follow up on the planned actions until they are completed.

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Purpose

The VA Office of Inspector General (OIG) was required to conduct this review by the Joint Explanatory Statement that accompanied P.L. 113-235, Consolidated and Further Continuing Appropriations Act, 2015.[5] Specifically we were instructed to: (1) review a complaint to the Montana Board of Psychologists (the Board), which resulted in the Board reprimanding a VA psychologist in Ft. Harrison, MT, for practicing outside the scope of his professional qualifications when performing a Compensation and Pension (C&P) examination for traumatic brain injury (TBI), and (2) review the protocols VA uses for examinations for TBI throughout the Veterans Health Administration (VHA) to determine if VA needs to revise its protocols nationwide. We expanded the review at the request of Congressman Tim Walz and Congressman Mike Coffman to include information to assist the House Committee on Veterans' Affairs in understanding if the appropriate providers are conducting the TBI C&P examinations.

Background

The Disability Benefits Claims Process

VA provides monthly benefits to veterans, their spouses, dependent children, and dependent parents as compensation for economic loss resulting from a veteran's service-connected disability. VA pays a tax-free monetary benefit to veterans whose "…disabilities are the result of a disease or injury incurred or aggravated during active military service." In order to be awarded disability compensation, the service member or veteran must receive a service-connected rating. VA compensation rates for impairment are contingent upon the combined percentage of VA disability rating, number of dependents, and special circumstances. The degree to which a service member or a veteran is disabled determines the percent of service-connection. Service-connected disabilities are rated in increments of 10 percent and range from 10 percent to 100 percent. Special monthly compensation is an additional tax-free benefit provided to veterans with special circumstances including need of aid and attendance and clothing allowances.

The claims process for applying for disability benefits is comprised of eight steps: (1) claim received; (2) under review; (3) gathering of evidence; (4) review of evidence; (5) preparation for decision; (6) pending decision approval; (7) preparation for notification; and (8) complete. Claims may bypass steps three and four and move directly to preparation for decision approval in those cases where adequate evidence is present. Factors impacting the length of time it takes to process a claim include the type of claim filed, number and complexity of the disability(ies), and availability of evidence in support of the claim.

[5] https://www.congress.gov/113/plaws/publ235/PLAW-113publ235.pdf. Accessed March 28, 2017.

VA requires that veterans provide all evidence relevant to their claim or information to assist VA in acquiring additional evidence and to ensure a sufficient case file exists for review. Veterans need to submit their DD214 (separation papers), service treatment records, and any other available medical records related to their claim.

Disability Benefit Questionnaires Disability Benefit Questionnaires (DBQ) are condition and disease specific question and answer forms that provide the medical evidence needed for VBA to process and rate veterans' disability claims. DBQs provide a standardized format for communication of medical evidence as part of a veteran's claim for VA disability benefits and are developed in collaboration with VBA and the Office of Disability and Medical Assessment (DMA) which is responsible for providing leadership and support to VHA's disability examination program. DMA works closely with VBA and other stakeholders, such as the Department of Defense (DoD), to support the disability examination process.

More than 70 DBQs are available and cover a wide range of medical conditions, including DBQs for initial TBI and TBI residual disability examinations. Disability examiners are expected to complete the DBQ form(s) in a step by step manner, answering and documenting only the questions on the DBQ. VBA may also rely on a DBQ provided by a clinician (either in the VA or a private provider) who treats the veteran and is familiar with his/her condition.

VA's Schedule for Rating Disabilities Disability ratings are intended to represent (as far as can practically be determined) the average impairment in earning ability in civilian occupations which results from the service-connected disease or injury and their residual conditions. The specified degree(s) of disability is generally considered adequate to compensate for the loss of working time proportional to the disability. While an individual's ability to overcome a disability can vary, the disability rating is based primarily on the average impairment in earning capacity which must be overcome and does not take into consideration a particular individual's success in overcoming the disability. A total disability will be considered to exist when the individual's service-connected disability is sufficient to make it impossible for the average person to have a gainful occupation or employment.

The basis of the disability evaluation is the ability of the body as a whole to function under the ordinary conditions of daily life, including employment. This requires the clinical examiner to provide a full description of the effects of the disability on the veteran's ordinary activity. Different clinical examiners may not describe the same disability in the same language. A VBA rating specialist interprets and reconciles the examination reports, and then compares the examination findings to the rating schedule to determine a current rating. This rating is intended to reflect elements of each disability from the point of view of the veteran working or seeking work. The disability(ies) may result in a veteran being too disabled to engage in employment but able to function fairly comfortably at home or in a limited activity environment.

The Code of Federal Regulations *Title 38 Pensions, Bonuses, and Veterans' Relief*[6] outlines VA's Schedule for Rating Disabilities. This rating schedule serves as the guide for the evaluation of disability that results from all types of injuries and diseases faced as part of military service. Complete descriptive and detailed medical examinations are required in order to apply the rating schedule. Special focus is placed on limitation of activity caused by the disabling condition.

For veterans with no dependents, the 2016 monthly rates of compensation benefit range from $133.17 (10 percent) to $2,915.55 (100 percent).[7] The monthly rate increases incrementally with disability percentage.[8]

TBI

A TBI is an acquired brain injury caused by sudden damage to the brain from an object suddenly hitting the head or an explosive force. Blast injuries may occur in three ways: (1) Primary blast injuries occur as a direct result of changes in atmospheric pressure; (2) Secondary blast injuries result from flying objects that hit people; and (3) Tertiary blast injuries are caused by individuals' bodies put in motion by the blast and colliding with something such as the ground or the inside of a vehicle.[9]

TBI from an explosion or blast is a common occurrence among troops in Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) and as such has been referred to as the "signature wound" of these wars.[10] Experts from the DoD and Veterans Brain Injury Center suggest that compared to past wars, the apparent increase of TBI diagnoses resulting from recent wars may be due to increased: (1) frequency of improvised explosive device (IED)[11] attacks; (2) survival rates due to the advanced body armor worn by military personnel; and (3) knowledge about TBI.[12]

[6] Code of Federal Regulations, *Title 38 Pensions, Bonuses, and Veterans' Relief*, http://www.ecfr.gov/cgi-bin/text-idx?gp=&SID=332affe363c8f9ba5fe222c4785238af&mc=true&tpl=/ecfrbrowse/Title38/38tab_02.tpl. Accessed February 8, 2016.
[7] Veterans Compensation Benefits Rate Tables. http://www.benefits.va.gov/compensation/resources_comp01.asp. Accessed January 25, 2017.
[8] Ibid.
[9] Warden, Deborah, Military TBI during the Iraq and Afghanistan wars, *Journal of Head Trauma Rehabilitation*, September/October 2006, p. 398-402.
[10] Where Soldiers Come From: Traumatic Brain Injury, November 10, 2011, PBS Documentary, http://www.pbs.org/pov/wheresoldierscomefrom/traumatic-brain-injury/. Accessed December 30, 2015.
[11] "An IED is a bomb designed to cause death or injury using explosives alone or in combination with chemicals or other materials. IEDs take a variety of shapes and sizes and have been employed in a number of different ways. For example, in Iraq, many IEDs have been hidden and disguised along traffic routes and then remotely detonated." United States Government Accountability Office, Report to Congressional Requesters, VA Health Care, Mild Traumatic Brain Injury Screening and Evaluation Implemented for OEF/OIF Veterans, but Challenges Remain, http://www.gao.gov/new.items/d08276.pdf, GAO-08-276, February 2008, page 1. Accessed February 18, 2016.
[12] Warden, p. 398-402.

OEF/OIF troops were exposed to ambushes by roadside bombs, rocket propelled grenades, and/or IEDs. Additionally, these military service members were likely to have multiple deployments, increasing likelihood of recurrent blast exposure. Experts estimated that out of 2 million troops who served in OEF/OIF, more than 800,000 had multiple deployments; many had five or more.[13] Researchers estimated that approximately 78 percent of the OEF/OIF combat injuries were the result of explosive munitions.[14] Further, they found that the proportion of head and neck wounds in OEF/OIF service members was significantly higher than that experienced in World War II, Korean, or Vietnam wars (16–21 percent).[15] A 2008 report estimated that nearly 20 percent of OEF/OIF veterans sustained a TBI during deployment.[16]

DoD and VA define TBI and the diagnostic criteria as:

> *A traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event:*
>
> - *Any period of loss of or a decreased level of consciousness*
> - *Any loss of memory for events immediately before or after the injury (posttraumatic amnesia)*
> - *Any alteration in mental state at the time of the injury (e.g., confusion, disorientation, slowed thinking, alteration of consciousness/mental state)*
> - *Neurological deficits (e.g., weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia) that may or may not be transient*
> - *Intracranial lesion*[17]

A TBI diagnosis can be made based on these specific criteria, and a physical examination is not always performed; however, additional assessment is necessary to determine the cognitive and other deficits arising from the TBI. Imaging, blood tests, and electroencephalography are not consistently effective in diagnosing TBI or assessing symptoms and deficits.[18]

TBIs are classified into mild, moderate, and severe categories based on duration of loss of consciousness (LOC), post-traumatic amnesia (PTA), Glasgow Coma Score (GCS),

[13] Where Soldiers Come From: Traumatic Brain Injury, PBS Documentary, November 10, 2011, http://www.pbs.org/pov/wheresoldierscomefrom/traumatic-brain-injury/. Accessed December 30, 2015.
[14] Owens, B.D., Kragh, J.F., Jr., Wenke, J.C., Macaitis J., Wade, C.E., Holcomb, J.B. (2008). Combat wounds in operation Iraqi Freedom and operation Enduring Freedom. *Journal of Trauma, 64*, 295-299.
[15] Ibid.
[16] Tanielian T, Jaycox LH, editors. Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery. Santa Monica, CA: Rand Corporation; 2008, http://www.rand.org/pubs/monographs/MG720/. Accessed January 5, 2016. See page xxi, Key Findings, Prevalence of Mental Health Conditions and TBI.
[17] VA/DOD *Clinical Practice Guideline for Management of Concussion/Mild Traumatic Brain Injury*, 2009. http://www.healthquality.va.gov/guidelines/Rehab/mtbi/.
[18] Lisa A. Brenner PhD, *Neuropsychological and neuroimaging findings in traumatic brain injury and post-traumatic stress disorder*, Dialogues in Clinical Neuroscience, September 2011, 13 (3): 311-323.

and structural imaging findings (computed tomography scanning or magnetic resonance imaging). (See Table 1.)

Table 1. Classification of TBI Severity

Criteria	Mild	Moderate	Severe
Structural Imaging	Normal	Normal or Abnormal	Normal or Abnormal
Loss of Consciousness	0–30 min	> 30 min and < 24 hrs	> 24 hrs
Alteration of Consciousness/Mental State (AOC)*	A moment up to 24 hrs	> 24 hours. Severity based on other criteria	
Post-Traumatic Amnesia	0–1 day	> 1 and < 7 days	> 7 days
Glasgow Coma Score (Best Available Score in First 24 Hours)	13–15	9–12	< 9

Source: VA/DoD Clinical Practice Guideline for Management of Concussion/Mild Traumatic Brain Injury, 2000.

* Note: Alteration of mental status must be immediately related to the trauma to the head. Typical symptoms would be: looking and feeling dazed and uncertain of what is happening, confusion, difficulty thinking clearly or responding appropriately to mental status questions, and being unable to describe events immediately before or after the trauma event.

If a veteran's criteria fall into more than one category, the higher severity classification is designated. Many factors impact functioning and therefore a veteran's ultimate functional abilities may not be clearly predictable.[19] Multiple individual factors also impact recovery, including severity of injury, rate and completeness of physiological healing, types of functions affected, meaning of dysfunction in the individual's life, and resources available to aid recovery.[20]

The most common TBI-related cognitive deficits are processing speed; complex attention; memory of facts and events; and higher level thinking such as planning, reasoning, and problem solving. Behavioral disturbances may include delusions, hallucinations, moodiness, and agitation.[21] Veterans with more severe TBI (such as those caused by penetrating injury) may demonstrate additional serious deficits such as problems producing and understanding speech.

Mild TBI Over 80 percent of diagnosed TBIs are mild TBIs (mTBIs), also known as concussions, in both military and civilian populations. Veterans with mTBI present with

[19] VA/DOD *Clinical Practice Guideline for Management of Concussion/Mild Traumatic Brain Injury*, Appendix C, 2009, http://www.healthquality.va.gov/guidelines/Rehab/mtbi/.
[20] Mount Sinai Medical Center, http://www.brainline.org/content/2008/07/what-impact-will-moderate-or-severe-tbi-have-persons-life_pageall.html,. Accessed February 24, 2016.
[21] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, 2013, pages 624-627.

diverse symptoms and recovery courses. mTBIs can lead to problems with concentration and memory; emotional problems such as anxiety, moodiness, or irritability; and physical symptoms such as balance disturbance, fatigue, headaches, hearing deficits, light and noise sensitivity, ringing in the ears, and sleep disturbance. Research studies have shown that such symptoms are temporary, with most veterans experiencing a rapid and full recovery within 3 months of initial injury. However, a small percentage of veterans exhibit symptoms for months or years.[22]

Researchers suggest that recovery from mTBI is related to the specific injury as well as non-injury factors including age, neurological and psychiatric history, alcohol abuse, and educational level. Stressful events occurring after injury, including illness or injury, litigation, and/or compensation claims, can also have a negative effect on recovery.[23]

Consistent with a 2004 World Health Organization review,[24] a 2014 peer reviewed systematic literature review of 21 studies found that most patients recover from mTBI within 3 months to one year.[25] However, between 7 percent and 33 percent of patients reported persistent symptoms. One of the most frequently reported symptoms post-TBI is disordered thinking.

The Challenges of Separating TBI and Post-Traumatic Stress Disorder on the Basis of Symptoms

TBI and post-traumatic stress disorder (PTSD) are each individually complex conditions and the manifestations of both are contingent on a wide range of individual and systemic factors. Further study regarding the relationship between these two conditions is necessary to facilitate increased understanding and ultimately develop assessment and treatment strategies for those with co-occurring disorders.

Symptoms of mTBI may go undetected due to comorbid mental health condition(s). One significant challenge to mTBI assessment is the presence of neurobehavioral symptoms that may be a result of conditions such as PTSD, depression, and other mood or anxiety disorders. A 2007–2009 study found that VHA clinicians did not diagnose mTBI in 21.3 percent of veteran assessments for which a diagnosis would have been appropriate under American Congress of Rehabilitation Medicine guidelines.

[22] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, 2013, pages 624-627.
[23] Report to Congress on Mild Traumatic Brain Injury in the United States: Steps to Prevent a Serious Public Health Problem, 2003, http://www.cdc.gov/traumaticbraininjury/pdf/mtbireport-a.pdf, page 8.
[24] Carroll LJ, Cassidy JD, Peloso PM, et al. *Prognosis for mild traumatic brain injury: results of the WHO Collaborating Centre Task Force on Mild Traumatic Brain Injury*, Journal of Rehabilitation Medicine, 2004; 36(43 Suppl):84-105, https://www.medicaljournals.se/jrm/content/search/?searchString=Prognosis+for+mild+traumatic+brain+injury%3A+results+of+the+WHO+Collaborating+Centre+Task+Force+on+Mild+Traumatic+Brain+Injury&type=title.
[25] J. David Cassidy, PhD, DrMedSc, Carol Cancelliere, DC, MPH, Linda J. Carroll, PhD, et al. *Systematic Review of Self-Reported Prognosis in Adults After Mild Traumatic Brain Injury: Results of the International Collaboration on Mild Traumatic Brain Injury Prognosis,* Archives of Physical medicine and Rehabilitation, 2014; 95(3 Suppl 2): 132-51. http://www.archives-pmr.org/article/S0003-9993(13)01104-0/fulltext.

Researchers identified that injury etiology, neurobehavioral symptoms, and suspected psychiatric conditions were factors in the lack of concordance between providers who did not diagnose mTBI and the American Congress of Rehabilitation Medicine guidelines that supported the diagnosis.[26]

Symptoms of mTBI may present similarly to symptoms of PTSD or may be comorbid with PTSD. Some researchers have concluded that the presence of PTSD actually reduces the accuracy of VHA's TBI screening.[27] Another study found that approximately 10 percent of VHA patients who were seen from fiscal year 2010 to fiscal year 2012 had a TBI diagnosis and most of them also had a mental health diagnosis, with about half of those also diagnosed with PTSD and a pain condition.[28] A 2009 literature review found no published studies that reviewed the accuracy of diagnostic tests to enable providers to differentiate between mTBI and PTSD symptoms when the conditions co-occur.[29]

VA's C&P System for TBI

Service Members For service members with TBI, a determination is made by DoD as to whether they will remain on active duty and in what capacity. Service members determined unfit for duty may be given a proposed VA disability rating prior to leaving the service. The DoD medical evaluation board makes a recommendation for granting a service-connected disability rating while remaining on active duty. A service member may remain on active duty while receiving service-connected disability compensation. Upon discharge from active duty, a service member may or may not have a service-connected rating but must file a claim with VBA to pursue VA disability compensation and can do so immediately prior to discharge or at any time following military discharge.

Service members who sustain catastrophic injuries from combat or combat related operations are eligible for an expedited disability evaluation through DoD. This process quickly places the service member on permanent disability retirement, opening access for him/her to obtain benefits from the VA.

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[26] Pogoda TK, Iverson KM, Meterko M, Baker E, Hendricks AM, Stolzmann KL, Krengel M, Charns MP, Amara J, Kimerling R, Lew HL. Concordance of clinician judgment of mild traumatic brain injury history with a diagnostic standard. *J Rehabil Res Dev*. 2014;51(3):363–76.http://dx.doi.org/10.1682/JRRD.2013.05.0115 http://www.rehab.research.va.gov/jour/2014/513/pdf/jrrd-2013-05-0115.pdf. Accessed February 26, 2016.

[27] Polytrauma and Blast-Related Injuries, QUERI, http://www.polytrauma.va.gov/TBIReports/vha-tbi-screening-eval.pdf. Updated July 28, 2014. Accessed February 26, 2016.

[28] Taylor BC, Campbell E, Nugent S, Cutting A, Bidelspach DE, Carlson KF, Sayer NA. Fiscal Year 2012 VA utilization report for Iraq and Afghanistan war Veterans diagnosed with TBI. Prepared for the VA Polytrauma and Blast-Related Injuries QUERI #PLY 05-2010-2. Feb 2014., http://www.queri.research.va.gov/ptbri/docs/FY12-TBI-Diagnosis-HCU-Report.pdf. Accessed February 26, 2016.

[29] Carlson, Kathleen: Kehle, Shannon; Meis, Laura; Greer, Nancy; MacDonald, Rod; , and Rutks, Indulis. The Assessment and Treatment of Individuals with History of Traumatic Brain Injury and Post-Traumatic Stress Disorder, A Systematic Review of the Evidence, NCBI Bookshelf, Washington (DC): Department of Veterans Affairs (US); 2009 Aug., http://www.ncbi.nlm.nih.gov/books/NBK49144/. Accessed February 21, 2016.

Diagnosis of TBI In order to be considered for benefits based on a TBI, the veteran must have a TBI diagnosis. The diagnosis of TBI can be made based on objective or historical factors relating to the incident and does not always require a physical examination and assessment. Typically, a diagnosis of TBI is made by DoD personnel at or around the time of the incident. In these and other instances where the veteran had previously had a diagnosis of TBI (either in or out of a VA setting), VBA's policy is to accept that diagnosis for purposes of the C & P examination.

Veterans presenting for initial TBI disability examinations without a previous diagnosis of TBI are required to be examined and a diagnosis made by a VHA physician who is Board certified or Board eligible in one of the following four specialties (hereinafter "a required specialist"): neurology, neurosurgery, physiatry (physical medicine and rehabilitation (PM&R)), or psychiatry prior to the completion of the disability evaluation.

The Disability Benefits Examination Process for TBI

A C&P examination for a veteran with diagnosed TBI requires the examiner to provide and assess information that will enable the VBA to determine an appropriate disability rating. The assessment of mTBI can be particularly challenging because, unlike more severe TBI, mTBI does not always occur with visible external injuries, or present on radiological imaging and laboratory tests.[30] Due to the subtlety of mTBI symptoms, the assessment and any psychological testing should be performed by a provider with expertise.

VA's Schedule for Rating Disabilities outlines three main areas where dysfunctions may occur as a result of TBI: cognitive, emotional/behavioral, and physical. As part of the process of assessing the residual impacts of TBI, the examiner will utilize a DBQ specifically tailored to TBI. The examiner is responsible for completing the DBQ and can also rely on other information such as a form completed by a clinician who is treating the veteran and is familiar with his/her condition (either in the VA or a private provider.)

The DBQ is divided into three sections. The first requires information about the TBI diagnosis. The second requires an assessment of ten specific facets of TBI-related cognitive impairment and subjective symptoms of TBI, as follows:[31]

- Memory, attention, concentration, and executive functions
- Judgment
- Social interaction

[30] Mild Traumatic Brain Injury – Concussion, Pocket Guide For Clinicians, October 2010, http://www.publichealth.va.gov/docs/exposures/TBI-pocketcard.pdf. Accessed December 30, 2015.
[31] Per the Federal Rating Schedule for TBI, "The table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" contains 10 important facets of TBI related to cognitive impairment and subjective symptoms."

- Orientation
- Motor activity
- Visual spatial orientation
- Subjective symptoms
- Neurobehavioral effects
- Communication
- Consciousness

The third section serves as a "catch all" which seeks information on additional residuals, other findings, diagnostic testing, functional impact, and other remarks. If other medical conditions are claimed as a residual of a TBI, such as hearing loss or visual impairment, the DBQ for that condition must also be completed.

The standardized questions in the TBI DBQs conform to VA's Schedule for Rating Disabilities, assess each facet, and aim to improve the quality and timeliness of the medical evidence needed to support a veteran's claim for disability benefits.

The Role of Psychometric Testing and Neuropsychological Assessment

The TBI DBQ notes, "Neuropsychological testing may need to be performed in order to be able to accurately complete this section." A neuropsychological assessment is a performance based test or battery of tests that is commonly used to assess cognitive symptoms. Neuropsychologists[32] use valid and reliable tests that evaluate specific functional domains including attention, language, memory, intelligence, motor speed, and educational achievement.[33] Neuropsychologists use their expertise to select an individualized set of tests that aim to evaluate the extent of functional loss. A C&P examiner has the authority to order testing that will assist in the assessment of TBI symptoms and impairment. Given the diverse symptoms seen, each veteran may require different testing. (Appendix B includes some examples of neuropsychological tests.) Neuropsychological assessment also provides information about the veteran's thinking to inform diagnosis, treatment planning, treatment response, and prognosis.[34]

The performance on neuropsychological testing is based on data that compares an individual's performance to reference groups of the same age, sex, race, and educational attainment. These comparisons allow specialists to determine if an

[32] According to the American Psychological Association, clinical neuropsychologists complete specialized training at both the doctoral and postdoctoral levels to "…apply specialized knowledge in the assessment, diagnosis, treatment and rehabilitation of individuals with neurological, medical, or neurodevelopmental disorders across the lifespan." http://www.apa.org/ed/graduate/specialize/neuro.aspx. Accessed December 23, 2016.
[33] Robert D. Rondinelli, MD, PhD, AMA Guides® to the Evaluation of Permanent Impairment, sixth edition, American Medical Association, 2012.
[34] Phillip D. Harvey PhD, *Clinical Applications of Neuropsychological Assessment*, Dialogues in Clinical Neuroscience, March 2012, 14 (1): 91–99.

individual is performing as would be expected given lifetime levels of achievements and educational attainment, or if test performance is poorer than expected.[35] Interpretation and analysis of results is also dependent on clinical factors such as medical history, physical exam, and pre-injury level of function.

Certification of Providers Performing Disability Examinations

VHA policy defines a disability examination as a "medical professional's opinion, personal observation, and/or evaluation of a claimant."[36] VHA requires providers who conduct VA C&P disability examinations to complete training prior to performing them. DMA staff maintain the certification program for disability examiners.

The required C&P training consists of four interactive web-based training modules titled Disability Examination Management Office (DEMO) General Certification Overview Course, DMA Military Sexual Trauma and Disability Examination Process, DMA Medical Opinions, and DMA Aggravation Opinions. Each module is to take one hour to complete.

VA has placed some additional qualifications on diagnosing physicians who conduct TBI C&P examinations. An initial diagnosis of TBI must be given by one of required physician specialists (a neurologist, a neurosurgeon, a physiatrist (PM&R), or a psychiatrist) unless the patient had a prior diagnosis that was done under conditions acceptable to VA. VA selected these four specialties because these providers have training and experience in diagnosing TBI. The diagnosing provider and the C&P examiner might be different individuals. The diagnosing specialists are not required to complete C&P training in order to diagnose TBI; however, they must complete C&P training if they conduct C&P TBI disability examinations.

If a TBI diagnosis is already in place, the C&P examiner is not required to be one of the required physician specialists or to have any particular expertise with TBI; VHA's only requirement is the completion of the one hour TBI-specific DEMO training module. As noted above, TBI C&P examinations may be conducted by any provider qualified to conduct C&P exams as long as the diagnosis of TBI was made either while in the military or by one of the required physician specialists in either VA or non-VA settings.

American Medical Association Guides

The American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment* (AMA Guides) are widely used to rate disability impairment in non-VA settings in the United States as well as internationally. The latest (sixth) edition is based on the World Health Organization's International Classification of Functioning, Disability, and Health and provides guidance for quantifying impairment, disability, or

[35] Phillip D. Harvey PhD, *Clinical Applications of Neuropsychological Assessment*, Dialogues in Clinical Neuroscience, March 2012, 14 (1): 91–99.
[36] VHA Directive 1046, *Disability Examinations,* April 23, 2014.

loss of function. The AMA Guides were developed to "provide an impairment rating guide that is authoritative, fair, and equitable to all parties."[37] We reviewed these guides for context about how TBI assessment is conducted in non-VA settings.

The AMA Guides highlight the critical importance of clinical context when individualizing testing for patients with TBI: "[d]espite the wide range of available psychological tests, the patient interview, review of records and mental status exam remain the foundation for evaluation of the patient and determination of the impairment rating."[38]

The AMA Guides list neuropsychological testing as a common clinical study for the evaluation of neurological and psychiatric conditions. The AMA Guides call for an examiner who is knowledgeable about such testing and recommend that the examining physician review neuropsychological test results to ensure that the:

- Testing was done by a trained examiner
- Findings are internally consistent
- Tester documented which test materials were reviewed
- Test results were consistent with information in the record
- Patient's pre-morbid baseline level of function was explored and documented
- Appropriate normative data are listed for each test; and the testing contained at least two validity tests[39][40]

Scope and Methodology

We initiated our review January 2015 and completed our work March 2017.

We reviewed TBI-related literature and VA policies, procedures, memoranda, directives, handbooks, and other documents pertinent to our review.

To review the veteran's case, we conducted a site visit July 7–8, 2015 at the VA Montana Health Care System, Fort Harrison Regional Benefit Office, and the Board in Helena, MT. We spoke with staff knowledgeable about the C&P process and/or the veteran's case. In mid-2015, we interviewed the veteran and his/her spouse in Missoula, Montana. We also reviewed documents, electronic health records, and transcripts related to the veteran's case from the DoD; VA Montana Health Care System; Fort Harrison Regional Benefit Office; VBA, Board of Veterans' Appeals; and the Board.

[37] Robert D. Rondinelli, MD, PhD, AMA Guides® to the Evaluation of Permanent Impairment, sixth edition, American Medical Association, 2012.
[38] Ibid.
[39] Validity tests refer to how well a test measures what it is supposed to measure.
[40] Robert D. Rondinelli, MD, PhD, AMA Guides® to the Evaluation of Permanent Impairment, sixth edition, American Medical Association, 2012. p. 351.

To review VA protocols for TBI C&P examinations, we conducted a site visit to Minneapolis VA Health Care System in Minneapolis, MN, on June 18, 2015. While onsite, we interviewed staff knowledgeable in TBI and/or C&P processes including department Chiefs and Staff Members for PM&R; the Acute Inpatient Team; C&P; Extended Care and Rehabilitation Team Members; and Neuropsychology staff.

We telephonically interviewed VBA Quality Assurance Chiefs and Officers; VHA Office of Medical and Disability Assessment staff; Director, VHA PM&R staff; and VA OIG Office of Audits and Evaluations personnel.

To assess the content of the DMA curriculum and training, an OIG physician with expertise in PM&R took the DEMO General Certification Overview Course as well as the DEMO Traumatic Brain Injury (TBI) Examination course in 2016.

We assessed the compliance of the TBI C&P exams performed in 2015 by both VHA personnel and contractors with regard to the requirements about specialists performing the TBI C&P examination unless the diagnosis of TBI had already been made in accordance with VA policy. Because we had access to different data sources (see discussion below) for examinations performed by contractors versus VHA employees, we employed different methodologies to assess each group of providers. We focused on initial TBI exams because if the initial exams were done correctly, review exams should be in compliance with VA policy with regard to who performed the TBI diagnosis.

TBI C&P exams were performed either by VHA staff or by contractors hired by VHA or VBA. VHA and VBA generally contracted with providers who were board certified in at least one of the four specialties to perform the complete examination, whether or not a diagnosis was already in place. To test compliance with VA's requirement, we obtained information directly from the contractors on the board certification of the specialists performing TBI C&P examinations. We validated a convenience sample[41] of providers who performed 90 percent of the contracted TBI C&P examinations in 2015 by matching them to information we obtained from the respective specialty boards. We also verified the board certification status of the contractors identified in our random sample (described below in our paragraph on the review of the administrative data).

We retrieved the set of all 2015 C&P exams available in Corporate Data Warehouse[42] that contained the words "TBI" and "Initial." The specialty of the providers who performed the examinations was determined for this set by matching it with administrative data maintained by the VA. We identified two primary sources of duplicate erroneous entries in the data set. The first was duplication in the type of C&P examination (for example, a veteran who had two different types of TBI examinations that were recorded as being performed at the same time and place). The second was in the specialty assigned to providers (such as a provider who had two or more different

[41] This convenience sample is a non-randomized sample. We chose this convenience sample as we were able to cover a significant portion of the examinations performed by the contractors.
[42] The Corporate Data Warehouse is VA's centralized data repository.

specialties assigned to them). We reconciled and validated the dataset after examination of electronic health records (EHR) as well as the specialty boards listed on relevant web sites.

We used a two-stage approach to identify examinations performed by the appropriate specialist and to identify veterans whose initial TBI C&P examinations were performed by the appropriate specialist in accordance with VA requirements. By looking first for examinations performed by one of the four specialists, we were able to identify those exams where we were certain that the diagnosis was performed in accordance with VA policy (either because the original diagnosis was acceptable to VA, such as one performed by DoD, or because an initial diagnosis was performed during the C&P examination by a required specialist).[43] We could not determine from our review of the available data for the remaining examinations whether they were performed in accordance with VA requirements for both the diagnosis and assessment. We therefore manually reviewed the EHRs of a randomly selected sample of the remaining veterans in order to estimate how many veteran examinations were performed in accordance with requirements. We estimated the percentage of veterans who had their TBI C&P examinations performed in compliance with VA requirements by computing the sample variation to calculate the confidence interval using an appropriate statistical methodology.[44]

We subsequently combined the results from our analysis to produce our estimate of the percentage of TBI C&P veterans who had examinations performed by VHA employees consistent with VA policy.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[43] Those examinations considered consistent with VA policy were those where the examiner was one of the four required specialists or those examinations where a required specialist had previously seen the patient and used a TBI diagnosis code.

44 We used the first several terms of the multivariable Taylor series expansion after applying the logit transformation.

Inspection Results

Issue 1: TBI C&P Protocols

Number of Examinations

We focused our review on all initial 2015 TBI C&P examinations available in the Corporate Data Warehouse.[45] If the initial examinations were performed according to requirements, then review examinations could be performed by any provider who was qualified to perform C&P examinations. We found that these examinations were performed by contractors requested by VHA, contractors requested by VBA, and VHA C&P staff, many of whom were one of the four physician specialists, even though they were not required to be. Contractor examinations were expected to meet the same standards as examinations performed by VHA staff.

Examinations by VHA and VBA Contractors

In 2015, VHA contractors who were one of the four physician specialists completed 5,626 of 5,651 (99.6 percent) initial TBI C&P examinations assigned to them, and VBA contractors completed 7648 of 7650 (99.97 percent) initial TBI C&P examinations assigned to them. See Table 2 for the breakdown of the examining providers by specialty. This means that for close to 100 percent of these veterans, either their diagnosis had been previously performed in accordance with VA requirements, or the diagnosis was made in conjunction with their C&P examination by a required specialist.

Table 2. Initial TBI C&P Examinations by VA Contractor by Specialty in 2015

Examiners	Specialty				Total Specialists	Total Non-Specialists	Percent Non-Specialists
	Neurology	Neurosurgery	PM&R	Psychiatry			
VHA Contractors	2047	131	2683	765	5626	25	0.44 %
VBA Contractors	767	342	1154	5385	7648	2	0.03%
Totals	2814	473	3837	6150	13274	27	0.20%

Source: OIG analysis of VHA DMA data

C&P Examinations Performed by VHA Staff

An additional 17,778 veterans had an initial TBI C&P examination performed by VHA staff in 2015. Of these, we were able to identify that for 10,596 of 17,778 (59.6 percent) veterans, a specialist performed both the diagnosis and assessment in 2015 based on the administrative data we reviewed. From our review of the remaining 7,182 veterans

[45] The Corporate Data Warehouse is VA's centralized data repository.

whose examinations were performed by VHA clinicians who were not one of the four specialists, we estimated that 95.9 percent (95 percent confidence interval: 94.3–97.0 percent) of the TBI examinations done by VHA employees were compliant with VHA requirements (that is, the diagnosis had been performed by a required specialist or otherwise as allowed by VHA policy, and the clinician performing the assessment had been trained consistent with VHA policy).

We noted that when TBI C&P examinations were not done in accordance with VA requirements, they may have been performed in a clinically appropriate manner, and the failure to meet the requirements does not necessarily have a direct correlation to the quality of the assessment. For example, one physician who was not a required specialist documented detailed clinical assessments and also consulted with a neuropsychologist, who performed a full battery of testing. The number of these examinations, if counted as appropriately performed examinations, would not meaningfully change VA's overall compliance with policy. Because the number of non-compliant examinations was relatively small, these clinically appropriate examinations represented a significant minority (20 percent) of the non-compliant examinations in our sample population.

During our review of TBI C&P examinations, we also identified a few instances where required specialists made the diagnosis of TBI for a veteran based on a review of the record without an in-person assessment. This implies that the diagnoses relied on the EHR and could even be based solely on objective data regarding the initial event (veteran lost consciousness for 5 minutes and was dazed for several hours afterwards). The subsequent assessment of the residual effects of the TBI would be made without the benefit of a detailed assessment by the diagnosing specialist and based entirely on the opinion of the TBI C&P examiner who may have minimal training in this area.

Qualifications of VA TBI C&P Examiners

Sufficiency of Examiners' Training The diagnosis of TBI, particularly mTBI, is largely based on the historical record of an event such as the veteran's proximity to an explosion or head trauma with a physical examination consistent with the veteran's history. While VA had requirements for the specialty of the provider who diagnosed TBI, we found no restrictions were placed on the specialty of the provider who conducted the remainder of the TBI examination, which may be the more challenging portion of the assessment.

Assessment of a veteran for the TBI C&P examination can be a complex task. It requires a detailed history, physical examination, and the selection and interpretation of appropriate diagnostic testing. Constructing an appropriate battery of tests may also require the provider to be familiar with the strengths and weaknesses of each method of testing. Providers without TBI or neuropsychological testing experience may not be able to recognize some of the subtle distinctions and manifestations that require more experienced and sophisticated evaluations. Furthermore, the interpretation of findings may need to be individualized to account for factors such as the veteran's age, physical and mental diseases, and medications. Disentangling which symptoms are caused by a

specific diagnosis remains a complex challenge for experienced physicians and neuropsychologists according to VA staff familiar with both TBI and the C&P process.

We found that the level of documentation of examination findings in TBI C&P examinations was insufficient to determine the basis of the assessment of traumatic brain injury. We noted examinations where the assessments used templated language from the DBQ without explanation of how the examiner reached his or her conclusion. During our review of TBI C&P assessments, documented responses had insufficient detail to indicate whether the examiner relied upon veteran self-report, a report from a third party such as a spouse, the examiner's clinical assessment, or the EHR.

Given the complexity of TBI assessment, a one-hour DEMO TBI training module appeared inadequate to train providers to properly conduct C&P exams unless the provider has prior experience assessing and treating TBI. The observed lack of appropriate documentation for clinical findings raises concerns about the ability to properly perform quality assurance and other after-the-fact reviews of the examination process and findings.

Translating Clinical Findings to Disability Ratings When performing TBI C&P evaluations, the examiner must determine if the symptom is caused by TBI, but many TBI symptoms are present in other diseases or disorders, such as PTSD. The TBI algorithm for assigning a rating is unique in that it is based on the highest rating in any single domain of the TBI DBQ. In other words, the rating level assigned will correspond to the highest rating for any single domain, meaning that if one domain is rated "severe", that rating will be the overall disability rating assigned. In contrast, for other conditions with similar symptoms, such as PTSD, the rating algorithm calls for a broader assessment of a veteran's global functioning, and an overall rating is assigned that considers all domain ratings. Although the disability rating is intended to be based on the functional losses experienced by the veteran rather than being dependent on a particular diagnosis, these common symptoms make it difficult to ensure veterans with the same symptoms and disability receive the same rating because the TBI and PTSD algorithms are different.

In other words, two veterans with identical symptoms deriving from a diagnosis of either TBI or PTSD could receive a different disability rating depending on his or her specific diagnosis, with potentially different financial implications.

For example, a 25-year-old veteran on active duty was injured in an explosion that also killed his best friend. He reports difficulties with memory, concentration, judgment, and sleep. He is also experiencing irritability and bouts of verbal and physical aggressiveness.

For symptoms deemed as being caused by TBI, the C&P examiner would assess such a veteran in ten domains (Memory, attention, concentration, executive functions; judgment; social interaction; orientation; motor activity; visual spatial orientation; subjective symptoms; neurobehavioral effects; communication; and consciousness). If

the TBI symptoms primarily impact a single domain out of proportion to the others, the VBA rating specialist is to base the disability rating on that single domain.

The same symptoms can also lead to a diagnosis of PTSD. Under those circumstances, the C&P examiner would assess such a veteran using a different method based on the veteran's overall global functioning rather than a single domain. Since symptoms are typically distributed unevenly across the domains, it is likely that the global assessment will yield a lower disability rating score, potentially leading to different disability benefits.

Issue 2: Montana Board of Psychologists Findings

We were instructed to review a complaint filed with the Board which reprimanded a VA psychologist in Ft. Harrison, MT, for practicing outside the scope of his/her professional qualifications when the psychologist performed a C&P examination for TBI.[46]

The complaint concerned a veteran with a diagnosis of TBI which resulted from proximity to an explosion while serving in the military in 2006. The veteran underwent neuropsychological testing in 2006, 2007, and 2009, that demonstrated persistent findings related to the diagnosed TBI. The 2009 examination documented there appeared to be relative stability of dysfunction in these areas, and 3 years post-injury, the veteran's deficits were likely to be stable and permanent.

The veteran exited the military in 2009; in 2011 (5 years post-injury), the veteran was evaluated by a VA psychologist for TBI and PTSD as part of the C&P process. After clinical interview, review of records (*excluding the 2009 neuropsychological exam which was not available to the VA psychologist at the time*), and performing a neuropsychological assessment called the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), the VA psychologist concluded that the veteran's thinking disorder was mild, if present, and the VA psychologist did not feel further neuropsychological testing was needed because the veteran's symptoms were suggestive of PTSD.

The veteran subsequently filed a complaint with the Board regarding this examination and the conclusions that were used to lower his/her disability rating from 100 to 90 percent.

The Board identified specific deficits in the VA psychologist's assessment. The Board determined that the VA psychologist had not provided testing of a specific category of thinking skills called *executive function* (which was relevant in light of the deficits seen in the veteran's 2006, 2007, and 2009 neuropsychological assessments), and aside from clinical interview, had not tested *judgment and neurobehavioral effects*.

[46] https://www.congress.gov/congressional-record/2014/12/11/house-section/article/h9307-1. Accessed January 25, 2017.

The Board commented that the natural history of TBI is that recovery occurs in the first few years and is commonly considered maximal at 2 years. The Board asserted that based on prior testing and veteran complaints, the VA psychologist should have addressed and evaluated the veteran's executive function. The Board noted the RBANS test selected by the VA psychologist did not have subtests designed to test functional areas relevant to deficits noted in prior assessments of the veteran. Therefore, the Board concluded that VA testing was faulty due to construction.

We spoke with a neuropsychologist, who was not involved in the Board's deliberations or the veteran's evaluation, who agreed that the RBANS test lacks an executive function component.

The Board also disagreed with the VA psychologist's interpretation of the RBANS results and indicated that the VA psychologist concluded the veteran's test scores were within the *average* range; however, the Board neuropsychologists interpreted the attention index score to be in the *low average range* which "is a level of performance commonly viewed as impaired by neuropsychologists."

We spoke with Board members who were involved in this case, and they reported that they had reviewed the VHA training materials for TBI C&P examination and had concerns about the sufficiency of TBI C&P examiner training. Although they declined to detail a specific standard for provider training or an algorithm for the assessment of TBI patients, they stated that the standard should be higher than the information covered by the TBI module.

Conclusions

TBI evaluations are complex determinations that rely significantly on the clinical experience and judgement of the examiner. TBI C&P examinations are among the most complex of the C&P examinations conducted by VA. Our review of a widely-used standard for non-VA experts who conducted TBI examinations for administrative purposes indicated that the quality of the assessment of veterans with TBI relies on the skills and knowledge of the practitioners involved.

Generally, we found evidence that VA practice is consistent with requirements with regard to the specialty and training of the provider conducting the TBI C&P examination. In cases where the TBI examination was not performed by a C&P examiner who was a required specialist, we found that the diagnosis of TBI in most of these examinations was made either while the veteran was in the military or based on a diagnosis by a required specialist.

However, because we found that TBI evaluations are reliant on the clinical skills and judgment of the providers performing them, we had concerns that the training providers received to perform TBI examinations had only basic information about the TBI exam. The required DEMO module on TBI explicitly recommended additional training to further the provider's competency in TBI examination and noted that determination of causation

is a complex issue. Because additional training was not required by VA policy, a provider's only TBI training and experience may have been the one hour DEMO module. Given the complexity of evaluating TBI, we determined that VA training requirements were insufficiently rigorous.

We recognized that VA required certain specialists to make the diagnosis of TBI to raise the quality of these examinations. However, this requirement for TBI C&P examination only applies to the diagnosis of TBI and not to the evaluation of the impact of TBI and other factors on a veteran's cognitive performance. Apportioning the impact of TBI and other diagnoses with similar symptoms such as PTSD is often challenging. The requirement results in the need for a required specialist to make the diagnosis, while allowing examiners with considerably less training or experience with cognitive and psychiatric symptoms to evaluate the impact of these symptoms for disability evaluation purposes.

We found that the level of documentation of examination findings in TBI C&P examinations was insufficient to determine how testing was done, if testing was done, or if detail was sufficient to detect problems. This lack of detail could be problematic from the perspective of quality assurance and in cases where the rating decision is appealed.

Under the current system of assigning disability ratings, the assignment of causation of symptoms may significantly impact a veteran's rating. VBA uses different rules (or facets) to convert the clinical findings on examination into a percentage rating depending upon the diagnosis which underlies the findings. Veterans with identical symptoms and functional limitations might end up with different ratings based on their diagnosis and how causation was assigned. For example, the rules for converting TBI findings base the rating on the highest score in any domain versus PTSD, where a more global assessment is used.

Assigning disability ratings based on symptoms and clinical findings without regard to the specific diagnosis would avoid such dissimilarities in ratings, and the potential for a disparate financial impact upon the veteran. The emphasis should more properly be placed upon the determination of the impact of these disabilities upon the veteran, irrespective of the cause. An evaluation that determines the impact of cognitive symptoms for disability purposes should not rely upon, for example, one rating pathway for TBI and a different pathway for PTSD, with two different potential outcomes. Using two distinct pathways may result in different disability ratings for a veteran with cognitive symptoms that could be caused by either or both conditions, and this potentially could have a negative financial impact on the veteran.

Recommendation

We recommended that the Executive in Charge, Office of the Under Secretary for Health and Acting Under Secretary for Benefits convene experts to develop a plan to:

1. Ensure that personnel performing the traumatic brain injury Compensation and Pension examination have comprehensive training on the evaluation of traumatic brain injury, including the assessment and evaluation of cognitive disorders.
2. Develop requirements for documentation of the traumatic brain injury Compensation and Pension examination process, including the basis for determinations of cognitive impairment and other residuals of traumatic brain injury.
3. Consider whether to provide disability ratings to veterans with claims arising from cognitive issues based upon their clinical signs and symptoms, not primarily based upon the diagnosis or cause of their cognitive deficits (that is. traumatic brain injury or post-traumatic stress disorder).

Appendix A

Prior OIG Reports March 31, 2014–February 1, 2017

Relevant Prior Reports

Review of Alleged Manipulation of Quality Review Results at VA Regional Office San Diego, CA
May 9, 2016 | 15-02376-239

Inspection of VA Regional Office Montgomery, AL
April 11, 2016 | 15-04987-198

Inspection of the VA Regional Office in Manila, Philippines
February17, 2016 | 15-05024-97

Inspection of the VA Regional Office Oakland, California
February 11, 2016 | 15-05023-112

Inspection of VA Regional Office Little Rock, Arkansas
February 2, 2016 | 15-04983-86

Healthcare Inspection – Poor Follow-Up Care and Incomplete Assessment of Disability, VA San Diego Healthcare System San Diego, California
January 5, 2016 | 15-00827-68

Inspection of VA Regional Office Hartford, CT
December 15, 2015 | 15-04986-42

Inspection of VA Regional Office Los Angeles, California
September 30, 2015 | 15-01110-493

Inspection of VA Regional Office Phoenix, Arizona
September 17, 2015 | 15-01381-437

Inspection of VA Regional Office Honolulu, Hawaii
September 17, 2015 | 15-01996-503

Inspection of VA Regional Office Sioux Falls, South Dakota
September 15, 2015 | 15-01860-502

Inspection of VA Regional Office San Diego, California
September 9. 2015 | 15-00399-410

Inspection of VA Regional Office Fort Harrison, Montana
September 9, 2015 | 15-02706-485

Inspection of VA Regional Office Lincoln, Nebraska
September 8, 2015 | 15-02614-434

Inspection of VA Regional Office, Winston-Salem, North Carolina
August 26, 2015 | 15-00452-411

Inspection of VA Regional Office Wichita, Kansas
August 26, 2015 | 15-01290-435

Inspection of VA Regional Office St. Petersburg, Florida
August 25. 2015 | 15-00001-436

Inspection of VA Regional Office Cleveland, Ohio
July 30, 2015 | 14-04983-412

Inspection of VA Regional Office Louisville, Kentucky
July 28, 2015 | 15-01193-433

Healthcare Inspection – Quality of Care Issues, Sheridan VA Healthcare System, Sheridan, Wyoming
July 14, 2015 | 14-00903-422

Inspection of VA Regional Office Pittsburgh, Pennsylvania
May 20, 2015 | 14-04878-205

Inspection of VA Regional Office Indianapolis, Indiana
May 19, 2015 | 14-04876-204

Inspection of VA Regional Office Manchester, New Hampshire
March 26, 2015 | 14-04623-120

Inspection of VA Regional Office Fargo, North Dakota
March 26, 2015 | 14-04622-150

Inspection of the VA Regional Office Boston, Massachusetts
February 24, 2015 | 14-02689-122

Review of Allegations Regarding the Technical Acquisition Center's Award of Sole-Source Contracts to Tridec for the Virtual Office of Acquisition
December 8, 2014 | 12-02387-59

Inspection of VA Regional Office Huntington, West Virginia
November 17, 2014 | 14-02101-09

Inspection of VA Regional Office Providence, Rhode Island
November 13, 2014 | 13-03221-08

Inspection of VA Regional Office Buffalo, New York
November 10, 2014 | 14-02577-07

Inspection of VA Regional Office Portland, Oregon
October 8, 2014 | 14-02100-271

Inspection of VA Regional Office Salt Lake City, Utah
October 8, 2014 | 14-01688-303

Inspection of VA Regional Office White River Junction, Vermont
September 30, 2014 | 14-02889-310

Inspection of VA Regional Office Chicago, Illinois
September 25, 2014 | 14-02357-270

Inspection of VA Regional Office Seattle, Washington
September 24, 2014 | 14-01502-259

Inspection of VA Regional Office Des Moines, Iowa
August 7, 2014 | 14-01501-229

Inspection of VA Regional Office Columbia, South Carolina
August 7, 2014 | 14-01253-208

Inspection of VA Regional Office Atlanta, Georgia
August 5, 2014 | 14-00902-207

Inspection of VA Regional Office St. Louis, Missouri
July 24, 2014 | 14-01497-188

Inspection of the VA Regional Office New Orleans, LA
July 10, 2014 | 14-01053-172

Inspection of VA Regional Office New York, NY
June 24, 2014 | 14-00383-171

Inspection of the VA Regional Office, Reno, Nevada
June 10, 2014 | 13-04324-170

Review of the Lease Awarded to Westar Development Company, LLC for the Butler, Pennsylvania Health Care Center
March 31, 2014 | 13-02697-113

OIG reports are available on our web site at **www.va.gov/oig**.

Appendix B

Table 3: Examples of Neuropsychological Tests by Cognitive Domain

Domain	Test
Intelligence	Weschler Adult Intelligence Scale-Revised (WAIS-R)
	National Adult Reading Test
Verbal Learning and Memory	Wechsler Memory Scale-Revised (WMS-R)
	Selective Reminding Test
	Fuld Object Memory Test
	Rey Auditory Verbal Learning Test
Non-Verbal Learning and Memory	Visual Reproduction Subscale of Wechsler Memory Scale
	Benton Visual Retention Test
	Rey-Osterrieth Complex Figure Test
	Delayed Recognition Span Test
Executive Function	Trail Making Test
	Ravens Progressive Matrices
	Wisconsin Card Sorting Test
	Stroop Color-Word Interference Test
	WAIS-R Similarities Test
	Gorham Proverb Interpretation Test
Language	Aphasia Screening Battery
	Halstead-Wepman Aphasia Screening Test
	Confrontation Naming
	Boston Naming Test
	Verbal Fluency
Visuospatial Abilities	WAIS-R Performance Subtests
	Clock Drawing Test
Sustained Attention	Digit Spin from WAIS-R
	Attention Concentration Index from WMS-R
	Continuous Performance Test
Clinical Batteries	Halstead-Reitan Neuropsychological Battery
	Luria-Nebraska Neuropsychological Battery*
Cognitive Screening Tools	Mini-Mental State Exam
	Montreal Cognitive Assessment (MoCA)†**
	Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)†

Source: Reformatted and excerpted from the Cognitive and Emotional Health Project: The Healthy Brain, List of Cognitive Measures, retrieved from National Institutes of Health Website on May 21, 2016.

†Added to source table by OIG†
*Cognitive and Emotional Health Project: *The Healthy Brain, List of Cognitive Measures*, National Institutes of Health Website, http://trans.nih.gov/CEHP/hbpcog-list.htm. Accessed May 21, 2016
**http://www.mocatest.org/. Accessed May 21, 2016.

Appendix C

Executive in Charge
Office of the Under Secretary for Health
Comments

Department of Veterans Affairs

Memorandum

Date: DEC 14 2017

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: Revised OIG Draft Report, Healthcare Inspection, Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for Traumatic Brain Injury Compensation and Pension Examinations (VAIQ 7842330)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report, Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for Traumatic Brain Injury Compensation and Pension Examinations.

2. The Veterans Health Administration (VHA) concurs with recommendations 1 and 2 and provides the attached action plan. Additionally, VHA provides comments below to enhance clarity throughout the report.

3. VHA finds the 5th paragraph on page i of the Executive Summary describing VA's Compensation ad Pension (C&P) process lacks some significant details. The OIG states "For veterans with a previous diagnosis made in accordance with VA policy, the C&P examination can be performed by any clinician certified to do so via a program established by Office of Disability and Medical Assessment (DMA), regardless of specialty." Exams can only be performed by C&P examiners who have completed the DMA certification course as well as taken and passed the Traumatic Brain Injury (TBI) examination training module established by DMA, regardless of specialty. Diagnosing specialists already have professional training and expertise that exceeds the information contained in a 1 hour module.

4. Additionally, VHA finds the 1st paragraph on page ii of the Executive Summary describing VHA's use of contract examiners incorrect and outdated. As of October 1, 2016, VHA no longer uses contract examiners.

5. In the Background section on page 10 (4th paragraph, 1st sentence), VHA finds that the phrase "…additional qualifications" has the potential to cause confusion. VHA offers the alternative phrase, "additional stipulation on who can diagnosis TBI within VHA."

6. Lastly, in the final paragraph on page 10, VHA finds that the first sentence lacks a significant point. The draft report states that VHA's only requirement is the completion of the one hour TBI-specific Disability Examination Management Office (DEMO) training module, however VHA requires completion of the DMA certification and taking and passing the one hour TBI-specific DEMO training.

7. VHA is pleased to announce that we have already established a partnership with experts from the National Academies of Sciences, Engineering, and Medicine to improve Traumatic Brain Injury exam assessments for Veterans and Servicemembers filing disability claims. Congressional support for this effort is outlined in Public Law 114-315. Goals of the partnership are to improve the tools and protocols used by the Department of Veterans Affairs, improve exam documentation, and make recommendations about the credentials necessary for health care specialists to perform needed evaluations.

8. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

Carolyn M. Clancy, M.D.

Attachment

Comments to OIG's Report

The following Under Secretary for Health comments are submitted in response to the recommendations in the OIG report:

OIG Recommendation

We recommended that the Under Secretary for Health and Acting Under Secretary for Benefits establish an expert panel to develop a plan to:

1) Ensure that personnel performing the traumatic brain injury Compensation and Pension examination have comprehensive training on the evaluation of traumatic brain injury, including the assessment and evaluation of cognitive disorders.
2) Consider whether to provide disability ratings to veterans with claims arising from cognitive issues based upon their clinical signs and symptoms, not primarily based upon the diagnosis or cause of their cognitive deficits (that is. traumatic brain injury or post-traumatic stress disorder).
3) Develop requirements for documentation of the traumatic brain injury Compensation and Pension examination process, including the basis for determinations of cognitive impairment and other residuals of traumatic brain injury

OIG Comment: For operational purposes, the Under Secretary for Health and Acting Under Secretary for Benefits addressed OIG's 3-part recommendation as 3 separate recommendations.

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report: Healthcare Inspection, Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for Traumatic Brain Injury Compensation and Pension Examinations

Date of Draft Report: November 21, 2017

Recommendations **Status** **Completion Date**

Actions

Recommendation 1: We recommended that the Executive in Charge, Office of the Under Secretary for Health convene experts to develop a plan to ensure that personnel performing the TBI C&P examination have comprehensive training on the evaluation of TBI, including the assessment and evaluation of cognitive disorders.

VHA Comments: Concur.

The VHA Office of Disability and Medical Assessment will convene experts to develop a plan to ensure that personnel performing the traumatic brain injury (TBI) Compensation and Pension examinations have comprehensive training on the evaluation of TBI, including the assessment and evaluation of cognitive disorders.

This work has begun under Public Law 114-315 requiring VHA to partner with National Academies of Sciences, Engineering and Medicine (NAS) to review the process by which impairments that result from TBI, for purposes of awarding disability compensation, are assessed.

The NAS and VHA have met face to face and via conference calls, and have reviewed and edited a draft statement of work. The VA provided the NAS with a listing of subject matter experts to work alongside NAS during their review.

VHA will provide the following documentation at completion of this action:

- List of group membership
- Initial meeting notes

Status: In Process Target Completion Date: March 2018

Recommendation 2: We recommended that the Executive in Charge, Office of the Under Secretary for Health convene experts to develop a plan to develop requirements for documentation of the TBI C&P examination process, including the basis for determinations of cognitive impairment and other residuals of TBI.

VHA Comments: Concur.

The VHA Office of Disability and Medical Assessment will convene experts to develop a plan to develop requirements for documentation of the traumatic brain (TBI) injury Compensation and Pension examination process, including the basis for determinations of cognitive impairment and other residuals of TBI.

This work has begun under Public Law 114-315 requiring VHA to partner with National Academies of Sciences, Engineering and Medicine (NAS) to review the process by which impairments that result from TBI, for purposes of awarding disability compensation, are assessed.

The NAS and VHA have met face to face and via conference calls, and have reviewed and edited a draft statement of work. The VA provided the NAS with a listing of subject matter experts to work alongside NAS during their review.

VHA will provide the following documentation at completion of this action:

- List of group membership
- Initial meeting notes

Status: In Process Target Completion Date: March 2018

Appendix D

Acting Under Secretary for Benefits Comments

Department of Veterans Affairs **MEMORANDUM**

Date: DEC 19 2017

From: Under Secretary for Benefits (20)

Subj: OIG Draft Report – Healthcare Inspection: Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for Traumatic Brain Injury Compensation and Pension Examinations – VAIQ 7828658

To: Assistant Inspector General for Healthcare Inspections (54)
Director, National Projects Office of Healthcare Inspections (54NR)

1. Attached is VBA's response to the OIG Revised Draft Report – Healthcare Inspection: Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for Traumatic Brain Injury Compensation and Pension Examinations.

2. Questions may be referred to Christine Ras, Program Analyst, at 461-9057.

Thomas J. Murphy
Acting

Attachment

cc: Acting Under Secretary for Health (10N)
Director, VHA Management Review Services (VHA 10E1D MRS Action)

Veterans Benefits Administration (VBA)

Action Plan

OIG Draft Report: Healthcare Inspection, Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for Traumatic Brain Injury Compensation and Pension Examinations

Date of Draft Report: November 21, 2017

Recommendations	Status	Completion Date

Actions

Recommendation 1: We recommended that the Under Secretary for Health and Acting Under Secretary for Benefits ensure that personnel performing the traumatic brain injury Compensation and Pension examination have comprehensive training on the evaluation of traumatic brain injury, including the assessment and evaluation of cognitive disorders.

VBA Response: The Veterans Benefits Administration (VBA) defers to the Veterans Health Administration (VHA) for response to this recommendation.

Recommendation 2: We recommended that the Under Secretary for Health and Acting Under Secretary for Benefits develop requirements for documentation of the traumatic brain injury Compensation and Pension examination process, including the basis for determinations of cognitive impairment and other residuals of traumatic brain injury.

VBA Response: VBA defers to VHA for response to this recommendation.

Recommendation 3: We recommended that the Under Secretary for Health and Acting Under Secretary for Benefits consider whether to provide disability ratings to veterans with claims arising from cognitive issues based upon their clinical signs and symptoms, not primarily based upon the diagnosis or cause of their cognitive deficits (that is. traumatic brain injury or post-traumatic stress disorder).

VBA Response: Concur in principle.

VBA's Compensation Service will consult with VA's Advisory Committee on Disability Compensation (ACDC), and relevant VHA personnel as appropriate, to evaluate whether to provide disability ratings to Veterans with claims arising from cognitive issues based upon their clinical signs and symptoms, not primarily based upon the diagnosis or cause of their cognitive deficits (that is, traumatic brain injury or post-traumatic stress disorder). This discussion will take place in the second quarter of fiscal year 2018. The purpose of the ACDC is to provide advice to the Secretary of Veterans

Affairs on establishing and supervising a schedule to conduct periodic reviews of the VA Schedule for Rating Disabilities.

Target Completion Date: March 31, 2018

VBA provides the following technical comments:

Executive Summary, Page i, Paragraph 1, Lines 7-9:

> "…2) review the protocols VA uses for examinations for TBI throughout the Veterans Health Administration (VHA) to determine if VA needs to revise its protocols nationwide."

VBA Comment: VBA recommends that OIG also discuss contract examinations here as traumatic brain injury (TBI) exams are conducted by both VHA and contract examiners. VBA recommends the sentence be revised as follows:

> "…2) review the protocols VA uses for examinations for TBI throughout the Veterans Health Administration (VHA) and examination contracts to determine if VA needs to revise its protocols nationwide."

Executive Summary, Page i, Paragraph 4, Lines 4-8:

> "If a veteran does not have a diagnosis of TBI as of the application for disability benefits, VA requires a diagnosis by one of the following four physician specialists (referred to in this report as "a required specialist"): neurologist, neurosurgeon, physiatrist (physical medicine and rehabilitation (PM&R)) or psychiatrist."

VBA Comment: There is nothing in VA statute, regulation, or policy that requires a diagnosis by a particular physician specialist to warrant service connection for disability compensation. Rather, internal VHA policy requires that one of four physician specialists provide an initial diagnosis of TBI. VBA contract examinations for initial TBI examinations also follow this policy, as VBA contract examination policies, related to appropriate clinical qualifications and specialties, mirror VHA C&P policies. VBA recommends the sentence be revised as follows:

> "If a Veteran does not have a diagnosis of TBI, as of the application for disability benefits, VBA may request a C&P examination to determine a diagnosis. In cases where the diagnosis is not already established, VHA policy requires a diagnosis by one of the following four physician specialists (referred to in this report as "a required specialist"): neurologist, neurosurgeon, physiatrist (physical medicine and rehabilitation (PM&R)) or psychiatrist."

Executive Summary, Page i, Paragraph 5, Lines 1-4:

> "For veterans with a previous diagnosis made in accordance with VA policy, the C & P examination can be performed by any clinician certified to do so via a

> program established by Office of Disability and Medical Assessment (DMA), regardless of specialty."

VBA Comment: As discussed above, there is no VBA policy requiring a diagnosis from a particular specialist. Additionally, the policy regarding non-specialists performing a TBI review examination is a VHA policy. VBA recommends the sentence be revised as follows:

> "For Veterans whose diagnosis of TBI is already established, VHA policy provides that the C&P examination can be performed by any clinician certified to do so via a program established by Office of Disability and Medical Assessment (DMA), regardless of specialty."

Executive Summary, Page i, Paragraph 4 through Page ii, Paragraph 2:

> "The process for determining a veteran's eligibility for disability benefits based on TBI involves several steps, the first of which is a TBI diagnosis. For many veterans, the TBI diagnosis will occur at the time of their injury during active service, and VA policy is to accept that diagnosis for purposes of determining eligibility for disability benefits. If a veteran does not have a diagnosis of TBI as of the application for disability benefits, VA requires a diagnosis by one of the following four physician specialists (referred to in this report as "a required specialist"): neurologist, neurosurgeon, physiatrist (physical medicine and rehabilitation (PM&R)) or psychiatrist.
>
> For veterans with a previous diagnosis made in accordance with VA policy, the C & P examination can be performed by any clinician certified to do so via a program established by Office of Disability and Medical Assessment (DMA), regardless of specialty. This certification process includes completion of a TBI examination-training module, which is a one-hour training course. The examination can also be completed by the required specialist who provided the diagnosis for the first part of the examination process.
>
> VBA can also send the TBI disability examination to an outside contractor (the majority of whom are one of the four physician specialists, in the event a diagnosis is needed), or it can send the examination request to VHA. VHA can then choose to have the examination performed by members of its medical staff (which includes physician specialists), or can refer the examination to its contractors. A significant factor in selecting the provider who will perform the examination is a determination by the VBA employee processing the application about which path will be fastest based on available resources and work flow at the time."

VBA Comment: In addition to the VBA technical comments provided above, VBA notes that the disability compensation process, to include the C&P examination process, is not

accurately described in these three paragraphs. Veterans apply for disability compensation benefits by submitting an application to VBA. If VBA determines that a C&P examination is needed to establish benefits, it will request a C&P examination from either VHA or a VBA contract examination vendor, depending on availability and capacity. In the case of an initial TBI claim, a C&P examination may be necessary to establish some or all of the following: (1) a diagnosis of TBI; (2) the origin of the TBI; and/or (3) the severity of the TBI (for assigning the appropriate disability evaluation). In cases where a Veteran is requesting an increased evaluation for his or her previously service-connected TBI, a review TBI examination will be requested to evaluate the severity of the TBI.

Executive Summary, Page iii, Paragraph 5 through Page iv, Paragraph 1:

> "Another significant challenge to TBI assessment is the requirement that the examiner assess the presence of neurobehavioral symptoms which may also be a result of conditions such as post-traumatic stress disorder (PTSD), depression, and other mood or anxiety disorders. Under the current system of assigning disability ratings, the assignment of causation of symptoms by the TBI examiner may significantly impact a veteran's rating. VBA converts the clinical findings on examination into a percentage rating depending upon the diagnosis causing the findings. Veterans with identical symptoms and functional limitations might end up with different ratings based on how causation was determined and assigned by the examiner. For example, the rules for converting TBI findings base the rating on the highest score in any domain in contrast to PTSD where a more global assessment is used."

VBA Comment: This paragraph appears to imply that an eligible Veteran would be rated either for TBI residuals or for PTSD alone. However, if an examiner diagnoses a Veteran with a mental disorder as well as residuals of TBI, separate evaluations would be warranted if the manifestations could be clearly differentiated.

As noted in the draft report, the criteria for assigning a disability evaluation are different for these disorders. TBI is rated based on cognitive impairment and other residuals, and PTSD is rated based on occupational and social impairment. However, this is appropriate and is in accordance with the Schedule for Rating Disabilities (Title 38 Code of Federal Regulations (CFR) Part 4) under the tables, "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" and the "General Rating Formula for Mental Disorders."

Page 1, Paragraph 1, Lines 7-9:

> "…2) review the protocols VA uses for examinations for TBI throughout the Veterans Health Administration (VHA) to determine if VA needs to revise its protocols nationwide."

VBA Comment: VBA recommends that OIG also discuss contract examinations here as TBI exams are conducted by both VHA and contract examiners. VBA recommends the sentence be revised as follows:

> "…2) review the protocols VA uses for examinations for TBI throughout the Veterans Health Administration (VHA) and examination contracts to determine if VA needs to revise its protocols nationwide."

Page 10, Paragraph 4, Lines 1-5:

> "VA has placed some additional qualifications on diagnosing physician who conduct TBI C&P examinations. An initial diagnosis of TBI must be given by one of required physician specialists (a neurologist, a neurosurgeon, a physiatrist (PM&R), or a psychiatrist) unless the patient had a prior diagnosis that was done under conditions acceptable to VA."

VBA Comment: There is nothing in VA statute, regulation, or policy that requires a diagnosis by a particular physician specialist to warrant service connection for disability compensation. Rather, internal VHA policy requires that one of four physician specialists provide an initial diagnosis of TBI. VBA contract examinations for initial TBI examinations also follow this policy, as VBA contract examination policies, related to appropriate clinical qualifications and specialties, mirror VHA C&P policies. As drafted, this statement implies there is one "set of conditions" acceptable to VA. Actually, VBA applies a legal standard that does not require a diagnosis by one of the four required physician specialists. VBA recommends the sentence be revised as follows:

> "VHA has placed some additional qualifications on diagnosing physician who conduct TBI C&P examinations. As noted above, in cases where a diagnosis is not already established and VBA requests a C&P examination of a Veteran, in part for diagnostic purposes, VHA policy requires a diagnosis by one of four physician specialists (a neurologist, a neurosurgeon, a physiatrist (PM&R), or a psychiatrist)."

Page 12, Paragraph 5, Lines 1-4:

> "We assessed the compliance of the TBI C&P exams performed in 2015 by both VHA personnel and contractors with regard to the requirements about specialists performing the TBI C&P examination unless the diagnosis of TBI had already been made in accordance with VA policy."

VBA Comment: There is nothing in VA statute, regulation, or policy that requires a diagnosis by a particular physician specialist to warrant service connection for disability compensation. Rather, internal VHA policy requires that an initial diagnosis of TBI be provided by one of four physician specialists. VBA contract examinations for initial TBI examinations also follow this policy as VBA contract examination policies related to appropriate clinical qualifications and specialties mirror VHA C&P policies. VBA recommends the sentence be revised as follows:

> "We assessed the compliance of the TBI C&P exams performed in 2015 by both VHA personnel and contractors with regard to the requirements about specialists performing the TBI C&P examination unless the diagnosis of TBI was already established."

Page 12, Paragraph 6, Lines 4-6:

> "To test compliance with VA's requirement, we obtained information directly from the contractors on the board certification of the specialists performing TBI C&P examinations."

VBA Comment: There is nothing in VA statute, regulation, or policy that requires a diagnosis by a particular physician specialist to warrant service connection for disability compensation. Rather, internal VHA policy requires that an initial diagnosis of TBI be provided by one of four physician specialists. VBA contract examinations for initial TBI examinations also follow this policy as VBA contract examination policies related to appropriate clinical qualifications and specialties mirror VHA C&P policies. VBA recommends the sentence be revised as follows:

> "To test compliance with VHA's examination policy, we obtained information directly from the contractors on the board certification of the specialists performing TBI C&P examinations."

Page 13, Paragraph 2, Lines 3-10:

> "By looking first for examinations performed by one of the four specialists, we were able to identify those exams where we were certain that the diagnosis was performed in accordance with VA policy (either because the original diagnosis was acceptable to VA, such as one performed by DoD, or because an initial diagnosis was performed during the C&P examination by a required specialist). We could not determine from our review of the available data for the remaining examinations whether they were performed in accordance with VA requirements for both the diagnosis and assessment."

VBA Comment: There is nothing in VA statute, regulation, or policy that requires a diagnosis by a particular physician specialist to warrant service connection for disability compensation. Rather, internal VHA policy requires that an initial diagnosis of TBI be provided by one of four physician specialists. VBA contract examinations for initial TBI examinations also follow this policy as VBA contract examination policies related to appropriate clinical qualifications and specialties mirror VHA C&P policies. VBA recommends the sentence be revised as follows:

> "By looking first for examinations performed by one of the four specialists, we were able to identify those exams where we were certain that the diagnosis was performed in accordance with VHA policy (either because the original diagnosis was acceptable to VA, such as one performed by DoD, or because an initial diagnosis was performed during the C&P examination by a required specialist).

> We could not determine, from our review of the available data for the remaining examinations, whether they were performed in accordance with VHA requirements for both the diagnosis and assessment."

Page 14, Paragraph 2, Lines 5-8:

> "This means that for close to 100 percent of these veterans, either their diagnosis had been previously performed in accordance with VA requirements, or the diagnosis was performed in conjunction with their C&P examination by a required specialist."

VBA Comment: There is nothing in VA statute, regulation, or policy that requires a diagnosis by a particular physician specialist to warrant service connection for disability compensation. Rather, internal VHA policy requires that an initial diagnosis of TBI be provided by one of four physician specialists. VBA contract examinations for initial TBI examinations also follow this policy as VBA contract examination policies related to appropriate clinical qualifications and specialties mirror VHA C&P policies. VBA recommends the sentence be revised as follows:

> "This means that for close to 100 percent of these veterans, either their diagnosis had been previously performed in accordance with VHA requirements, or the diagnosis was performed in conjunction with their C&P examination by a required specialist."

Page 16, Paragraph 5, Lines 1-3:

> "In other words, a veteran with identical symptoms which could derive from a diagnosis of either TBI or PTSD could receive a different disability rating depending on his or her specific diagnosis, with potentially different financial implications."

VBA Comment: This statement appears to imply that an eligible Veteran would be rated either for TBI residuals or for PTSD alone. However, if an examiner diagnoses a Veteran with a mental disorder as well as residuals of TBI, separate evaluations would be warranted if the manifestations could be clearly differentiated.

As was noted in the draft report, the criteria for assigning disability evaluations are different for these disorders: TBI is rated based on cognitive impairment and other residuals, and PTSD is rated based on occupational and social impairment. However, this is appropriate and is in accordance with the Schedule for Rating Disabilities (Title 38 CFR Part 4) under the tables, "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" and the "General Rating Formula for Mental Disorders."

Page 17, Paragraph 2, Lines 4-6:

> "Since symptoms are typically distributed unevenly across the domains, it is likely that the global assessment will yield a lower disability rating score, potentially leading to different disability benefits."

VBA Comment: This statement seems to imply that a Veteran with identical symptoms (and presumably identical functional impairment) would receive a different disability rating because the most severe symptom would be more heavily weighted when evaluating based on TBI than on a mental disorder such as PTSD. However, VA's Schedule for Rating Disabilities assigns a percentage evaluation based on average impairment in earning capacity. The intent behind this structure is to evaluate similar levels of functional impairment across a variety of diseases and conditions at a similar percentage. Furthermore, under 38 CFR 4.7, VBA must consider assigning a higher evaluation if a disability picture more nearly approximates the criteria required for that rating. Thus, even when a more global assessment is used to evaluate the disability, individual symptoms that represent a more severe disability picture, may be the basis for a higher disability rating.

Appendix A, Pages 21 through 23:

> **Review of Alleged Manipulation of Quality Review Results at VA Regional Office San Diego, CA**
> *May 9, 2016 | 15-02376-239*
> **Inspection of VA Regional Office Montgomery, AL**
> *April 11, 2016 | 15-04987-198*
> **Inspection of the VA Regional Office in Manila, Philippines**
> *February17, 2016 | 15-05024-97*
> **Inspection of the VA Regional Office Oakland, California**
> *February 11, 2016 | 15-05023-112*
> **Inspection of VA Regional Office Little Rock, Arkansas**
> *February 2, 2016 | 15-04983-86*
> **Inspection of VA Regional Office Hartford, CT**
> *December 15, 2015 | 15-04986-42*
> **Inspection of VA Regional Office Los Angeles, California**
> *September 30, 2015 | 15-01110-493*
> **Inspection of VA Regional Office Phoenix, Arizona**
> *September 17, 2015 | 15-01381-437*
> **Inspection of VA Regional Office Honolulu, Hawaii**
> *September 17, 2015 | 15-01996-503*
> **Inspection of VA Regional Office Sioux Falls, South Dakota**
> *September 15, 2015 | 15-01860-502*
> **Inspection of VA Regional Office San Diego, California**
> *September 9. 2015 | 15-00399-410*
> **Inspection of VA Regional Office Fort Harrison, Montana**
> *September 9, 2015 | 15-02706-485*
> **Inspection of VA Regional Office Lincoln, Nebraska**
> *September 8, 2015 | 15-02614-434*

Inspection of VA Regional Office, Winston-Salem, North Carolina
August 26, 2015 | 15-00452-411
Inspection of VA Regional Office Wichita, Kansas
August 26, 2015 | 15-01290-435
Inspection of VA Regional Office St. Petersburg, Florida
August 25. 2015 | 15-00001-436
Inspection of VA Regional Office Cleveland, Ohio
July 30, 2015 | 14-04983-412
Inspection of VA Regional Office Louisville, Kentucky
July 28, 2015 | 15-01193-433
Inspection of VA Regional Office Pittsburgh, Pennsylvania
May 20, 2015 | 14-04878-205
Inspection of VA Regional Office Indianapolis, Indiana
May 19, 2015 | 14-04876-204
Inspection of VA Regional Office Manchester, New Hampshire
March 26, 2015 | 14-04623-120
Inspection of VA Regional Office Fargo, North Dakota
March 26, 2015 | 14-04622-150
Inspection of the VA Regional Office Boston, Massachusetts
February 24, 2015 | 14-02689-122
Inspection of VA Regional Office Huntington, West Virginia
November 17, 2014 | 14-02101-09
Inspection of VA Regional Office Providence, Rhode Island
November 13, 2014 | 13-03221-08
Inspection of VA Regional Office Buffalo, New York
November 10, 2014 | 14-02577-07
Inspection of VA Regional Office Portland, Oregon
October 8, 2014 | 14-02100-271
Inspection of VA Regional Office Salt Lake City, Utah
October 8, 2014 | 14-01688-303
Inspection of VA Regional Office White River Junction, Vermont
September 30, 2014 | 14-02889-310
Inspection of VA Regional Office Chicago, Illinois
September 25, 2014 | 14-02357-270
Inspection of VA Regional Office Seattle, Washington
September 24, 2014 | 14-01502-259
Inspection of VA Regional Office Des Moines, Iowa
August 7, 2014 | 14-01501-229
Inspection of VA Regional Office Columbia, South Carolina
August 7, 2014 | 14-01253-208
Inspection of VA Regional Office Atlanta, Georgia
August 5, 2014 | 14-00902-207
Inspection of VA Regional Office St. Louis, Missouri
July 24, 2014 | 14-01497-188
Inspection of the VA Regional Office New Orleans, LA
July 10, 2014 | 14-01053-172

Inspection of VA Regional Office New York, NY
June 24, 2014 | 14-00383-171
Inspection of the VA Regional Office, Reno, Nevada
June 10, 2014 | 13-04324-170

VBA Comment: VBA disagrees with the inclusion of the above listed OIG benefit inspection reports in Appendix A. According to OIG's website, the benefit inspection reports "focus on claims processing and Veterans Service Center operations." As such, any OIG focus on TBI claims in a benefit inspection report would be related to whether the claim was appropriately developed and rated, and not whether the training and credentialing of a C&P examiner was appropriate. VBA requests the above listed OIG benefit inspection reports be deleted from Appendix A.

Appendix E

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Terri Julian, Ph. D Sami O'Neill, MA Susan Tostenrude, MS Robert Yang, M.D., MHA
Other Contributors	Limin X. Clegg, Ph.D Kathy Gudgell, RN ,JD Chip Harvey, MS Sandra Parsons Jason Reyes Victor Rhee Natalie Sadow, MBA Barbara Wright, JD Jarvis Yu, MS

Appendix F

Report Distribution

VA Distribution

Office of the Secretary
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Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
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Senate Committee on Homeland Security and Governmental Affairs
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This report is available on our web site at **www.va.gov/oig**.