APPENDIX C TO PART 4—ALPHABETICAL INDEX OF DISABILITIES—Continued

	Diagnostic code No.
* * * * * * *	
Septum, nasal, deviation of	6220
* * * * * * *	
Sleep apnea syndromes	6847
* * * * * * *	
Vocal cord paralysis	6236
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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AQ82

Schedule for Rating Disabilities: Mental Disorders

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend the portion of the rating schedule dealing with mental disorders, including revising the General Rating Formula for Mental Disorders and combining currently separate General Rating Formula for Mental Disorders with the General Rating Formula for Eating Disorders in the VA Schedule for Rating Disabilities (VASRD or rating schedule). The proposed rule reflects changes made by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders 5 (DSM–5), advances in medical knowledge, and recommendations from VA's Mental Disorders Work Group.

DATES: VA must receive comments on or before April 18, 2022.

ADDRESSES: Comments may be submitted through *www.Regulations.gov.* Comments received will be available at *www.Regulations.gov* for public viewing, inspection or copies.

FOR FURTHER INFORMATION CONTACT: Ioulia Vvedenskaya, M.D., M.B.A., Medical Officer, Regulations Staff, (210A), Compensation Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, *211PolicyStaff.Vbavaco@va.gov,* (202) 461–9700. (This is not a toll-free telephone number.)

SUPPLEMENTARY INFORMATION:

I. The Need for Updated Rating Criteria

As part of its ongoing revision of the VASRD, VA proposes changes to the rating schedule for mental disorders, including the General Rating Formula for Mental Disorders codified at 38 CFR 4.130. The proposed changes would update evaluation criteria based on the DSM–5, medical advances since the last substantive revision of the rating schedule for mental disorders in 1996, and current understanding of functional impairment associated with, or resulting from, mental disorders. These changes also reflect comments received from subject matter experts in the Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), Board of Veterans' Appeals (BVA), Department of Defense (DoD), and Veterans Service Organizations (VSOs). Overall, VA did not rely on one particular input for these proposed changes, but the multitude of published, publicly available, and peer-reviewed, scientific and medical sources cited below.

In 2006, the Veterans' Disability Benefits Commission (VDBC) asked the Institute of Medicine (IOM) (now named the National Academy of Medicine) to study and recommend improvements for the VASRD. The IOM recommended updating the medical content of the rating schedule, by placing greater emphasis on a disabled veteran's ability to function in the work setting, rather than focusing on symptoms alone. Institute of Medicine, ''A 21st Century System for Evaluating Veterans for Disability Benefits'' 113–14 (Michael McGeary et al. eds., 2007).

In March 2015, VA published a final rule (RIN 2900–AO96) that updated the nomenclature for mental disorders and removed outdated references to the fourth editions of DSM (DSM–IV and DSM–IV–TR), replacing them with references to the latest fifth edition (DSM–5). While this rule updated the nomenclature to conform to the DSM–5, VA did not update the rating criteria used to evaluate mental disorders.

VA now proposes, however, to update the rating criteria for mental disorders in accord with IOM's recommendation and the latest medical science. VA's updates are based on the framework associated with the International Classification of Functioning, Disability, and Health (ICF) and its companion assessment instrument, the World Health Organization (WHO) Disability Assessment Schedule 2.0 (WHODAS 2.0), as well as the International Classification of Diseases (ICD), and concepts and methodology from the DSM–5.

The WHODAS 2.0 is a validated instrument that assesses health and disability across all diseases, including mental, neurological, and addictive disorders. O. Garin et al., ''Validation of the 'World Health Organization Disability Assessment Schedule, WHODAS–2' in patients with chronic diseases,'' 8 Health and Quality of Life Outcomes 51 (2010). It assesses the ability to perform tasks in six functional domains by measuring the impact of a disability across various life functions and assigning a score for each domain. ''WHO Disability Assessment Schedule 2.0 (WHODAS 2.0),'' World Health Organization, *https://www.who.int/classifications/icf/whodasii/en/* (last visited Nov. 19, 2019) (hereinafter ''WHODAS 2.0'').

The ICD is a standard tool for the diagnosis of disabilities for the purposes of epidemiology, health management, and clinical practice. By employing a standardized numerical labeling system, the ICD allows disease to be classified, monitored, and analyzed for statistical purposes. ''Classifications,'' World Health Organization, *https://www.who.int/classifications/en/* (last visited Nov. 19, 2019).

Finally, the DSM–5 is a standardized classification of mental disorders for mental health professionals in the

United States. The DSM–5 contains every mental health disorder recognized by the American Psychiatric Association and provides detailed diagnostic criteria. As a standard for mental health, the DSM–5 is also used to collect data regarding public health matters involving psychiatric disorders. *See generally* American Psychiatric Association (APA), ''Diagnostic and Statistical Manual of Mental Disorders'' (American Psychiatric Publishing, 5th ed. 2013) (hereinafter ''DSM–5'').

Previous versions of the DSM relied upon a categorical diagnostic classification scheme requiring a clinician to determine whether a disorder was absent or present with a multiaxial system, each axis of which gave a different type of information about the diagnosis. Axis V, in particular, was comprised of the Global Assessment of Functioning (GAF) scale, which was used by clinicians to assess an individual's overall level of functioning on a hypothetical continuum of mental health illness.

The DSM–5 eliminates the multiaxial approach and instead provides for a ''dimensional approach, which allows a clinician more latitude to assess the severity of a condition.'' APA, ''DSM–5's Integrated Approach to Diagnosis and Classifications,'' *https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Integrated-Approach.pdf.* According to the APA, a growing body of scientific evidence supports multi-faceted or multi-dimensional concepts in assessing functional impairment due to mental disorders. DSM–5 at 733–737. Clinicians who assess the consequences of mental disorders should consider a combination of all domains of functioning, and a comprehensive approach incorporates variations of features within the individual, rather than relying on a simple combination of presented symptoms. *Id.*

This dimensional approach incorporates differential severity of individual symptoms both within and outside of a disorder's diagnostic criteria as measured by intensity, duration, or number of symptoms, along with other features such as type and severity of disabilities. DSM–5 at 733. In sum, the dimensional approach is consistent with current diagnostic practice and comprehensively examines the functional consequences of a mental disability. *Id.; see* Lonnie R. Bristow, *Preface to* ''A 21st Century System for Evaluating Veterans for Disability Benefits'' xii (some of the signature injuries incurred in Operations Enduring Freedom/Iraqi Freedom, such as posttraumatic stress disorder (PTSD), must be evaluated in terms of their functional consequences). Accordingly, the DSM–5 now advocates for assessments like the WHODAS 2.0, which ''has proven useful as a standardized measure of disability for mental disorders.'' DSM–5 at 21. The WHODAS 2.0 corresponds to concepts contained in the WHO's ICF. T. Bedirhan Üstün et al., ''Developing the World Health Organization Disability Assessment Schedule 2.0,'' Bull. World Health Organ. 815 (2010) (hereinafter ''Developing WHODAS 2.0''). The WHODAS 2.0 does not depend on symptom levels. Rather, the WHODAS 2.0 is a 36-item or 12-item measure that assesses an individual's performance over the past 30 days in activities in the following six domains (areas of functioning): (1) Understanding and communication; (2) getting around; (3) self-care; (4) getting along with people; (5) life activities; and (6) participation in society. World Health Organization, ''Measuring Health and Disability Manual for WHO Disability Assessment Schedule WHODAS 2.0'' 4–5 (T.B. Üstün et al. eds., 2010) (hereinafter ''Manual''). The WHODAS 2.0 asks how much difficulty the individual has had performing certain activities within each domain using the following scale: No difficulty (1), mild difficulty (2), moderate difficulty (3), severe difficulty (4), and extreme difficulty or cannot do (5). *Id.* at 38, 41.

The WHODAS 2.0 is similar to the Clinician-Administered PTSD Scale for DSM–5 (CAPS–5), which is the ''gold standard in PTSD assessment.'' *See* Frank W. Weathers et al., ''The Clinician-Administered PTSD Scale for DSM–5 (CAPS–5)'' (2013), cited at *https://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp* (last visited Nov. 19, 2019) (hereinafter ''Weathers 2013''); Frank W. Weathers et al., ''The Clinician-Administered PTSD Scale for DSM–5 (CAPS–5): Development and Initial Psychometric Evaluation in Military Veterans,'' Psychol. Assess. 30(3) (2018), available at *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5805662/* (last visited Nov. 19, 2019). The CAPS–5 is a 30-item structured interview administered by clinicians and clinical researchers that is used to render a diagnosis of PTSD and assess the severity of the 20 PTSD symptoms in the DSM–5 based on symptom frequency and intensity using a scale similar to the WHODAS 2.0, *i.e.,* absent (0), mild (1), moderate (2), severe (3), and extreme (4). *See* Weathers 2013, *supra.* The scores for frequency and intensity are combined to form a single severity score for each symptom, and a total severity score is calculated by combining all the individual severity scores for the 20 PTSD symptoms. *Id.*

There is evidence that a standardized assessment for disability related to mental disorders, such as the WHODAS 2.0 and CAPS–5, leads to a more reliable and valid disability examination process. IOM, ''Psychological Testing in the Service of Disability Determination'' 66 (2015), *https://www.nap.edu/read/21704.* The WHODAS 2.0 ''has good psychometric qualities, including good reliability and item-response characteristics'' and shows concurrent validity when compared with other measures of disability or health status or with clinician ratings. Developing WHODAS 2.0, *supra.* A VA study compared clinical interviews with standardized assessments that incorporated the CAPS–5 for PTSD diagnosis and the WHODAS 2.0 for functional impairment and found that administering a standardized disability assessment resulted in more complete assessment of functional impairment and diagnostic coverage of PTSD. Ted Speroff et al., ''Compensation and Pension Examination for PTSD,'' VA Office of Health Services Research & Development Service Forum 7 (May 2012). VA therefore proposes a General Rating Formula for Mental Disorders, h is explained below, that would provide a standardized assessment of disability similar to the WHODAS 2.0 and CAPS–5. It would also create a common language between clinicians and adjudicators, which VA believes will lead to more efficient and accurate adjudication of claims for mental disorders.

Another important purpose for updated rating criteria is the fact that, since September 11, 2001, the United States has deployed more than 2.5 million American service members to Iraq, Afghanistan, and other dangerous regions around the world. These deployments have exposed service members to a variety of stressors, including sustained risk of, and exposure to, injury and death, as well as an array of family pressures. U.S. Department of Defense, ''DoD, VA, Other Agencies Team to Study PTSD, TBI,'' American Forces Press Service (Aug. 14, 2013) *https://archive.defense.gov/News/NewsArticle.aspx?ID=120620* (last visited Nov. 19, 2019). Multiple deployments involve prolonged exposure to combat-related stressors. The psychological toll of these deployments must be taken seriously. RAND Corporation, *Preface to* ''Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery'' iii (T.

Tanielian & L.H. Jaycox eds., 2008). Recent reports have referred to PTSD and traumatic brain injury (TBI) as the signature wounds of the conflicts in Afghanistan and Iraq. *Id.* With increasing incidence of suicide and suicide attempts among returning veterans, concern about depression and other mental health disorders is also on the rise.

Indeed, individuals with mental disorders such as depression, anxiety and adjustment disorders frequently experience recurrent absences from work. I. Arends et al., ''Prevention of Recurrent Sickness Absence in Workers with Common Mental Disorders: Results of a Cluster-Randomized Controlled Trial,'' 71 Occupational Envtl Med. 21 (2014). As compared to physical disorders, mental disorders cause less engagement in life activities, including work. M.A. Buist-Bouwman et al., ''Comparing Functioning Associated with Mental and Physical disorders,'' 113 Acta Psychiatr. Scand. 499 (2006). One comprehensive study based on a WHO questionnaire estimated that employees with bipolar disorder lost the equivalent of about 28 work days annually from sick time and other absences. ''Mental health problems in the workplace,'' Harvard Mental Health Letter (Feb. 2010), *https://www.health.harvard.edu/newsletter_article/mental-health-problems-in-the-workplace; see also* N.L. Kleinman et al., ''Lost Time, Absence Costs, and Reduced Productivity Output for Employees With Bipolar Disorder,'' 47 J. Occupational & Envtl. Med. 1117, 1121 (Nov. 2005). Moreover, compared to the general population, the risk of recurrent sickness absence is higher for employees with mental disorders, and such recurrent absences are often more serious and long-lasting. *See* 71 Occupational Envtl Med. at 21.

As the understanding of mental disorders has advanced, so has the ability to recognize and quantify the components that form both the diagnosis as well as its attendant disability. Therefore, VA proposes to update the section of the rating schedule that addresses mental disorders to provide clear, consistent, and accurate evaluation criteria. Updating the General Rating Formula for Mental Disorders will also improve the timeliness and accuracy of adjudications by providing uniform objective criteria based on modern medical science.

Finally, the proposed changes are necessary to address potential inadequacies in the current mental health criteria of the VASRD. In August 2007, the Center for Naval Analyses (CNA) prepared an earnings loss study in response to a request from the VDBC to assess compensation levels under the VASRD. Eric Christensen et al., ''Final Report for the Veterans' Disability Benefits Commission: Compensation, Survey Results, and Selected Topics'' (CNA 2007). The study found that those veterans with primary mental disabilities do not receive adequate compensation to offset any earnings losses. *Id.* at 193. On the basis of its findings, CNA recommended that VA review and adjust evaluations for mental disorders to provide adequate compensation for earnings losses. *Id.*

Another study, completed by Economic Systems, Inc. (EconSys), in September 2008, focused on the adequacy of VA benefits to compensate for loss of earnings and functional impairment. EconSys, ''A Study of Compensation Payments for Service-Connected Disabilities'' (2008). Like CNA, EconSys found that veterans with mental disorders generally were undercompensated by the VASRD. *Id.* at 33. EconSys also recommended a re-evaluation of the criteria for mental disorders, noting that VA should update the VASRD to reflect modern medical science. *Id* at 35.

Given the foregoing, VA proposes to adopt new evaluation criteria that more accurately capture the occupational impairment caused by mental disabilities and provide more adequate compensation for the earnings losses experienced by veterans with service-connected mental disorders. A more detailed discussion of the specific evaluation criteria VA proposes and how VA will apply it follows.

II. The Current Rating Schedule and a New Framework for Evaluation

The current rating schedule for mental disorders provides two separate rating formulas, the General Rating Formula for Mental Disorders and the Rating Formula for Eating Disorders. The General Rating Formula for Mental Disorders bases evaluations on a list of signs and symptoms that characteristically produce a particular level of disability. 61 FR 52695, 52700 (Oct. 8, 1996). VA believes that an updated formula considering the severity, frequency and duration of symptoms would provide the most accurate and consistent method for evaluating functional impairment.

The current Rating Formula for Eating Disorders bases evaluations on the extent of weight loss, incapacitating episodes, and required periods of hospitalization, in accordance with the now-outdated DSM–IV. 60 FR 54825, 54829 (Oct. 26, 1995). VA believes that an updated formula can better evaluate how symptoms or episodes attributable to eating disorders actually translate into functional and occupational impairment.

As noted above, the understanding of disability resulting from mental disorders has evolved with the science. The IOM report recognized that some of the signature injuries (*e.g.,* PTSD) incurred in Operations Enduring Freedom/Iraqi Freedom are not visible or subject to a laboratory test. *See also* Bristow, *supra.* Instead, they must be evaluated in terms of their functional consequences. *Id.* In that regard, properly evaluating mental disability requires the ability to recognize and quantify the components that form the diagnosis as well as resulting impairment. While symptoms determine the diagnosis, they do not necessarily translate directly to functional impairment. Thus, we believe that, in order to accurately measure functional impairment, VA must consider the frequency and severity of the symptoms and how they impact functioning and performance across a variety of domains: That, is aspects of human behavior and functioning.

To ensure evaluations are accurate and consistent with modern medicine, VA is proposing a new, comprehensive general rating formula for all mental disorders, to include eating disorders. The proposed evaluation criteria will measure a veteran's essential ability to participate in the work environment and the impact of the mental disorder on earning capacity via a comprehensive assessment of occupational and social functioning. Diagnoses must still be established according to the DSM–5. 38 CFR 4.125(a). However, once an examiner has diagnosed a specific mental disorder, the proposed rating criteria will enable VA to assign an evaluation by analyzing the frequency, intensity, and overall severity of occupational and social impairment due to the diagnosed mental disorder and in accordance with the updated clinical standards of the DSM–5.

The proposed evaluation criteria, as further discussed below, encapsulate the dimensional approach of the WHODAS 2.0, ICD, DSM–5, and CAPS–5.

III. The Proposed General Rating Formula for Mental Disorders

A. Domains of Functional Impairment

Congress requires VA to base its rating schedule, ''as far as practicable, upon the average impairments of earning capacity'' in ''civil occupations'' that a veteran will experience due to the

disability in question. 38 U.S.C. 1155. VA recognizes that a veteran's earning capacity after disability is highly dependent upon both occupational and social functioning. Studies have shown that the objective evaluation of functional performance, rather than subjective criteria, is a strong predictor of impairment in earning capacity in individuals with a diagnosed mental disorder. A. Galvao et al., ''Predicting Improvement in Work Status of Patients With Chronic Mental Illness After Vocational and Integrative Rehabilitation Measurements,'' 44 Rehabilitation 208, 208–14 (2005). VA has therefore determined that a multidimensional approach to evaluating mental disorders will provide the most efficient and satisfactory method for measuring the impact of mental health disabilities on a veteran's earning capacity.

VA would continue to require that a diagnosis of a mental disorder be established in accordance with the DSM–5 as required by 38 CFR 4.125(a). However, for purposes of rating the extent of disability attributable to a mental disorder, VA proposes a rating formula using five domains of functioning to evaluate the extent of disability, similar to the approach of the WHODAS 2.0.

As explained above, the WHODAS 2.0 assesses an individual's ability to perform life activities based upon six domains (areas of functioning): (1) Understanding and communicating, (2) ability to move and get around, (3) caring for oneself, (4) getting along with people, (5) carrying out life activities, and (6) participating in society. However, ''getting along with people'' and ''participation in society'' can essentially be categorized as one domain of ''interpersonal interactions and relationships'' for VA's purpose of evaluating a veteran's earning capacity. 38 U.S.C. 1155. Therefore, the proposed General Rating Formula for Mental Disorders would evaluate the extent of a veteran's disability based upon all evidence of record relevant to the following five domains: (1) Cognition (*i.e.,* understanding and communicating), (2) interpersonal interactions and relationships (*i.e.,* interacting with people and participating in society), (3) task completion and life activities, (4) navigating environments (*i.e.,* getting around), and (5) self-care.

The domain of ''Cognition'' would assess a veteran's mental processing involved in gaining knowledge and comprehension. These processes include, but are not limited to, memory, concentration, attention, goal setting, speed of processing information, planning, organizing, prioritizing, problem solving, judgment, decision making, or flexibility in adapting when appropriate.

The domain of ''Interpersonal Interactions and Relationships'' would assess a veteran's ability to effectively interact with other people in both social and occupational settings and participate in society. This domain includes both informal (social, associational, etc.) and formal (coworkers, supervisors, etc.) relationships.

The domain of ''Task Completion and Life Activities'' would assess a veteran's ability to manage task-related demands. This domain includes, but is not limited to, the following types of activities: Vocational, educational, domestic chores, social, or caregiving.

The domain of ''Navigating Environments'' would assess a veteran's physical and mental ability to go from place to place. This domain includes, but is not limited to, the following: leaving the home, being in confined or crowded spaces, independently moving in surroundings, navigating new environments, driving, or using public transportation.

The domain of ''Self-Care'' would assess a veteran's ability to take care of himself or herself. This domain would include, but would not be limited to, the following types of activities: Hygiene, dressing appropriately, or nourishment.

B. Assessing the Level of Functioning

In order to accurately measure occupational and social impairment due to a mental disorder, VA proposes to measure a veteran's functioning within each of the five domains discussed above based upon the level of difficulty the veteran experiences in performing tasks associated with the domain (intensity) and the percentage of time that these difficulties occur (frequency). *See* Jon D. Elhai et al., ''Posttraumatic Stress Disorder's Frequency and Intensity Ratings Are Associated With Factor Structure Differences in Military Veterans,'' 22 Psychol. Assess. 723 (2010); A.J. Rush, Jr., et al., ''Handbook of Psychiatric Measures'' 103–05 (American Psychiatric Publishing, 2d ed. 2008). This approach would be outlined in 38 CFR 4.126(a), which will state that, when evaluating a mental disorder, an adjudicator must consider the intensity and frequency of psychiatric symptoms that bear on the five domains discussed above. Section 4.126(a) would also state that VA will assess the intensity and frequency of symptoms in each domain and will assign an evaluation based on the combined levels of functioning in these domains as explained in the General Rating Formula For Mental Disorders. VA would delete paragraph (b) of current section 4.126, which provides that VA will consider social impairment but will not assign an evaluation ''solely on the basis of social impairment,'' as obsolete, because that principle would be more clearly addressed in one of the domains for assessment, providing for consideration of ''interpersonal interactions and relationships.'' Paragraphs (c) and (d) would be redesignated as paragraphs (b) and (c), respectively.

As to the proposed General Rating Formula, there will be 100, 70, 50, 30, and 10 percent evaluations based on the severity of impairment in all five domains. To measure the severity in an individual domain, VA will first evaluate the intensity of impairment in that domain. Intensity refers to the difficulties in functioning, *i.e.,* interference with completing tasks. The levels of intensity for each domain will be none, mild, moderate, severe, or total, generally defined as follows:

''None''—''No difficulties'' associated with the domain;

''Mild''—''Slight difficulties in one or more aspects'' of the domain that ''do not interfere with tasks, activities, or relationships;''

''Moderate''—''Clinically significant difficulties in one or more aspects'' of the domain ''that interfere with tasks, activities, or relationships;''

''Severe''—''Serious difficulties in one or more aspects'' of the domain ''that interfere with tasks, activities, or relationships;''

''Total''—''Profound difficulties in one or more aspects'' of the domain ''that cannot be managed or remediated; incapable of even the most basic tasks within one or more aspects'' of the domain; ''difficulties that completely interfere with tasks, activities, or relationships.''

As a technical note, the ''task completion and life activities'' domain uses slightly different criteria to define these levels, and several of the domains consider the effect of accommodations or assistance in their assessment.

When evaluating intensity under the proposed criteria, examiners and VA adjudicators should be cognizant of the fact that some symptoms may overlap between domains. VA will provide training or additional guidance to help avoid the artificial inflation of the severity of a condition through the double-counting of symptoms. *Cf.* 38 CFR 4.14. Moreover, consistent with 38 U.S.C. 1155 (VASRD shall compensate for impairments in earning capacity), examiners and VA adjudicators generally should assess impairments with a view toward their effect on earning capacity. Finally, examiners and

VA adjudicators generally should assess impairments due to the service-connected disability, not other causes. *See* ICF Checklist (Version 2.1a, Clinician Form) (''The level of capacity should be judged relative to that normally expected of the person, or the person's capacity before they acquired their health condition.''), *https://www.who.int/classifications/icf/icfchecklist.pdf?ua=1; see also* Manual at 39 (WHODAS 2.0 responses should address difficulties with activities due to health conditions, rather than to other causes). Again, training and additional guidance will be provided to VA personnel for further edification on appropriately applying the revised general rating formula.

After determining the intensity for each domain, VA would address frequency. Frequency refers to the percentage of time, in the past month, that impairment occurs. Consistent with the WHO's ICF Checklist rates and the CAPS–5, VA proposes to differentiate between impairment occurring less than 25 percent of the time over the past month, and 25 percent of the time or more over the past month. The CAPS–5 distinguishes in its ratings between a frequency of ''some of the time'' (20 to 30 percent) and more frequent occurrences. Weathers 2013, *supra.* The WHO's ICF checklist, upon which the WHODAS 2.0 is based, similarly distinguishes between impairments that are present less than 25 percent of the time and those occurring more than 25 percent of the time in the past month. *See* ICF Checklist, pt. 2; *see also* Manual at 39 (''Recall abilities are most accurate for the period of one month.''). Like other validated measures, VA recognizes that impairments that occur 25 percent or more of the time present a greater impact on social and occupational functioning than those that occur less frequently.

Consideration of both the intensity and frequency would yield the level of impairment of functioning in each domain, and each level would correlate to a numerical value, ranging from 0 to 4, which would be defined as follows:

''0 = None''—''No difficulties;''

''1 = Mild impairment at any frequency; or moderate impairment that occurs less than 25% of the time;''

''2 = Moderate impairment that occurs 25% or more of the time; or severe impairment that occurs less than 25% of the time;''

''3 = Severe impairment that occurs 25% or more of the time; or total impairment that occurs less than 25% of the time;'' and

''4 = Total impairment that occurs 25% or more of the time.''

C. Assigning a Disability Rating

Once an adjudicator determines the level of impairment of functioning for each domain caused by a mental disorder, VA would assign an evaluation of 10, 30, 50, 70, or 100 percent for the disorder based upon the numerical value for each domain and the number of domains affected. VA would assign the following ratings based upon the following criteria:

Disability rating	Score	
	Level of impairment (0–4)	Number of affected domains
100	4	in 1 or more domains.
	3	in 2 or more domains.
70	3	in 1 domain.
	2	in 2 or more domains.
50	2	in 1 domain.
30	1	in 2 or more domains.
10	Minimum rating.	

As reflected in this formula, veterans who have more severe impairment in more domains will receive higher ratings. Veterans with less severe impairment in less domains will receive lower ratings. But, notably, a numerical value of 4 in just one domain will warrant a 100 percent rating; and a numerical value of 3 in just one domain will warrant a 70 percent rating. This criterion should generally lead to more generous compensation for veterans than the current rating formula, which requires ''total occupational and social impairment'' for a 100 percent rating and ''deficiencies in most areas'' for a 70 percent rating. Moreover, VA proposes to eliminate the current rating formula's provision for a noncompensable rating, and to provide a minimum rating of 10 percent for all mental disorders. This is because a disorder that meets the DSM–5 requirements for being a mental disorder must include elements indicative of both harm and dysfunction. Michael B. First et al., ''Diagnostic Criteria as Dysfunction Indicators: Bridging the Chasm Between the Definition of Mental Disorder and Diagnostic Criteria for Specific Disorders,'' 58 Canadian J. of Psychiatry 663, 665 (Dec. 2013). Thus, a DSM–5 disorder will rarely produce zero dysfunction. *Id.* Because the DSM–5 requirements represent thresholds of minimal clinical confidence that a dysfunction is present, VA will assign at least a 10 percent rating for such disorders. *Id.* at 668.

IV. Elimination of Rating Formula for Eating Disorders

As previously noted, current § 4.130 includes two separate rating formulae for mental disorders—the General Rating Formula for Mental Disorders and the Rating Formula For Eating Disorders. VA created a separate Formula for Eating Disorders ''because their more disabling aspects are manifested primarily by physical findings rather than by psychological symptoms.'' 60 FR at 54829. The current Rating Formula for Eating Disorders bases evaluations on the extent of weight loss, incapacitating episodes, and required periods of hospitalization. *Id.* However, in the DSM–5 at 339, the only eating disorder for which weight is a diagnostic criterion is anorexia nervosa, and body mass index (BMI) (weight in kilograms divided by height in meters squared (kg/m^2)) is used to specify the current severity of the disorder. Weight and BMI are not diagnostic criteria in the DSM–5 for other eating disorders, such as bulimia nervosa and binge-eating disorder, nor are they specifiers for the severity of other eating disorders. DSM–5 at 329–54.

As explained above, assessments like the WHODAS 2.0 can be used to assess an individual's ability to perform life activities based upon six areas of functioning as a result of *any* disorder, including eating disorders. Liza H. Gold, ''DSM–5 and the Assessment of Functioning: The World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0),'' 42 J. Am

Acad. Psychiatry L. 173, 174–75 (2014). The test-retest reliability, internal consistency, and concurrent validity of the WHODAS 2.0 in comparison to other instruments for measuring disability has been established in various patient populations and in general population samples. Manual at 19–25. Based upon the diagnostic criteria and severity specifiers for most eating disorders in the DSM–5 and the universal applicability of the WHODAS 2.0, VA no longer sees a need for a separate rating formula for eating disorders, and VA proposes to instead evaluate the extent of disability caused by eating disorders based upon the effect of an individual's disorder on the five domains of functioning under the General Rating Formula for Mental Disorders discussed above. VA seeks comment on this approach.

V. Proof-of-Concept Study

To derive the appropriate level to assign to each domain (*e.g.,* 0 through 4), VA conducted a proof-of-concept study with 100 veterans with service-connected mental disorders. Commonly known as feasibility studies, proof-of-concept studies are designed to examine new methods or treatments. The results of such studies improve the program or evaluation procedure before using it on a larger scale. L. Thabane et al., ''A tutorial on pilot studies: the what, why, and how,'' BMC Medical Research Methodology 10:1, *https://www.biomedcentral.com/content/pdf/1471-2288-10-1.pdf* (last visited Nov. 19, 2019).

VA identified four specific aims of the proof-of-concept study to examine the feasibility of the proposed rating criteria for mental disorders. The first objective was to examine the distribution of evaluations under the current and proposed rating criteria for mental disorders. The second objective was to examine the extent to which the revised Mental Disorders Disability Benefits Questionnaire (DBQ) would adequately collect information needed to rate disabilities based upon the proposed rating criteria. The third objective was to examine the extent to which adjudicators were easily able to extract rating data from the revised DBQ and apply the new evaluation criteria. The fourth objective was to examine the extent to which Compensation and Pension (C&P) examiners found the revised DBQ adequate and easy to use.

Regarding the first objective, the proof-of-concept study found that the proposed General Rating Formula for Mental Disorders would increase the average disability evaluation. Compared to the current rating formula, fewer veterans would be rated at or below 50 percent disability and more would be rated above 50 percent under the proposed criteria. The two formulae seemed to yield similar results at 70 percent disabling, and the number of veterans who would receive 100 percent disability was greater under the proposed criteria than under the current criteria.

Regarding the second objective, adjudicators reported that the revised Mental Disorders DBQ provided all the information they needed to evaluate based on the proposed criteria. Regarding the third objective, adjudicators reported that they were easily able to extract rating data from the revised DBQ and apply new evaluation criteria. Finally, C&P examiners reported that the revised DBQ was adequate and easy to use in a clinical setting.

Importantly, one major theme in the feedback regarding mental disorders has been the need for a common language in the VASRD—a language familiar to both clinicians and adjudicators. According to the proof-of-concept study results, VA achieved this objective with the proposed General Rating Formula for Mental Disorders.

VI. Notes to the Proposed General Rating Formula

VA proposes to add three notes at the end of the General Rating Formula for Mental Disorders to promote greater consistency and accuracy in applying the criteria.

The first note would provide that only one evaluation will be assigned for co-existing service-connected mental disorders. According to 38 U.S.C. 1155, the VA rating schedule shall compensate veterans for ''impairments of earning capacity,'' not specific diagnoses. And according to 38 CFR 4.14, evaluations of the same disability or manifestation under different diagnoses is to be avoided. Most mental disorders are ''composed of multiple emotional, cognitive, and behavioral dimensions, many of which are shared across disorders.'' Lee Ann Clark et al., ''Three Approaches to Understanding and Classifying Mental Disorder: ICD–11, DSM–5, and the National Institute of Mental Health's Research Domain Criteria (RDoC),'' 18 Psychol. Sci. in the Pub. Int. 72, 112 (2017). In addition, co-existing mental disorders, that is, comorbidity, ''is the rule rather than the exception.'' *Id.* Therefore, consistent with 38 U.S.C. 1155 and the rule against pyramiding, 38 CFR 4.14, Note (1) will instruct adjudicators not to assign individual disability ratings to more than one mental disorder given the likelihood of comorbid mental disorders and the prevalence of overlapping symptoms among such disorders.

The second note would explain that evaluations under the General Rating Formula for Mental Disorders would consider any ameliorating effects of medications prescribed for a mental disorder. In other words, if a veteran were receiving medication for a mental disability, VA would rate only the disabling symptomatology that exists after the ameliorative effects of medication are taken into account. We are adding this note because in *Jones* v. *Shinseki,* 26 Vet. App. 56, 63 (2012), the United States Court of Appeals for Veterans Claims held that, ''[a]bsent a clear statement [in the rating criteria] setting out whether or how the Board [of Veterans' Appeals (Board)] should address the effects of medication,'' the Board should not take those effects into account when evaluating a claimant's disability. However, consideration of ameliorating effects of medications is consistent with 38 CFR 4.2, which states that VA adjudicators should consider a disability ''from the point of view of the veteran working or seeking work'' and provide a current rating that ''accurately reflect[s] the elements of disability present.'' VA adjudicators should not be basing ratings on speculation of how severe a veteran's disability might be if he or she were not taking medication; the rating should be based on the actual elements of disability present. *See generally McCarroll* v. *McDonald,* 28 Vet. App. 267, 276–78 (2016) (Kasold, J., concurring in part).

The third note would explain that, in evaluating frequency, VA adjudicators should consider the percentage of time, in a given month, that impairment occurs. As discussed above, this is consistent with the WHO's ICF Checklist rate. VA seeks comment on the three proposed notes.

VII. Technical Amendments

Finally, VA proposes to update Appendix A of part 4 to reflect the above proposed amendments to the rating schedule for mental disorders.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review)

emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined that this rule is an economically significant regulatory action under Executive Order 12866. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *www.regulations.gov.*

Regulatory Flexibility Act

The Secretary hereby certifies that this rulemaking will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601–612). The certification is based on the fact that no small entities or businesses would be subject to the rating criteria revisions or assign evaluations for disability claims. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any given year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

This proposed rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

Assistance Listing

The Assistance Listing numbers and titles for this rule are 64.104, Pension for Non-Service-Connected Disability for Veterans; 64.109, Veterans Compensation for Service-Connected Disability; and 64.110, Veterans Dependency and Indemnity Compensation for Service-Connected Death.

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on July 9, 2021 and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Michael P. Shores,

Director, Office of Regulation Policy & Management, Office of the Secretary, Department of Veterans Affairs.

For the reasons set out in the preamble, VA proposes to amend 38 CFR part 4, subpart B as set forth below:

Part 4—SCHEDULE FOR RATING DISABILITIES

■ 1. The authority citation for part 4 continues to read as follows:

Authority: 38 U.S.C. 1155, unless otherwise noted.

■ 2. Amend § 4.126 by:
■ a. Revising paragraph (a);
■ b. Removing paragraph (b); and
■ c. Redesignating paragraphs (c) and (d) as paragraphs (b) and (c).

The revisions read as follows:

§ 4.126 Evaluations of disability from mental disorders.

(a) When evaluating a mental disorder, the rating agency shall consider all the evidence of record relevant to the intensity and frequency of psychiatric symptoms that bear on the following domains (major areas of functioning):

(1) Cognition (*i.e.,* understanding and communicating);

(2) interpersonal interactions and relationships (*i.e.,* interacting with people and participating in society);

(3) task completion and life activities;

(4) navigating environments (*i.e.,* getting around); and

(5) self-care.

The rating agency shall assess the intensity and frequency of symptoms in each domain and assign an evaluation based on the combined levels of functioning in these domains as explained in section 4.130.

* * * * *

■ 3. Amend § 4.130 by:
■ a. Republishing the entry for diagnostic code (DC) 9440;
■ b. Adding immediately following (DC) 9440, the entries for (DCs) 9520 and 9521;
■ c. Revising the table ''General Rating Formula for Mental Disorders'';
■ d. Removing immediately following the table ''General Rating Formula for Mental Disorders'' the entries for (DCs) 9520 and 9521; and
■ e. Removing the table ''Rating Formula for Eating Disorders''.

The additions and revisions read as follows:

§ 4.130 Schedule of ratings—Mental disorders.

* * * * *

9440 Chronic adjustment disorder
9520 Anorexia nervosa
9521 Bulimia nervosa

GENERAL RATING FORMULA FOR MENTAL DISORDERS

	Rating
The General Rating Formula for Mental Disorders contains five domains related to function: Cognition; interpersonal interactions and relationships; task completion and life activities; navigating environments; and self-care. The criteria below describe each domain.	
The General Rating Formula for Mental Disorders provides criteria for each domain for levels of function ranging from 0 to 4, as appropriate. The highest level of impairment, a score of 4, signifies ''total,'' and the lowest level of impairment, a score of 0, signifies ''no difficulties.''	
Evaluate based on the level of impairment in each domain and the number of affected domains, as follows:	
Level 4 in one or more domains, or Level 3 in two or more domains	100
Level 3 in one domain, or Level 2 in two or more domains	70
Level 2 in one domain	50
Level 1 in two or more domains	30
Minimum rating	10

Note (1): Coexisting mental disorders cannot receive distinct and separate disability evaluations without violating the anti-pyramiding regulation of § 4.14. Therefore, assign a single evaluation reflecting all impairment due to coexisting service-connected mental disorders using the General Rating Formula in this section.

Note (2): Include any ameliorating effects of medications when evaluating the extent of disability under the General Rating Formula in this section.

Note (3): In evaluating frequency of impairment, consider the percentage of time, in a given month, that impairment occurs.

Domain	Level of impairment	Criteria
1. *Cognition:* May include, but is not limited to, memory, concentration, attention, goal setting, speed of processing information, planning, organizing, prioritizing, problem solving, judgment, making decisions, or flexibility in adapting when appropriate.		
	0 = None	No difficulties: Cognitive functioning intact.
	1 = Mild impairment at any frequency; or moderate impairment that occurs less than 25% of the time.	Mild: Slight difficulties in one or more aspects of cognitive functioning that do not interfere with tasks, activities, or relationships.
	2 = Moderate impairment that occurs 25% or more of the time; or severe impairment that occurs less than 25% of the time.	Moderate: Clinically significant difficulties in one or more aspects of cognitive functioning that interfere with tasks, activities, or relationships.
	3 = Severe impairment that occurs 25% or more of the time; or total impairment that occurs less than 25% of the time.	Severe: Serious difficulties in one or more aspects of cognitive functioning that interfere with tasks, activities, or relationships.
	4 = Total impairment that occurs 25% or more of the time	Total: Profound difficulties in one or more aspects of cognitive functioning that cannot be managed or remediated; incapable of even the most basic tasks within one or more aspects of cognitive functioning; difficulties that completely interfere with tasks, activities, or relationships.
2. *Interpersonal interactions and relationships:* Includes both informal (social, associational, etc.) and formal (coworkers, supervisors, etc.).		
	0 = None.	No difficulties: Individual able to have relationships and interact with others at work, school, and other contexts.
	1 = Mild impairment at any frequency; or moderate impairment that occurs less than 25% of the time.	Mild: Slight difficulties in one or more aspects of interpersonal functioning that do not interfere with tasks, activities, or relationships.
	2 = Moderate impairment that occurs 25% or more of the time; or severe impairment that occurs less than 25% of the time.	Moderate: Clinically significant difficulties in one or more aspects of interpersonal functioning that interfere with tasks, activities, or relationships.
	3 = Severe impairment that occurs 25% or more of the time; or total impairment that occurs less than 25% of the time.	Severe: Serious difficulties in one or more aspects of interpersonal functioning that interfere with tasks, activities, or relationships, even with accommodations or assistance.
	4 = Total impairment that occurs 25% or more of the time	Total: Profound difficulties in one or more aspects of interpersonal functioning that cannot be managed or remediated; incapable of even the most basic tasks within one or more aspects of relationships; difficulties that completely interfere with tasks, activities, or relationships.
3. *Task completion and life activities:* May include, but are not limited to, the following types of activities: Vocational, educational, domestic, social, or caregiving.		
	0 = None	No difficulties: Individual able to perform tasks and participate in life activities; needs no accommodations or assistance.
	1 = Mild impairment at any frequency; or moderate impairment that occurs less than 25% of the time.	Mild: Slight difficulties in one or more aspects of task completion or life activities that were completed with minor stress or minor accommodations.
	2 = Moderate impairment that occurs 25% or more of the time; or severe impairment that occurs less than 25% of the time.	Moderate: Clinically significant difficulties in one or more aspects of task completion or life activities that were completed with significant stress or accommodations.
	3 = Severe impairment that occurs 25% or more of the time; or total impairment that occurs less than 25% of the time.	Severe: Serious difficulties in two or more aspects of task completion or life activities that were completed with significant stress and accommodations.
	4 = Total impairment that occurs 25% or more of the time	Total: Profound difficulties in two or more aspects of task completion or life activities, one of which must be vocational, that were not completed even with considerable accommodations due to overwhelming stress; incapable of even the most basic tasks within one or more aspects of task completion or life activities.
4. *Navigating environments:* May include, but is not limited to, the following: Leaving the home, being in confined or crowded spaces, independently moving in surroundings, navigating new environments, driving, or using public transportation.		
	0 = None.	No difficulties: Capability to navigate environments intact.
	1 = Mild impairment at any frequency; or moderate impairment that occurs less than 25% of the time.	Mild: Slight difficulties in one or more aspects of navigating environments that do not interfere with tasks, activities, or relationships.
	2 = Moderate impairment that occurs 25% or more of the time; or severe impairment that occurs less than 25% of the time.	Moderate: Clinically significant difficulties in one or more aspects of navigating environments that interfere with tasks, activities, or relationships.
	3 = Severe impairment that occurs 25% or more of the time; or total impairment that occurs less than 25% of the time.	Severe: Serious difficulties in one or more areas of navigating environments that interfere with tasks, activities, or relationships, even with accommodations or assistance.

Domain	Level of impairment	Criteria
	4 = Total impairment that occurs 25% or more of the time	Total: Profound difficulties in one or more aspects of navigating environments that cannot be managed or remediated; incapable of even the most basic tasks within one or more aspects of environmental navigation; difficulties that completely interfere with tasks, activities, or relationships.
5. *Self-care:* May include, but is not limited to, the following types of activities: Hygiene, dressing appropriately, or taking nourishment.		
	0 = None	No difficulties: Self-care capabilities intact.
	1 = Mild impairment at any frequency; or moderate impairment that occurs less than 25% of the time.	Mild: Slight difficulties in one or more aspects of self-care that do not interfere with tasks, activities, or relationships.
	2 = Moderate impairment that occurs 25% or more of the time; or severe impairment that occurs less than 25% of the time.	Moderate: Clinically significant difficulties in one or more aspects of self-care that interfere with tasks, activities, or relationships without accommodations or assistance.
	3 = Severe impairment that occurs 25% or more of the time; or total impairment that occurs less than 25% of the time.	Severe: Serious difficulties in one or more aspects of self-care that interfere with tasks, activities, or relationships, even with accommodations or assistance.
	4 = Total impairment that occurs 25% or more of the time	Total: Profound difficulties in one or more aspects of self-care that cannot be managed or remediated; difficulties that completely interfere with tasks, activities, or relationships, even with accommodations or assistance.

■ 4. Amend Appendix A to part 4, § 4.130, to read as follows:

Appendix A to Part 4—Table of Amendments and Effective Dates Since 1946

Sec.	Diagnostic code No.	
*	*	* * * * *
4.130	....	Re-designated from § 4.132 November 7, 1996; General Rating Formula for Mental Disorders revision [*Effective date of final rule*].
	9520	Added November 7, 1996; criterion [*Effective date of final rule*].
	9521	Added November 7, 1996; criterion [*Effective date of final rule*].
*	*	* * * * *

(Authority: 38 U.S.C. 1155)

[FR Doc. 2022–02051 Filed 2–14–22; 8:45 am]

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FEDERAL MARITIME COMMISSION

46 CFR Chapter IV, Subchapter B

[Docket No. 22–04]

RIN 3072–AC90

Demurrage and Detention Billing Requirements

AGENCY: Federal Maritime Commission.

ACTION: Advance Notice of Proposed Rulemaking.

SUMMARY: The Federal Maritime Commission (Commission) is issuing this Advance Notice of Proposed Rulemaking (ANPRM) to seek comment on whether the Commission should require common carriers and marine terminal operators to include certain minimum information on or with demurrage and detention billings. Also, the Commission is interested in receiving comments on whether it should require common carriers and marine terminal operators to adhere to certain practices regarding the timing of demurrage and detention billings. These changes were recommended by the Fact Finding Officer in Commission Fact Finding 29: International Ocean Transportation Supply Chain Engagement.

DATES: Submit comments on or before March 17, 2022.

ADDRESSES: You may submit comments, identified by Docket No. 22–04, by e*mail at secretary@fmc.gov.* For comments, include in the subject line: ''Docket No. 22–04, Comments on Demurrage and Detention Billing Requirements ANPRM.'' Comments should be attached to the email as a Microsoft Word or text-searchable PDF document. Only non-confidential and public versions of confidential comments should be submitted by email.

Instructions: For detailed instructions on submitting comments, including requesting confidential treatment of comments, and additional information on the rulemaking process, see the Public Participation heading of the Supplementary Information section of this document. Note that all comments received will be posted without change to the Commission's website unless the commenter has requested confidential treatment.

Docket: For access to the docket to read background documents or comments received, go to the Commission's Electronic Reading Room at: *https://www2.fmc.gov/readingroom/proceeding/22-04.*

FOR FURTHER INFORMATION CONTACT: William Cody, Secretary; Phone: (202) 523–5725; Email: *secretary@fmc.gov.*

SUPPLEMENTARY INFORMATION:

I. Public Participation

How do I prepare and submit comments?

Your comments must be written in English. To ensure that your comments are correctly filed in the docket, please include the docket number of this document in your comments.