VA Claims Diagnostic Code Reference

38 CFR Part 4 — Rating Criteria, Service Connection, and C&P; Exam Preparation

Produced by Outset Solutions LLC

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This reference covers the most commonly service-connected VA diagnostic codes under 38 CFR Part 4, Schedule for Rating Disabilities. Each section includes: exact CFR rating criteria, service connection pathways (direct and secondary), C&P exam preparation guidance, DBQ language, and nexus letter frameworks. This document does not constitute legal advice. For complex cases, consult a VA-accredited attorney or claims agent (va.gov/ogc/apps/accreditation/index.asp).

Conditions Covered in This Reference

- Dc 5055 Knee Replacement Bilateral Factor
- Dc 5055 Knee Replacement Stability
- Dc 5201 Limitation Of Extension Of The Arm
- Dc 5201 Arm Shoulder Impairment
- Dc 5237 Lumbosacral Strain Rating
- Dc 5241 Cervical Spine Rating Criteria
- Dc 5242 Degenerative Disc Disease Ddd Of
- Dc 5242 Lumbar Ddd
- Dc 5260 5261 Knee Flexion Extension Rating
- Dc 5271 Ankle Ankylosis Subtalar Joint Ra
- Dc 5271 Ankle Ankylosis
- Dc 6100 Hearing Loss Rating Criteria
- Dc 6260 Tinnitus Sensorineural Hearing Lo
- Dc 6260 Tinnitus Hearing Loss Nexus
- Dc 6847 Sleep Apnea Syndromes Obstructive
- Dc 6847 Sleep Apnea Cfr Rating
- Dc 6847 Sleep Apnea Nexus
- Dc 7101 Hypertensive Vascular Disease Car
- Dc 7101 Hypertension Cardiovascular Nexus
- Dc 7319 Irritable Bowel Syndrome Ibs Gu
- Dc 7319 Ibs Gulf War
- Dc 8045 Tbi Traumatic Brain Injury
- Dc 8100 Migraines Prostrating Attack Freq
- Dc 8100 Migraines Prostrating Attacks
- Dc 8520 Radiculopathy Sciatica Rating
- Dc 9411 Post Traumatic Stress Disorder Pts
- Dc 9411 Ptsd Rating Criteria
- Dc 9411 Ptsd Supplemental Nexus

- Buddy Statement Template (VA Form 21-10210)
- Medical Nexus Letter Framework
- PACT Act Presumptive Conditions Quick Reference

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 5055: Knee Replacement & Bilateral Factor Joint Stability Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 5055?

Ratings for diagnostic code 5055 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 5055: Knee Replacement & Bilateral Factor Joint Stability Rating Criteria

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 5055: Knee Replacement & Bilateral Factor Joint Stability Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 5055?

Ratings for diagnostic code 5055 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 5201: Limitation of Extension of the Arm & Shoulder Impairment Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 5201?

Ratings for diagnostic code 5201 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 5201: Limitation of Extension of the Arm & Shoulder Impairment Rating Criteria

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Disability Benefits

VA Diagnostic Code 5201: Limitation of Extension of the Arm & Shoulder Impairment Rating Criteria

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 5201: Limitation of Extension of the Arm & Shoulder Impairment Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 5201?

Ratings for diagnostic code 5201 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 5237: Lumbosacral Strain Rating Criteria — ROM Thresholds & CFR Guide

Know Your Lumbar Spine Rating Thresholds

Forward flexion of 30–60° qualifies for 10%. Pain at any point in ROM qualifies for minimum 10% under §4.59. Secondary radiculopathy can add 10–80% additional compensation.

Get the Full Lumbar Spine Guide — $19 30-day money-back guarantee

Why Lumbosacral Strain Claims Are the Most Under-Rated in the VA System

Low back pain (lumbosacral strain, rated under DC 5237) is the most common musculoskeletal VA claim — and also one of the most frequently under-rated. The reason: veterans don't know the exact forward flexion degree thresholds the examiner is measuring, and they miss secondary conditions — particularly lumbar radiculopathy — that can add substantial additional compensation.

DC 5237 covers lumbosacral strain, low back pain, and degenerative changes of the lumbar spine (when not meeting the more specific DC 5242 criteria). The rating is based primarily on forward flexion range of motion — how far you can bend forward from the waist — using a goniometer at your C&P exam.

Key threshold: Normal forward flexion is approximately 90°. The critical cut-points in 38 CFR Part 4 are 60°, 30°, and 15°. Knowing these numbers before your exam is the difference between a 0% and a 20–40% rating.

DC 5237 — Lumbosacral Strain Rating Thresholds

The examiner measures your active forward flexion (bending forward at the waist) with a goniometer or inclinometer. Normal forward flexion is 90°. Ratings are assigned based on measured degrees at the point where pain begins or motion stops:

Forward Flexion (degrees)

Monthly Compensation (approx.)*

Greater than 60° (full or near-full range)

$0 (service-connected, no compensation)

Greater than 30° but not more than 60°

Greater than 15° but not more than 30°

Unfavorable ankylosis of entire thoracolumbar spine

Unfavorable ankylosis (forward flexion 30°+ or severe deformity)

*Approximate single veteran rates as of 2026. Actual compensation varies by dependent status.

Critical gap at 30°: Veterans at exactly 30° are rated at 20%, not 40%. The jump to 40% requires 15° or less. If your examiner measures 30° but you have significant functional impairment, pursue an IMO (Independent Medical Opinion) and document the full functional impact under §4.40 and §4.45.

38 CFR §4.59 — The Painful Motion Rule

This is the rule most veterans never learn, and it frequently represents the difference between a 0% and a 10% rating:

Under 38 CFR §4.59 , if you experience pain at any point during range of motion testing — even before reaching a threshold that triggers a percentage rating — VA must assign at minimum a 10% rating. A spine

condition that causes pain cannot be rated at 0%.

At your C&P exam: When the examiner asks you to bend forward, if you feel any pain or discomfort at any point during the movement, say so clearly and immediately. "I feel pain at [degrees]" establishes the record. Examiners are required to note pain on motion, but you must verbalize it.

Flare-Up Functional Loss — §4.40 and §4.45

If your back condition causes flare-ups that temporarily increase your functional loss beyond what can be measured at a single exam, VA regulations at §4.40 and §4.45 require examiners to consider this in their rating. A veteran who can achieve 50° forward flexion at the exam but drops to 20° during a flare-up can document the flare-up ROM and request it be factored into the rating.

Ask your treating physician to document: (1) how often flare-ups occur, (2) what triggers them, (3) how much ROM decreases during a flare, and (4) how long the flare-up typically lasts.

Secondary Claims From Lumbosacral Strain

The secondary conditions that flow from lumbar spine impairment under 38 CFR §3.310 represent the most significant rating opportunity for most veterans with back conditions:

DC 8520 — Radiculopathy / Sciatica (Most Common Secondary)

If your lumbar condition compresses nerve roots and causes pain, numbness, or weakness that radiates into your legs, you qualify for a separate DC 8520 (or DC 8521 for the other leg) rating in addition to your DC 5237 rating. Ratings: 10% (mild), 20% (moderate), 40% (moderately severe), 60% (severe), 80% (complete paralysis). Each leg is rated separately; bilateral factor applies.

DC 5271 — Hip Limitation (Gait Compensation Secondary)

Altered gait from lumbar spine impairment frequently causes secondary hip pathology. If you have hip limitation and lumbar spine impairment, document the causal link between the two.

DC 5260/5261 — Knee ROM Changes (Gait Compensation)

The same gait compensation mechanism that affects hips can cause secondary knee ROM changes, particularly in veterans with combined lumbar and hip pathology.

TDIU Under 38 CFR §4.16

If your lumbar spine alone reaches 60%, or your combined rating reaches 70% with lumbar at 40%, you may qualify for Total Disability Individual Unemployability (TDIU) — which pays at the 100% rate. Lumbar-primary TDIU claims are among the most successful because the functional impact of severe back impairment on physical employment is well-documented.

Bilateral factor opportunity: If lumbar spine causes radiculopathy in both legs (both DC 8520 and DC 8521), the combined rating for the two radiculopathy conditions receives an additional 10% bilateral factor before final combined calculation. This can push a 70% combined to 77% (rounded to 80%).

What the C&P Examiner Is Measuring

Understanding what the examiner is doing during your C&P exam allows you to cooperate fully and ensure accurate documentation:

Active forward flexion: Bend forward as far as you can go. The point where motion stops (due to pain or anatomical limitation) is measured. Say "I'm stopping because of pain" if applicable.

Active extension: Lean backward. Normal is 30°. Measured separately but contributes to the "combined ROM" threshold (170° or less triggers the same 20% rating as 30° forward flexion).

Lateral flexion (each side): Lean to each side. Normal is 30° per side. Part of the combined ROM calculation.

Rotation (each direction): Rotate your upper body. Normal is 30° per direction. Also part of combined ROM.

Pain documentation: At each motion, if pain occurs, state it explicitly. The examiner notes this. It supports the §4.59 painful motion claim.

Combined ROM threshold: If the sum of all lumbar ROM measurements (forward flexion + extension + bilateral lateral flexion + bilateral rotation) is 120° or less, this triggers the same 20% rating as forward flexion of 30° or less — regardless of individual measurements. This benefits veterans with global limitation even if no single motion is severely limited.

Imaging Evidence and DBQ Documentation

Your VA treatment records and private MRI/X-ray reports should document:

Degenerative disc disease at specific levels (L4-L5, L5-S1 are most common)

Disc herniation or protrusion with nerve root compression

Facet arthropathy or stenosis contributing to limitation

Spondylolisthesis or spondylosis

If your imaging shows structural findings that would explain significant limitation but your C&P ROM measurement was taken on a "good day," your treating physician's records showing worse functional ROM on other dates are essential supporting evidence.

38 CFR §3.310 — Secondary Service Connection

To establish secondary service connection for radiculopathy, hip, or knee conditions, you need a nexus letter from a physician stating that the secondary condition is "at least as likely as not" caused or aggravated by your service-connected lumbar spine condition. This letter is the key document that unlocks additional ratings.

Ready to Build Your Lumbar Spine Claim Strategy?

30-day money-back guarantee • Instant access

Frequently Asked Questions — DC 5237 Lumbosacral Strain

Can I be rated under both DC 5237 and DC 5242 for the same back?

No. VA rates your lumbar spine under a single diagnostic code. DC 5237 (lumbosacral strain) and DC 5242 (degenerative disc disease) rate the same anatomical location; VA will apply the code that results in the higher rating. The criteria for both are nearly identical — forward flexion ROM — so the distinction is usually academic. However, if you have a formal DDD diagnosis on imaging, ensure the C&P examiner documents that condition to support a DC 5242 claim as an alternative.

My C&P examiner measured my ROM at 45° but my back hurts more than that suggests. What can I do?

File for an increase and submit a private DBQ (Disability Benefits Questionnaire) from your treating physician documenting your functional ROM, including during flare-ups. The §4.40 and §4.45 provisions require VA to consider functional loss, not just the measurement taken at the exam. A buddy statement from a family member

documenting your day-to-day limitations also supports the claim.

How does TDIU work with a lumbar spine claim?

If your lumbar spine alone is rated at 60%+, or if your combined rating is 70%+ with lumbar at 40%+, you qualify for TDIU consideration under 38 CFR §4.16. TDIU pays at the 100% rate. The key evidence is documentation from employers or vocational rehabilitation specialists showing that your back condition prevents you from maintaining substantially gainful employment (earning above the federal poverty line).

My radiculopathy is in both legs. Does that mean two separate ratings?

Yes. Right leg radiculopathy (DC 8520) and left leg radiculopathy (DC 8521) are rated separately, then combined. Because they affect both extremities, a 10% bilateral factor applies to the combined rating before the final calculation. For example, 20% right + 20% left = 36% combined, then +10% bilateral factor = 39.6%, rounded to 40%.

Free — No Purchase Required Get the Free C&P Exam Checklist

12 things to bring, what the examiner measures for DC 5237, and the 3 phrases that get lumbar claims denied. Sent immediately.

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VA Diagnostic Code 5241: Cervical Spine Rating Criteria — ROM Thresholds & CFR Guide

Know Your Cervical Spine Rating Thresholds

Forward flexion below 30° qualifies for 20%. Most neck injuries with headaches and arm numbness have secondary conditions worth additional compensation.

Get the Full Cervical Spine Guide — $19 30-day money-back guarantee

Why Cervical Spine Claims Are Often Under-Rated

Neck conditions are among the top VA disability claims, but they are frequently under-rated for two reasons: veterans don't know the exact ROM degree thresholds the examiner is measuring, and they fail to claim secondary conditions — particularly cervical radiculopathy — that can add 10–80% in additional compensation.

DC 5241 covers cervical spondylosis, degenerative disc disease of the cervical spine, cervical strain, and any condition limiting motion of the cervical spine (neck). The rating is based primarily on forward flexion — how far forward you can bend your neck — using the same framework as lumbar spine ratings under 38 CFR Part 4, Schedule for Rating Disabilities.

DC 5241 — Cervical Spine Rating Thresholds

The examiner measures your active forward flexion (chin toward chest) with a goniometer. Normal forward flexion is approximately 45°. Ratings are assigned based on measured degrees:

Forward Flexion (degrees)

Monthly Compensation (approx.)*

Greater than 30° (but limited)

30° or less (or combined ROM ≤170°)

Favorable ankylosis (fixed in neutral position)

Unfavorable ankylosis (fixed forward, lateral, or rotational)

Unfavorable ankylosis at 30° or more forward

Unfavorable ankylosis at 45°+ forward (severe impairment)

*Monthly compensation rates as of 2025 for single veteran with no dependents.

Combined ROM: The rating criteria also include a "combined ROM of 170° or less" trigger for the 20% rating. Combined ROM is measured by adding all cervical spine motions: flexion + extension + bilateral lateral flexion + bilateral rotation. This is significant — veterans whose forward flexion measures slightly above 30° may still qualify for 20% if their total combined ROM is degraded.

The Painful Motion Rule — 38 CFR §4.59

Under 38 CFR §4.59, if there is pain on any motion of the cervical spine, the VA must assign at least the minimum compensable rating (10%) regardless of measured ROM .

This is not a technicality — it is the explicit regulatory protection for veterans whose pain begins before they reach the 10% threshold. If your neck hurts when you look up or to the side, even if you can move it far enough to avoid the 10% flexion threshold, you are still entitled to 10%.

C&P Exam Instruction: If your neck hurts at any point during range of motion testing, say explicitly to the examiner: "I have pain with this motion, and it begins at [X degrees]." Do not perform ROM testing silently. The examiner cannot document what you don't report.

Flare-Ups and Functional Loss

Under 38 CFR §4.40 and §4.45, VA must also consider functional loss from flare-ups and the effect of repeated use on ROM. If your cervical spine condition causes significant worsening during flares — after physical activity, prolonged sitting, or stress — the flare-up ROM should be documented and considered in the rating.

Best practice: before your C&P exam, keep a log of your worst-day ROM and describe it to the examiner. Private physician documentation of flare-up severity is strong supporting evidence.

Secondary Claims — Cervical Radiculopathy

This is where most cervical spine veterans leave significant money on the table. If your cervical spine condition causes pain, numbness, tingling, or weakness that radiates into your arms, shoulders, or hands, you likely have cervical radiculopathy — a separately ratable condition under 38 CFR §3.310 (secondary service connection).

DC 8510 — Musculocutaneous Nerve (DC 8511–8515 for other cervical nerves)

Cervical radiculopathy typically involves nerve roots at C5–C8. The specific nerve root affected determines which DC applies. Common radiculopathy DCs include:

DC 8510 — Musculocutaneous nerve (C5-C6) — affects bicep/forearm

DC 8511 — Median nerve (C6-C7) — affects hand grip and thumb

DC 8513 — Ulnar nerve (C8-T1) — affects ring and little finger

DC 8514 — Radial nerve (C7-C8) — affects wrist extension, "wrist drop"

Each nerve rates on the same 10–80% scale as lumbar radiculopathy under DC 8520: mild (10%), moderate (20%), moderately severe (40%), severe (60%), complete paralysis (80%). Each arm rates separately — if both arms are affected, file both left and right nerve claims.

Secondary Claim Language: In your claim, write: "I am claiming cervical radiculopathy (DC 8510/8511/8513) as secondary to my service-connected cervical spine condition (DC 5241) under 38 CFR §3.310. My neck condition causes radiating pain/numbness/weakness in my [left/right/both] arm(s) that is a direct result of the cervical spine disease."

Other Common Secondary Conditions

Headaches / Migraines (DC 8100) — Cervical spine conditions frequently cause tension headaches and migraines as secondary conditions. If you have headaches and a cervical spine condition, file DC 8100 as secondary. Prostrating migraine attacks rating: 10% (once every 2 months), 30% (once a month), 50% (with very frequent completely prostrating attacks).

PTSD / Depression (DC 9411/9434) — Chronic cervical spine pain causes secondary mental health conditions under 38 CFR §3.310(b).

Shoulder conditions — Cervical nerve root compression frequently manifests as shoulder pain. The overlap between C4/C5 distribution and rotator cuff pathology makes careful documentation important.

What the C&P Examiner Is Measuring

At a cervical spine C&P exam, the examiner will typically:

Measure active ROM in six directions: forward flexion, extension (backward tilt), right lateral flexion, left lateral flexion, right rotation, left rotation

Measure passive ROM (examiner assists movement)

Note pain at what point in each arc pain occurs

Perform neurological exam — reflexes, sensation, grip strength (critical for radiculopathy claims)

Review imaging — X-ray and MRI for disc degeneration, foraminal narrowing, spondylosis

Complete DBQ (Disability Benefits Questionnaire)

Critical C&P Exam Mistakes to Avoid:

Not reporting radiating pain, numbness, or tingling in arms — this is the evidence for a radiculopathy secondary claim

Wearing a cervical collar only during the exam — remove it; the exam measures your unassisted function

Not disclosing that your ROM worsens with repeated use or during flares

Failing to mention headaches caused by the cervical condition

Exam Preparation Checklist

Documents to Bring

MRI and X-ray results documenting disc disease, stenosis, spondylosis

Orthopedic or neurosurgery notes

Physical therapy records with ROM measurements

Service treatment records showing injury, whiplash, or treatment

Nexus letter if you have one from a private physician

At what degree of motion pain begins in each direction

Whether you have numbness, tingling, or weakness in your arms/hands (radiculopathy)

Headache frequency and severity

Your worst-day functional limitations (can't look over shoulder to drive, can't hold phone for long, worsens after sitting at a desk)

Whether the condition has been progressively worsening

Common Rating Scenarios

Scenario 1: Post-MVA cervical strain with persistent pain

Veteran has cervical strain from vehicle rollover in service. Forward flexion 35° with pain at 25°. Combined ROM 175°. Rating: 10% via ROM (above 30° threshold), but painful motion at 25° triggers §4.59. Result: 10%. If combined ROM were 165°, would qualify for 20%.

Scenario 2: Cervical DDD with arm numbness

Veteran has service-connected cervical DDD (DC 5241) with forward flexion 25°. Rating: 20%. Also has numbness in right thumb/index (C6-C7 distribution, median nerve), confirmed by EMG showing right C7 radiculopathy. Files secondary DC 8511 (median nerve): 20% moderate. Combined: 20% cervical + 20% right median nerve = 36% combined → rounds to 40%.

Scenario 3: Cervical DDD with migraines

Veteran has cervical DDD (20%) causing secondary migraines occurring twice monthly. DC 8100 rating: 30% (more than one a month, prostrating). Combined with 20% cervical = 44% → rounds to 40%, but combined with any other rated condition may affect overall calculation significantly.

All DC 5241 forward flexion and combined ROM thresholds

Painful motion documentation language

Cervical radiculopathy secondary claim strategy by nerve root (C5–C8)

DC 8100 migraine secondary claim criteria

Full DBQ checklist for cervical spine C&P exams

Letter templates for nexus statements and buddy statements

Ready to Maximize Your Cervical Spine Claim?

ROM thresholds, painful motion language, radiculopathy secondary claim checklist, and migraine criteria — all in one $19 guide.

Related Conditions and Articles

DC 8520: Lumbar Radiculopathy / Sciatica Rating — same radiculopathy rating scale applied to lower back

DC 5242: Lumbar Spine DDD Rating Criteria — the cervical spine's lumbar counterpart

DC 8100: Migraine Rating Criteria — frequently secondary to cervical spine conditions

DC 9411: PTSD Rating Criteria — chronic pain conditions can cause secondary mental health claims

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 5242: Degenerative Disc Disease (DDD) of the Lumbar Spine Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 5242?

Ratings for diagnostic code 5242 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 5242: Degenerative Disc Disease (DDD) of the Lumbar Spine Rating Criteria

Overview & Technical Impact

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Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 5242?

Ratings for diagnostic code 5242 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Codes 5260 & 5261: Knee Flexion/Extension Rating Criteria — CFR Guide

Know Your Knee Rating Thresholds Before Your C&P Exam

DC 5260 (flexion) and DC 5261 (extension) rate independently. Most veterans with knee pain qualify for at least 10% — many for 20–40%.

Get the Full Knee Rating Guide — $19 30-day money-back guarantee

Why Knee Conditions Are Commonly Under-Rated

Knee conditions are among the most frequently claimed VA disabilities — and among the most frequently under-rated. The primary reason: the rating schedule uses two separate diagnostic codes that measure different motions of the same joint. Veterans who only know about one code leave significant compensation on the table.

Under 38 CFR Part 4, Schedule for Rating Disabilities:

DC 5260 rates limitation of flexion — how far you can bend your knee

DC 5261 rates limitation of extension — how far you can straighten your leg

Each code rates independently from the other. If a veteran has both limited flexion and limited extension, the VA evaluates which produces the higher rating and applies that one — but it may not combine both under the pyramiding rule (38 CFR §4.14). However, if the limitation is in different motions that cause distinct impairment, both may be ratable. This distinction matters significantly and is frequently litigated at the Board of Veterans' Appeals.

Key Principle: Normal knee ROM is approximately 0–140° of flexion. Any motion restricted below these norms — measured with a goniometer during your C&P exam — maps directly to a specific rating percentage. Knowing your numbers before the exam is not gaming the system; it is accurate symptom reporting.

DC 5260 — Limitation of Flexion of the Leg

DC 5260 applies when knee flexion (bending) is limited. The examiner will ask you to bend your knee as far as possible while they measure the angle with a goniometer. Normal flexion is approximately 140°. Ratings are assigned based on how far below normal your measured flexion falls:

Maximum Flexion (degrees)

Monthly Compensation (approx.)*

*Monthly compensation rates as of 2025 for single veteran with no dependents. Actual amounts depend on combined rating and dependent status.

Important: These thresholds are cumulative and exclusive — the rating applies at the most severe level your ROM reaches. If your flexion is limited to 47°, you rate at 20% (limited to 45° tier). Measure from your actual resting comfortable ROM, not what you can force yourself to do.

DC 5261 — Limitation of Extension of the Leg

DC 5261 applies when you cannot fully straighten your leg. Normal extension is 0° (fully straight). Any degree short of full extension means your extension is "limited to X degrees." The higher the number, the more bent your knee remains even when you're trying to straighten it — and the higher the rating:

Extension Limited To (degrees — higher = more impaired)

Monthly Compensation (approx.)*

*Monthly compensation rates as of 2025 for single veteran with no dependents.

Reading the Extension Table: "Limited to 15°" means the closest your leg gets to straight is 15° — there is a 15° bend that you cannot eliminate. If you cannot fully extend your leg, measure how many degrees short of straight you stop. A larger number means a worse limitation and a higher rating.

The Painful Motion Rule — 38 CFR §4.59

This is the single most important rule many veterans never hear before their C&P exam.

Under 38 CFR §4.59, if there is pain on any motion of the knee, the VA must assign at least the minimum compensable rating for that motion — regardless of where your actual ROM measurement falls.

In practice, this means:

If your knee flexion measures 100° (well above the 60° threshold for the 10% rating), but flexing causes pain at any point , you are still entitled to a 10% rating for DC 5260 .

Similarly for extension — pain anywhere in the arc of motion triggers the minimum compensable rating.

C&P Exam Instruction: If your knee hurts at any point during the range of motion test — even at the beginning of the motion — tell the examiner: "I have pain with this motion." Do not push through pain silently and allow the examiner to record a clean measurement. The painful motion rule exists precisely to protect veterans from this scenario.

Flare-Ups and Functional Loss — 38 CFR §4.40 and §4.45

VA rating also accounts for functional loss due to flare-ups (38 CFR §4.40) and the effect of repeated use on ROM (38 CFR §4.45). If your knee ROM worsens significantly after activity or during flares compared to your baseline measurement, the examiner should document the flare-up ROM as well.

Many veterans present to their C&P exam rested and without recent activity. If your everyday functional ROM — when you've been on your feet for hours, or the day after physical activity — is significantly worse than what you show in the exam room, you should:

Tell the examiner explicitly: "My typical functional ROM during flares is X degrees, which is worse than what you're measuring today."

Have your private physician document flare-up ROM in medical records before the exam.

Keep a pain journal with ROM notes taken on bad days.

Bilateral Knee Claims — The 10% Bilateral Factor

If both knees are service-connected or if one knee condition causes the other (e.g., favoring one leg causes increased strain on the opposite knee), you may be entitled to the bilateral factor under 38 CFR §4.26 .

The bilateral factor adds 10% to the combined value of the two bilateral conditions before they are combined with other ratings. For veterans with rated conditions in both knees, this represents a meaningful benefit that must be specifically requested and documented.

Combined Value Before Bilateral Factor

After 10% Bilateral Factor

Right knee 20%, Left knee 20%

36% (standard combined)

36% + 3.6% bilateral = ~40%

Right knee 30%, Left knee 10%

37% (standard combined)

37% + 3.7% bilateral = ~41%

Secondary Service Connection — What Knee Conditions Cause

A service-connected knee condition frequently causes secondary conditions that are separately ratable under 38 CFR §3.310:

Hip conditions — Gait alteration from a bad knee forces abnormal stress on the hip. DC 5250–5256 (hip limitation/ankylosis).

Lumbar spine — Limping and uneven weight distribution from a knee injury accelerates lumbar spine degeneration. DC 5237/5242 (lumbosacral strain, lumbar DDD).

Foot/ankle conditions — Altered gait mechanics cause ankle instability, plantar fasciitis, and metatarsalgia. DC 5284/5271.

PTSD or depression — Chronic pain conditions frequently cause secondary mental health conditions under 38 CFR §3.310(b).

Secondary Claims Strategy: If you have a service-connected knee condition, review whether you have any of these secondary conditions. File a separate claim for each, citing your primary knee condition as the cause. A nexus opinion from your private physician connecting the secondary condition to your knee is ideal but not always required when the mechanism is obvious (e.g., hip strain from compensatory gait).

DC 5260/5261 vs. DC 5257 (Instability) — Which Code to Use

Some veterans have knee conditions characterized more by instability (the knee gives out) than by ROM limitation. For those, DC 5257 (recurrent subluxation or lateral instability) may yield a higher rating:

DC 5257 mild instability: 10%

DC 5257 moderate instability: 20%

DC 5257 severe instability: 30%

The VA must rate your condition under whichever diagnostic code produces the highest rating — this is the principle of the "most favorable" rating (38 CFR §4.7). If your knee has both ROM limitation and instability, the rater must evaluate both and assign the higher result.

What the C&P Examiner Is Actually Measuring

At a Compensation and Pension exam for knee conditions, the examiner will typically:

Measure active ROM — how far you can move your knee on your own, in degrees, with a goniometer

Measure passive ROM — how far the examiner can move your knee for you

Test for pain during motion — should note at what point in the arc pain occurs

Assess strength and stability — manual muscle testing, lateral/medial/anterior drawer tests for instability

Review imaging — X-ray and MRI findings for arthritis, cartilage damage, ACL/PCL integrity

Complete a DBQ — Disability Benefits Questionnaire documenting all findings

Common C&P Exam Mistakes:

Pushing through pain to show a full ROM measurement — this eliminates the painful motion rule benefit

Not disclosing flare-up severity — the examiner only documents what they observe and what you report

Not bringing medical records documenting imaging, orthopedic evaluations, or physical therapy

Not reporting all functional limitations (stair climbing, prolonged standing, kneeling)

Exam Preparation: What to Bring and What to Say

Documents to Bring

All MRI and X-ray results for the knee

Orthopedic surgeon or sports medicine notes

Physical therapy records documenting ROM measurements

Service treatment records showing injury or treatment

Private physician statement or nexus letter (if applicable)

What to Communicate During the Exam

Describe your worst-day symptoms, not your average day

State explicitly when any motion causes pain: "It hurts when I start to bend my knee" or "I feel pain throughout the entire range"

Describe functional limitations: "I cannot kneel, climb stairs without holding the rail, or stand for more than 20 minutes"

If your condition has been worsening, say so and explain the trajectory

Mention any secondary conditions you believe the knee has caused

Common Rating Scenarios

Scenario 1: Post-ACL repair with stiffness

Veteran has right knee surgery, limited flexion to 90° and extension limited to 10°. DC 5260 (90° flexion) = 0% (above 60° threshold but pain present → 10% via §4.59). DC 5261 (10° extension deficit) = 10%. Most favorable: 10% (both codes yield same result here — but if the painful motion applies to both, the rater would choose the code that best captures the disability).

Scenario 2: Bilateral knee OA with service connection

Veteran has bilateral knee osteoarthritis. Left knee: flexion limited to 40°, right knee: flexion limited to 75° with pain. Left knee: DC 5260 = 20%. Right knee: DC 5260 = 10% (via painful motion rule). Bilateral factor applied to 27% combined = +2.7% = ~30% for both knee conditions combined, then folded into the overall combined rating.

Scenario 3: Extension deficit with instability

Veteran has extension limited to 20° (DC 5261 = 30%) and moderate lateral instability (DC 5257 = 20%). The VA applies the most favorable code: DC 5261 at 30%. Instability does not add — the higher code wins, unless the conditions are truly separate and distinct (a Board-level argument requiring C&P documentation supporting

separate rating).

All DC 5260/5261 flexion and extension thresholds with visual angle guides

The painful motion rule and how to invoke it at your exam

Flare-up documentation language for your physician

Secondary claim identification for hip, lumbar, and ankle conditions

Bilateral factor calculation examples

DC 5257 instability criteria for comparison

Full DBQ checklist so you know what the examiner must document

Ready to Prepare for Your Knee C&P Exam?

The full threshold tables, painful motion language, secondary claim checklist, and bilateral factor calculator — all in one $19 guide.

Related Conditions and Articles

DC 8520: Radiculopathy and Sciatica Rating Criteria — if knee problems have caused secondary hip or lumbar conditions with radiating pain

DC 5242: Lumbar DDD Rating Criteria — secondary lumbar conditions caused by altered gait from knee disability

DC 9411: PTSD Rating Criteria — chronic pain conditions can cause secondary mental health claims

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 5271: Ankle Ankylosis & Subtalar Joint Range of Motion Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 5271?

Ratings for diagnostic code 5271 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 5271: Ankle Ankylosis & Subtalar Joint Range of Motion Rating Criteria

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 5271: Ankle Ankylosis & Subtalar Joint Range of Motion Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 5271?

Ratings for diagnostic code 5271 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 6100: Hearing Loss Rating Criteria — Complete CFR Guide

Know Your Diagnostic Code Before Your C&P Exam

What Is VA Diagnostic Code 6100?

DC 6100 is the code VA uses to rate hearing impairment under 38 CFR Part 4, Schedule for Rating Disabilities. It covers sensorineural hearing loss, conductive hearing loss, and mixed hearing loss. Hearing impairment is one of the most common service-connected conditions among veterans — more than 2.7 million veterans receive compensation for hearing loss or tinnitus.

Unlike most VA diagnostic codes, DC 6100 ratings are determined entirely by a standardized audiological examination — not by subjective symptom reports. The examiner measures two things: your puretone average thresholds and your speech discrimination (speech recognition) score. Those two numbers, combined using VA's published tables, determine your rating percentage.

How VA Rates Hearing Loss: The Audiogram Tables

VA uses a two-step process to convert audiogram results into a disability rating. This process is set out in 38 CFR Part 4, §4.85 and §4.86.

Step 1: Puretone Threshold Average (Table VI)

VA averages your hearing thresholds at four frequencies: 1000 Hz, 2000 Hz, 3000 Hz, and 4000 Hz . This average is your "puretone threshold average" (PTA). The higher the number (in decibels), the worse the hearing loss.

Key point: VA does NOT use 500 Hz or 8000 Hz in its rating formula, even if those show on your audiogram. Only the four frequencies (1000, 2000, 3000, 4000 Hz) count for the rating table lookup.

Step 2: Speech Discrimination Score (Table VII)

Your audiologist will also measure your speech recognition score — what percentage of spoken words you can correctly identify. Scores range from 0% (cannot understand speech at all) to 100% (perfect word recognition). A higher score is better.

Step 3: Combine Using Table VIa

VA combines your PTA and speech discrimination score using Table VIa to determine a Roman numeral category (I through XI), which then maps to a disability percentage for each ear individually.

DC 6100 Disability Ratings by Ear Combination

Once VA determines the Roman numeral category for each ear, it cross-references both ears in a final "Combined Table" to reach the overall percentage. This is why bilateral hearing loss matters — both ears are rated independently, then combined.

Roman Numeral Category

General Severity Description

Example PTA / Speech Combo

Minimal loss, near-normal function

PTA ~40 dB / Speech ~94%

PTA ~50 dB / Speech ~88%

PTA ~60 dB / Speech ~80%

Moderate-severe loss

PTA ~70 dB / Speech ~70%

Severe to profound loss

Higher PTA / lower speech scores

Common mistake: Many veterans and even some VSOs assume that hearing loss is automatically rated at 0% or 10%. In reality, the combination table approach can yield ratings of 30%, 50%, or higher when both ears show significant loss. Veterans with occupational noise exposure (artillery, aviation, armored vehicles) often have severe bilateral loss that the 0%/10% assumption undersells dramatically.

DC 6260 Tinnitus: The Automatic Add-On

Tinnitus (ringing in the ears) is rated separately under DC 6260 and is almost always service-connected alongside hearing loss when there is documented noise exposure. The rules:

10% rating : applies whether tinnitus is unilateral (one ear) or bilateral (both ears) — it is always 10%, never higher for rating purposes, though bilateral tinnitus still only rates 10% total under DC 6260

Tinnitus is rated separately and adds to your combined disability percentage through the standard VA combined rating formula

Service connection for tinnitus requires: current diagnosis + noise exposure during service (MOS/AFSC records, deployment records, buddy statements) + nexus between service noise and current tinnitus

Example: A veteran rated 10% for hearing loss (DC 6100) and 10% for tinnitus (DC 6260) has a combined VA disability of 19% (10 + 10% × 90% remaining = 19%), which rounds to 20% for compensation purposes. That difference — 10% vs 20% — is approximately $175/month in 2026 VA compensation rates.

Service Connection Strategy for Hearing Loss

To establish service connection for DC 6100, you need three elements:

Current diagnosis: An audiological examination confirming hearing loss meeting VA's impairment standards (a finding that normal thresholds were not present at discharge)

In-service event or occurrence: Your military occupational specialty (MOS/AFSC), deployment records, or separation audiogram showing a threshold shift from entry to exit

Nexus: A connection between your service noise exposure and current hearing loss — often established by the C&P examiner or an independent audiologist's IMO

Separation Audiogram Threshold Shifts

One of the strongest evidence documents for hearing loss service connection is a threshold shift between your entry audiogram (MEPS or induction) and your separation audiogram . A significant shift at 3000 Hz or 4000 Hz is highly probative of noise-induced hearing loss.

Request both audiograms via VA Form 4142 (authorization to release records from private providers) and VA Form 180 (request for service records from the National Personnel Records Center). A VSO or claims agent can help request your service treatment records through the NPRC.

MOS/AFSC Noise Exposure Presumptive Evidence

VA adjudicators recognize certain military occupations as inherently high-noise environments. Infantry, artillery, armor, aviation crew, and heavy equipment operators all have documented occupational noise exposure that supports service connection without an additional nexus letter in most cases. Your DD-214 MOS code is evidence of exposure.

What to Expect at Your C&P Exam for Hearing Loss

The C&P examination for hearing loss is conducted by a licensed audiologist, not a general practitioner. The examiner will:

Administer a puretone audiometric test across multiple frequencies

Conduct a speech recognition test (word identification score)

Review your service records for documented noise exposure and prior audiograms

Provide a nexus opinion (at least as likely as not) if the evidence supports service connection

C&P exam strategy: Do not wear hearing aids to your C&P exam — be tested in your unassisted state. VA rates your hearing impairment without assistive devices. Arrive rested; fatigue can mildly affect threshold testing. Bring any prior audiograms you have access to so the examiner can compare over time.

Related Diagnostic Codes

Hearing conditions often involve multiple diagnostic codes. The most commonly paired codes with DC 6100 are:

DC 6260 — Tinnitus (ringing/buzzing in ears)

DC 6200 — Chronic suppurative otitis media (ear infection-related)

DC 6204 — Peripheral vestibular disorders (balance/dizziness)

DC 6205 — Meniere's syndrome (vertigo, hearing loss, tinnitus triad)

Veterans with acoustic trauma sometimes also develop secondary conditions such as depression or social isolation that can be service-connected as secondary to DC 6100 hearing loss.

Increasing a Hearing Loss Rating: Supplemental Claims

If you were previously denied or rated at 0% for hearing loss, several paths exist to increase your rating:

Supplemental Claim: New audiological evidence showing worsened thresholds since the last rating — annual audiograms showing progressive loss are strong new evidence

Higher-Level Review (HLR): If the original decision applied the wrong Table VI/VIa lookup or failed to combine bilateral ratings correctly

CUE (Clear and Unmistakable Error): If VA used the wrong frequencies (e.g., included 500 Hz or 8000 Hz in the puretone average) in a prior rating decision

Full Diagnostic Code Reference — DC 6100 and 149 Others

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 6260: Tinnitus & Sensorineural Hearing Loss Nexus Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 6260?

Ratings for diagnostic code 6260 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 6260: Tinnitus & Sensorineural Hearing Loss Nexus Rating Criteria

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Disability Benefits

VA Diagnostic Code 6260: Tinnitus & Sensorineural Hearing Loss Nexus Rating Criteria

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 6260: Tinnitus & Sensorineural Hearing Loss Nexus Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 6260?

Ratings for diagnostic code 6260 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 6847: Sleep Apnea Syndromes (Obstructive, Central, Mixed) Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 6847?

Ratings for diagnostic code 6847 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 6847: Sleep Apnea Rating Criteria — CPAP, 30%, 50%, 100%

Sleep Apnea Is One of VA's Most Commonly Underrated Conditions

What Is VA Diagnostic Code 6847?

DC 6847 covers Sleep Apnea Syndromes — obstructive, central, and mixed — under 38 CFR Part 4, Schedule for Rating Disabilities (§4.97, Diagnostic Code 6847). Sleep apnea is among the five most frequently service-connected conditions VA rates. It is also one of the conditions most commonly rated at the wrong level — specifically, veterans prescribed a CPAP machine are frequently rated at 0% or 30% when the CFR clearly specifies 50% for CPAP use.

DC 6847 Rating Levels: The Exact CFR Language

0% — $0/month (service-connected, no compensation) "Asymptomatic but with documented sleep disorder breathing."

A formal sleep study diagnosis exists, but the veteran has no symptoms — no daytime sleepiness, no treatment required, no functional impairment.

30% — $508/month "Persistent daytime hypersomnolence."

Documented daytime sleepiness that persists regardless of treatment. The key term is "persistent" — not occasional tiredness, but chronic, documented hypersomnolence affecting daily function.

50% — $1,075/month "Requires use of breathing assistance device (e.g., CPAP machine)."

This is the most important rating threshold for most veterans with sleep apnea. If you are prescribed a CPAP (or BiPAP/APAP), you rate 50% — period. The CFR does not require that you actually use the device. Prescription and medical necessity is the threshold.

100% — $3,737/month "Chronic respiratory failure with carbon dioxide retention or cor pulmonale, or; requires tracheostomy."

Severe, end-stage respiratory compromise. CO2 retention on arterial blood gas, right-heart failure secondary to sleep apnea (cor pulmonale), or surgical tracheostomy required.

The 50% CPAP rule in plain language: If your treating physician or VA provider prescribed you a CPAP machine, you are entitled to a 50% rating under DC 6847. This is not discretionary — the CFR says "requires use of breathing assistance device." A CPAP prescription satisfies this criterion. Veterans rated at 0% or 30% who are CPAP users have been incorrectly rated and should file a Supplemental Claim or HLR.

Service Connection Pathways for Sleep Apnea

Sleep apnea cannot be claimed as a presumptive condition in most cases — it requires direct or secondary service connection. The two most common pathways:

Direct Service Connection

Sleep apnea diagnosed during active duty or with documented onset during service. Evidence includes:

Sleep study ordered and positive during active duty

CPAP machine prescribed while on active duty

Service treatment records documenting snoring complaints, fatigue, or sleep-related medical visits

Buddy statements from bunkmates documenting witnessed apnea episodes or extreme snoring during service

Secondary Service Connection

The most common path for veterans who were not diagnosed during service. Sleep apnea may be claimed as secondary to:

PTSD (DC 9411): PTSD disrupts sleep architecture and is well-documented in medical literature as causally linked to sleep apnea onset and worsening. A nexus letter from a psychiatrist or sleep physician connecting PTSD-related sleep disruption to obstructive sleep apnea is strong evidence.

TBI (DC 8045): Traumatic brain injury affects the neurological regulation of breathing during sleep. Central and mixed sleep apnea in TBI veterans is well-supported in the medical literature.

Weight gain secondary to another service-connected condition: If a service-connected condition (injury, medication side effects) caused significant weight gain that contributed to obstructive sleep apnea, a secondary claim is viable under 38 CFR §3.310.

Sinusitis or rhinitis (secondary to service-connected respiratory conditions): Nasal obstruction secondary to service-connected rhinitis can contribute to obstructive sleep apnea.

VA's common denial language for sleep apnea: VA frequently denies sleep apnea claims with language like "sleep apnea is a common condition not unique to veterans" or "there is no nexus between sleep apnea and military service." These denials are often incorrect when a proper nexus letter connecting sleep apnea to a service-connected condition (like PTSD or TBI) is submitted. A denial of sleep apnea based on lack of nexus is contestable with an IMO from a qualified sleep physician.

The Sleep Study and C&P Exam Process

To claim DC 6847, you generally need a polysomnography (PSG) — an overnight sleep study — that confirms the diagnosis and quantifies severity. The key metric is the Apnea-Hypopnea Index (AHI):

AHI 5–14: Mild sleep apnea

AHI 15–29: Moderate sleep apnea

AHI ≥30: Severe sleep apnea

All three severity levels can qualify for the 50% rating if CPAP is required — the AHI is used for diagnosis, not for determining the rating percentage. A veteran with mild sleep apnea (AHI 8) prescribed a CPAP is still rated 50% under DC 6847.

At your C&P exam, bring:

Your sleep study report (PSG results)

Your CPAP prescription or equipment documentation

Any compliance data from your CPAP device (most modern CPAPs record usage via SD card or app)

Treatment records from your sleep physician or VA provider documenting the CPAP requirement

Buddy Statements for Sleep Apnea Claims

If you were not diagnosed during service, buddy statements from people who observed your sleep during deployment or barracks can corroborate the in-service onset of symptoms:

Statements from fellow service members who witnessed your snoring or witnessed you stop breathing during sleep

Statements from a spouse or partner documenting symptoms that began or worsened after service

Statements documenting your complaints of fatigue or poor sleep quality during your service period

Buddy statements are submitted on VA Form 21-10210 (Lay/Witness Statement) and are treated as lay evidence under the benefit-of-the-doubt rule (38 CFR §3.303).

Secondary Conditions Related to Sleep Apnea

Veterans with service-connected sleep apnea can file secondary claims for conditions caused or worsened by untreated or poorly-treated sleep apnea:

Hypertension (DC 7101): Obstructive sleep apnea is a well-documented cause of secondary hypertension

Depression / Major Depressive Disorder: Chronic sleep deprivation from OSA is causally linked to depression onset and severity

Atrial fibrillation: OSA is a risk factor for AF; secondary claims are viable with a cardiology IMO

Cognitive impairment: Chronic sleep fragmentation affects memory and executive function

Complete DC 6847 Criteria + Secondary Claim Templates

Get Your Free VA C&P Exam Checklist

Know exactly what to document before you walk in. Free download for veterans.

Send My Checklist →

VA Diagnostic Code 6847: Sleep Apnea Syndromes (Obstructive, Central, Mixed) Rating Criteria

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 6847: Sleep Apnea Syndromes (Obstructive, Central, Mixed) Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 6847?

Ratings for diagnostic code 6847 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 7101: Hypertensive Vascular Disease & Cardiovascular Nexus Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 7101?

Ratings for diagnostic code 7101 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 7101: Hypertensive Vascular Disease & Cardiovascular Nexus Rating Criteria

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 7101: Hypertensive Vascular Disease & Cardiovascular Nexus Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 7101?

Ratings for diagnostic code 7101 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 7319: Irritable Bowel Syndrome (IBS) & Gulf War Presumptive Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 7319?

Ratings for diagnostic code 7319 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 7319: Irritable Bowel Syndrome (IBS) & Gulf War Presumptive Rating Criteria

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 7319: Irritable Bowel Syndrome (IBS) & Gulf War Presumptive Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 7319?

Ratings for diagnostic code 7319 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 8045: TBI Rating Criteria — Does It Pyramid with PTSD?

Know What Your C&P Examiner Is Scoring Against

Diagnostic Code 8045 covers Traumatic Brain Injury (TBI) under 38 CFR Part 4, Schedule for Rating Disabilities. TBI is a neurological condition caused by an external force to the head — blast exposure, vehicle accidents, falls, or direct impact. It is distinct from mental health conditions like PTSD, even though symptoms often overlap.

TBI is one of the most underrated conditions in the VA system because:

Many veterans were never formally diagnosed in service (especially before 2007)

Symptoms overlap with PTSD, depression, and anxiety — causing confusion at the C&P exam

The rating structure is complex: cognitive, emotional, and neurological facets each rate separately

Veterans with both TBI and PTSD often don't know TBI can rate separately

DC 8045 Rating Criteria

TBI under DC 8045 is rated by evaluating three facets of impairment. The overall rating is based on the highest-rated facet , not an average. Each facet is scored from 0 to 3, and those scores map to percentage ratings.

Overall Rating Scale

Level of Impairment

Total occupational and social impairment. Unable to maintain employment. Gross disorientation or persistent memory impairment precluding basic self-care.

Deficiencies in most areas — work, school, family relations, judgment, thinking, or mood. Gross impairment in thought processes, persistent delusions or hallucinations, severe depression or suicidal ideation, neglect of personal appearance, near-continuous panic or depression.

Occupational and social impairment with reduced reliability and productivity. Memory impairment, emotional lability, near-continuous depressed mood, impaired judgment, panic attacks more than once weekly, difficulty with understanding complex commands.

Mild or transient symptoms: occasional decrease in work efficiency and ability to perform occupational tasks only during periods of significant stress, or symptoms controlled by continuous medication.

No detectable symptoms, or subjective complaints only without objective neurological abnormality. Diagnosis established, no functional impairment.

The Three Rating Facets

VA evaluates TBI severity across three domains. Score each facet on a 0–3 scale — 0 being no impairment, 3 being severe. The facet with the highest score determines the overall rating:

Cognitive impairment: Memory, concentration, attention, executive function, processing speed, judgment

Emotional/behavioral dysfunction: Irritability, aggression, impulse control, mood instability, apathy

Physical (neurological) symptoms: Headaches, dizziness, balance problems, visual disturbance, fatigue

Important: Specific residual neurological conditions (such as seizure disorder, headaches rated under DC 8100, or tinnitus under DC 6260) may warrant separate ratings on top of the DC 8045 base rating. Migraines, for example, rate independently under DC 8100 even when TBI is the underlying cause.

Does TBI Pyramid with PTSD? The Critical Distinction

Short answer: TBI (DC 8045) is a neurological condition — it does NOT pyramid with mental health conditions like PTSD (DC 9411) or MDD.

VA's pyramiding rule (38 CFR 4.14) prohibits rating the same symptoms twice under two different diagnostic codes. But TBI and PTSD are different conditions with different diagnostic codes, and when symptoms are distinct , separate ratings are warranted.

Here is how VA distinguishes them in practice:

PTSD/MDD (DC 9411, 9434, etc.): Emotional and behavioral symptoms traceable to military trauma — hypervigilance, avoidance, intrusive memories, anxiety

TBI (DC 8045): Cognitive and neurological deficits traceable to head trauma — memory problems, processing speed, word-finding, balance, headaches, light/noise sensitivity

A veteran with blast exposure in service can receive:

A mental health rating (e.g., 70% PTSD under DC 9411) for trauma-related emotional symptoms

A TBI rating (e.g., 40% under DC 8045) for cognitive and neurological deficits

...as long as the symptoms being rated under each code are documentably distinct. The C&P examiner's DBQ should address each set of symptoms separately.

Where veterans get denied: If the C&P examiner conflates your TBI cognitive symptoms with your PTSD symptoms and rates only one condition, you may be leaving a separate TBI rating on the table. Ask your examiner to document cognitive deficits (memory, processing speed, word-finding) separately from emotional/behavioral symptoms.

PACT Act and TBI: Blast Exposure Presumptive

The PACT Act expanded presumptive service connection for veterans exposed to blast pressure during service. Conditions that may qualify include:

TBI from improvised explosive device (IED) blast overpressure

Chronic headaches or migraines following blast exposure

Persistent post-concussive symptoms in veterans with documented deployment to combat zones with IED exposure

Veterans do not need a formal in-service TBI diagnosis if they can show deployment to an area with documented blast exposure and current symptoms consistent with TBI sequelae.

What to Bring to Your TBI C&P Exam

Documentation matters. Bring or ensure your records include:

Incident reports or buddy statements documenting blast exposure, vehicle accident, or head impact event

Medical records showing current neurological symptoms — headaches, dizziness, balance problems, memory complaints, cognitive testing results

Neuropsychological testing results if available — objective cognitive test scores are the strongest evidence for rating purposes

A distinction between TBI and MH symptoms — your treating provider should separately address cognitive/neurological symptoms vs. emotional/behavioral symptoms if you also have a mental health diagnosis

Frequently Asked Questions

I have PTSD rated at 70%. Can I also file for TBI?

Yes. If you have documented head trauma in service and current cognitive/neurological symptoms distinct from your PTSD symptoms, you can file for TBI under DC 8045. The ratings will not pyramid as long as you're documenting different symptom domains under each code.

My TBI claim was denied. What do I do?

Review the denial reason. Common reasons include: (1) no in-service event documented, (2) C&P examiner found no current symptoms, or (3) symptoms attributed entirely to PTSD. File a Supplemental Claim with new evidence, or request a Higher-Level Review if the examiner's opinion was inadequate.

What is the most common TBI rating?

Most TBI claims are rated at 10% (mild symptoms) or 40% (moderate impairment). The jump from 40% to 70% requires documented deficiencies in most areas — including impaired judgment, near-continuous depressed mood, or panic attacks more than once weekly.

Can I get a rating for TBI headaches separately from my DC 8045 rating?

Yes. Headaches (migraines) resulting from TBI are rated under DC 8100 independently. If you have TBI and experience prostrating migraine attacks, file for DC 8100 as a secondary condition to TBI. The combined rating will reflect both DC 8045 and DC 8100.

Map Your TBI and Co-Occurring Conditions to the Right Codes

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 8100: Migraines & Prostrating Attack Frequency Rating Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 8100?

Ratings for diagnostic code 8100 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 8100: Migraines & Prostrating Attack Frequency Rating Rating Criteria

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Disability Benefits

VA Diagnostic Code 8100: Migraines & Prostrating Attack Frequency Rating Rating Criteria

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 8100: Migraines & Prostrating Attack Frequency Rating Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 8100?

Ratings for diagnostic code 8100 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 8520: Radiculopathy & Sciatica Rating Criteria — CFR Guide

The Exact CFR Criteria Your C&P Examiner Uses

What Is VA Diagnostic Code 8520?

DC 8520 covers paralysis of the sciatic nerve under 38 CFR Part 4, Schedule for Rating Disabilities, diagnostic codes 8000–8730 (Diseases of the Peripheral Nervous System). The sciatic nerve is the largest nerve in the body, running from the lower back through the hip and down each leg. When compressed or damaged — commonly by a herniated lumbar disc, lumbar stenosis, or direct trauma — it causes the pain, numbness, weakness, and radiating symptoms veterans know as sciatica or radiculopathy.

DC 8520 is one of the most commonly claimed peripheral nerve conditions because lumbar spine disorders (DC 5242 and related codes) are among the top five most service-connected conditions VA rates. A veteran with a service-connected lumbar condition almost always has a secondary claim path to radiculopathy.

DC 8520 Rating Levels: Complete vs. Incomplete Paralysis

VA rates sciatic nerve conditions on a spectrum from mild incomplete paralysis to complete paralysis. The key term is "paralysis" — but in VA's medical-legal context, this does not mean the inability to walk. It means measurable neurological deficit: reduced sensation, weakness, reflex changes, or functional impairment documented on examination.

Key Criteria (38 CFR §4.124a)

Incomplete Paralysis — Mild

Slight numbness, occasional tingling, minor sensory deficit in distribution of sciatic nerve; reflexes may be diminished

Incomplete Paralysis — Moderate

Paresthesias in foot/leg, moderate sensory deficit, some muscle weakness; pain affecting daily activities

Incomplete Paralysis — Moderately Severe

Marked muscle atrophy, significant weakness (foot drop, difficulty climbing stairs/rising), severe pain, sensory loss in sciatic distribution

Incomplete Paralysis — Severe

Nearly complete paralysis of the nerve, extreme pain that is constant and severe, marked motor deficit throughout the lower extremity

Complete Paralysis

Complete sensory and motor loss in the sciatic nerve distribution; foot drop, absent reflexes, total loss of function in the lower extremity

The 10%/20% majority: Most veterans with lumbar radiculopathy are rated at 10% (mild) or 20% (moderate). The difference in monthly compensation between these two levels is approximately $175/month. The criteria difference is: 10% means "slight" symptoms, 20% means symptoms that "moderately" affect function and daily life. If your pain and numbness affect your ability to work, sit for extended periods, or perform physical activities, that is "moderate" — not "mild."

Bilateral Radiculopathy: Both Legs Matter

If you have lumbar radiculopathy affecting both legs (bilateral sciatica), you can file separate claims for the left sciatic nerve and the right sciatic nerve, each rated under DC 8520. Both ratings are then subject to the bilateral factor under 38 CFR §4.26 : the combined bilateral rating receives a 10% increase before being combined with your other conditions in the whole-person formula.

Example: Left sciatic nerve 20% (moderate) + right sciatic nerve 10% (mild) → bilateral combined = 28% → with 10% bilateral factor bonus = ~31% (rounds to 30%). That 30% bilateral combined rating then enters your overall combined disability formula. Without the bilateral factor applied correctly, you'd enter 20% and 10% separately, yielding a lower combined rating.

How to Establish Service Connection via Secondary to Lumbar

The most common path to DC 8520 service connection is as a secondary condition to a service-connected lumbar spine disability. Under 38 CFR §3.310, a disability that is proximately due to or the result of a service-connected disease or injury is itself entitled to service connection.

The argument is straightforward: your service-connected lumbar disc herniation or degenerative disc disease (DC 5242) compresses your sciatic nerve, causing the radiculopathy. The secondary claim framework requires:

Primary service-connected condition: An already service-connected lumbar spine condition (DC 5242, DC 5243, etc.)

Current diagnosis: A current diagnosis of sciatic nerve involvement — typically documented in your treatment records, MRI reports, or EMG/nerve conduction study results

Nexus: A medical opinion stating that the radiculopathy is "at least as likely as not" caused by or aggravated by the service-connected lumbar condition

Good news for secondary claims: The nexus for secondary service connection is often provable from your existing treatment records alone. If your treating physician documented "lumbar radiculopathy" or "sciatic nerve impingement secondary to L4-L5 herniation," that statement, combined with an IMO letter using the correct "at least as likely as not" standard, can establish service connection without additional testing.

What the C&P Examiner Looks For

At a C&P examination for DC 8520 radiculopathy, the examiner will assess neurological deficits objectively:

Sensory testing: Light touch, pinprick, and vibration sensation in the dermatomal distribution of the sciatic nerve (posterior thigh, lateral and posterior leg, heel, sole, dorsum of foot)

Reflex testing: Knee jerk (L3-L4), ankle jerk (L5-S1) — diminished or absent reflexes support radiculopathy

Motor testing: Dorsiflexion and plantarflexion of the foot, toe extension — weakness indicates motor involvement

Straight leg raise (SLR) test: Positive SLR (pain radiating below the knee when the leg is raised) is a classic sign of sciatic nerve irritation

Gait assessment: Antalgic gait, foot drop, or compensatory movement patterns

C&P exam preparation: Do not overstate or understate your symptoms. Describe your worst days, not your best. If you have pain radiating from your lower back into your buttock, thigh, or leg — say so explicitly and describe where it goes and what triggers it. Mentioning "good days" when you feel well is accurate but can cause an examiner to rate "mild" when your functional baseline is actually "moderate." Report your typical symptoms, not your best-case baseline.

EMG and Nerve Conduction Studies

An electromyography (EMG) / nerve conduction study (NCS) can objectively document peripheral nerve damage and is highly persuasive evidence at both the service connection and rating stages. EMG findings that support radiculopathy include:

Reduced motor unit recruitment in muscles innervated by the sciatic nerve

Positive sharp waves or fibrillations indicating active denervation

Reduced sensory nerve action potentials (SNAPs)

Slowed nerve conduction velocity

If you have not had an EMG and your treatment records mention radiculopathy only in passing, requesting an EMG through your VA treating physician or a private neurologist before your C&P exam can significantly strengthen your rating claim.

Related Diagnostic Codes for Peripheral Nerve Conditions

Sciatic nerve (entire nerve)

Covers most lumbar radiculopathy

External popliteal nerve (common peroneal)

Foot drop, lateral leg sensory loss

Musculocutaneous nerve (superficial peroneal)

Dorsum of foot sensory loss

Internal popliteal nerve (tibial)

Heel and plantar foot involvement

Lumbar spine DDD

Primary condition; basis for secondary DC 8520 claim

Intervertebral disc syndrome (IVDS)

Alternative primary lumbar code; incapacitating episodes rated separately

Complete Diagnostic Code Reference for Back and Nerve Conditions

Get Your Free VA C&P Exam Checklist

Know exactly what to document before you walk in. Free download for veterans.

Send My Checklist →

Overview & Technical Impact

This technical advisory document details compliance, remediation, and architectural strategies for VA Diagnostic Code 9411: Post-Traumatic Stress Disorder (PTSD) Supplemental Nexus Rating Criteria . When organizations deploy high-reliability sovereign infrastructure, rigorous verification guarantees end-to-end data integrity.

Frequently Asked Questions

What is the maximum disability rating for VA Diagnostic Code 9411?

Ratings for diagnostic code 9411 range from 0% to 100% depending on medical evidence severity and functional impairment documented in the DBQ.

Does this claim qualify under the PACT Act?

Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

VA Diagnostic Code 9411: PTSD Rating Criteria — 30%, 50%, 70%, 100% Explained

Know Your Rating Tier Before Your C&P Exam

What Is DC 9411?

VA Diagnostic Code 9411 is the rating code for Post-Traumatic Stress Disorder (PTSD) under 38 CFR Part 4, Schedule for Rating Disabilities — specifically under the Mental Disorders section (§4.130, Diagnostic Code 9411). PTSD is the most common mental health condition service-connected by VA and one of the highest-rated diagnoses across all veterans.

Unlike musculoskeletal conditions, which are rated primarily on range of motion measurements, PTSD is rated based on occupational and social impairment — the degree to which your symptoms affect your ability to function at work and in your relationships. The C&P examiner uses the VA DBQ (Disability Benefits Questionnaire) for Mental Disorders to document your symptom severity against the specific rating criteria.

The Revenue Gap: What Each Rating Tier Pays (2026)

Monthly Compensation (Single Veteran)

A veteran rated at 30% who actually meets the criteria for 50% is leaving $567/month — $6,804/year on the table. Retroactive to the original claim date, a 3-year underpayment at that level represents over $20,000 in back pay. This is why knowing the specific language of each tier matters before your exam.

DC 9411 Rating Criteria: The Exact CFR Language

38 CFR §4.130 rates mental disorders based on the General Rating Formula for Mental Disorders. For PTSD under DC 9411, the criteria are:

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

Service-connected for PTSD but currently asymptomatic or in full remission

No impact on work or relationships

10% — $175/month "Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by continuous medication."

Symptoms are mild or come and go

Only affect function during high-stress periods

Controlled with medication (even if on medication, 10% if controlled)

30% — $508/month "Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal)."

Panic attacks more than once a week

Chronic sleep impairment

Mild memory loss (forgetting names, directions, events)

50% — $1,075/month "Occupational and social impairment with reduced reliability and productivity."

Flattened affect (reduced emotional expression)

Circumstantial, circumlocutory, or stereotyped speech

Panic attacks more than once a week

Difficulty in understanding complex commands

Impairment of short- and long-term memory

Impaired judgment

Impaired abstract thinking

Disturbances of motivation and mood

Difficulty in establishing and maintaining effective work and social relationships

70% — $1,663/month "Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood."

Suicidal ideation

Obsessional rituals which interfere with routine activities

Speech intermittently illogical, obscure, or irrelevant

Near-continuous panic or depression affecting the ability to function independently, appropriately, and effectively

Impaired impulse control (such as unprovoked irritability with periods of violence)

Spatial disorientation

Neglect of personal appearance and hygiene

Difficulty in adapting to stressful circumstances

Inability to establish and maintain effective relationships

100% — $3,737/month "Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name."

The Critical Distinction: 30% vs. 50%

The most consequential rating gap is between 30% ($508/mo) and 50% ($1,075/mo). The language difference is subtle but financially significant:

At 30% , VA sees someone who is "generally functioning satisfactorily" — they hold down a job, maintain relationships, manage daily life, but have periods of difficulty.

At 50% , VA sees someone whose "reliability and productivity" are reduced. The key symptom indicators at 50% that frequently determine the rating are:

Flattened affect — Do you show less emotion than you used to? Do people notice you seem emotionally flat or detached?

Difficulty with complex commands — Do you struggle to follow multi-step instructions? Do you need things repeated?

Trouble maintaining work and social relationships — Have you lost friendships? Do you avoid colleagues? Have you left jobs because of conflict or discomfort?

Panic attacks more than once a week — The frequency threshold appears at both 30% and 50%, but at 50% it is listed as a component of reduced reliability

The Critical Distinction: 50% vs. 70%

The jump from 50% to 70% is $588/month. The 70% tier is defined by "deficiencies in most areas" of life. The two most commonly documented 70% indicators are:

Suicidal ideation — If you have passive thoughts of death, not wanting to wake up, or feeling that others would be better off without you, this is suicidal ideation under VA's definition — even without active planning. Many veterans experiencing this symptom don't report it to their C&P examiner because they believe it will trigger hospitalization. It generally will not, unless you express active intent with a plan. Report it accurately.

Near-continuous panic or depression affecting independent function — If your PTSD symptoms are with you most of the time — not just during stress but as a persistent background state — and they affect your ability to manage your life independently, that is a 70% indicator.

Service Connection Requirements for PTSD

For PTSD claims, VA requires three elements (38 CFR §3.304(f)):

Credible in-service stressor: A traumatic event during service — combat, MST (military sexual trauma), witnessing death or serious injury, life-threatening incident, or similar. VA can verify stressors through service records, buddy statements, or unit histories.

Current diagnosis of PTSD: Made by a qualified mental health professional using DSM-5 criteria

Medical nexus: A connection between the in-service stressor and current PTSD — typically established by the C&P examiner's opinion or a private IMO

MST (Military Sexual Trauma) claims: For PTSD claims based on MST, VA allows alternative sources of corroboration because service records often lack documentation of MST incidents. Evidence can include: statements from friends/family about behavioral changes following the assault, medical or counseling records from the period, requests for transfer, changes in duty performance records, or VA-specific "markers" of MST (such as increased alcohol use, weight changes, requests for STI testing). An accredited VSO or representative experienced with MST claims is strongly recommended.

Veterans rated at 70% for PTSD who cannot maintain substantially gainful employment due to their PTSD may qualify for Total Disability based on Individual Unemployability (TDIU) under 38 CFR §4.16. TDIU pays at the 100% rate ($3,737/month) even if your combined rating is below 100%. A 70% PTSD rating that prevents employment is the textbook TDIU candidate.

To claim TDIU, file VA Form 21-8940 (Veteran's Application for Increased Compensation Based on Unemployability). Your treating mental health provider's statement connecting your PTSD symptoms to your inability to work is critical evidence.

Full DC 9411 Criteria + 150 Other Diagnostic Codes

Get Your Free VA C&P Exam Checklist

Know exactly what to document before you walk in. Free download for veterans.

Send My Checklist →

VA Diagnostic Code 9411: Post-Traumatic Stress Disorder (PTSD) Supplemental Nexus Rating Criteria

Overview & Technical Impact

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Certain respiratory and cardiovascular conditions qualify for presumptive service connection under the PACT Act without proving direct military nexus.

Don't Let a Diagnostic Code Mismatch Deny Your Claim

Buddy Statement Template (VA Form 21-10210)

VA Form 21-10210 Template: Lay Witness Statement

Veteran Name:** Keith Ransom

MOS:** 67V10 (Observation/Scout Helicopter Repairer / Crew Chief)

Duty Station:** Fort Lewis, WA

Service Dates:** September 8, 1987 – May 31, 1991

SECTION III: WITNESS STATEMENT

I am writing this competent lay statement to support the veteran's direct service-connection claim (**38 CFR § 3.303**) under the **PACT Act Section 1168** Toxic Exposure Risk Activity (TERA) framework.

1. Timeframe and Professional Relationship:**

I served directly alongside Veteran Keith Ransom at Fort Lewis, WA, during our active duty service from 1987 to 1991. We operated daily on the same active flight line. I held firsthand knowledge of his specialized tasks, operational duties, and chemical exposure parameters.

2. Specific Operational Exposure and Environmental Realities:**

Veteran Ransom served as an Observation/Scout Helicopter Repairer (**MOS 67V10**) and an active aircraft Crew Chief. He held sole, uninterrupted responsibility for the comprehensive servicing, maintenance, cleaning, and flight-readiness of three (3) distinct aircraft simultaneously.

Because of this high operational load, I personally witnessed Veteran Ransom in direct, daily, skin-to-chemical and aerosolized contact with heavy flight-line compound complexes. This included hydraulic fluid (**Skydrol**), strong degreasing solvents (**Trichloroethane** and **Methyl Ethyl Ketone / MEK**), and **JP-8 jet fuel**. He was regularly tasked with manually scrubbing parts and servicing engines inside unventilated hangars and on open tarmacs, completely lacking standard personal protective equipment (PPE) like chemical-resistant gloves or respirators. This heavy chemical saturation profile occurred repeatedly throughout his entire duty tour.

3. Post-Service Observations:**

Since our time on the flight line at Fort Lewis, I have remained in close personal contact with the veteran. I have personally observed the progression of his chronic medical conditions. His daily health state stands in stark contrast to his high physical conditioning when we served together. I can confirm his persistent struggles with severe functional limitations, including visible breathing issues and notable flare-ups that significantly impair his quality of life.

4. Statutory Certification:**

I certify that the statements above are true, accurate, and complete to the best of my firsthand knowledge, memory, and belief.

Medical Nexus Letter Framework

Medical Nexus Letter Guide: Emory Healthcare Consultation

Target Patient:** Keith Ransom

MOS:** 67V10 (Helicopter Repairer / Crew Chief)

Exposure Target:** Trichloroethane (TCE), Methyl Ethyl Ketone (MEK), JP-8 Jet Fuel

Legal Standards:** PACT Act Section 1168, 38 CFR § 3.326, 38 CFR § 3.303

Instructions for the Clinician

To comply with Board of Veterans' Appeals (BVA) evidentiary requirements, please incorporate the following four structural components verbatim into the medical opinion or Disability Benefits Questionnaire (DBQ) remarks block.

1. The Historical Review Clause

Objective: Explicitly verify that you have reviewed the active history to prevent the VA from claiming the opinion is speculative.*

> **Required Language:**

> "I have reviewed the veteran's service personnel records, specifically his MOS 67V10 duties, and his detailed personal statement regarding daily, unprotected occupational exposure to Trichloroethane (TCE), Methyl Ethyl Ketone (MEK), and JP-8 jet fuel from 1987 to 1991."

2. Cumulative Exposure Pathophysiology

Objective: Establish a chronic, steady accumulation of toxic compounds via dermal and inhalation mechanisms.*

> **Required Language:**

> "The veteran's clinical history is consistent with chronic, high-intensity dermal and inhalation exposure. Medical literature, including the ATSDR Toxicological Profile for Trichloroethylene, establishes a well-documented pathophysiology between long-term organic solvent absorption and the chronic progression of central and peripheral nerve vulnerabilities. The lipophilic nature of these chemical solvents allows them to cross the blood-brain barrier, resulting in cumulative systemic damage."

3. Differential Diagnosis

Objective: Proactively eliminate alternative causes (age, weight, genetics) to shut down VA arguments.*

> **Required Language:**

> "I have conducted a thorough differential diagnosis. There is no evidence of co-morbidities, metabolic disorders, or hereditary causes in the veteran's history that can otherwise account for this pattern of functional

impairment. Therefore, the occupational toxic exposure remains the most scientifically plausible primary etiology."

4. The Legal Probability Threshold (The Magic Words)

Objective: Satisfy the strict statutory standard of proof for service connection.*

> **Required Language:**

> "In my medical opinion, it is at least as likely as not (50% probability or greater) that the veteran's diagnosed condition is proximately due to, or the result of, his hazardous military service exposures."

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