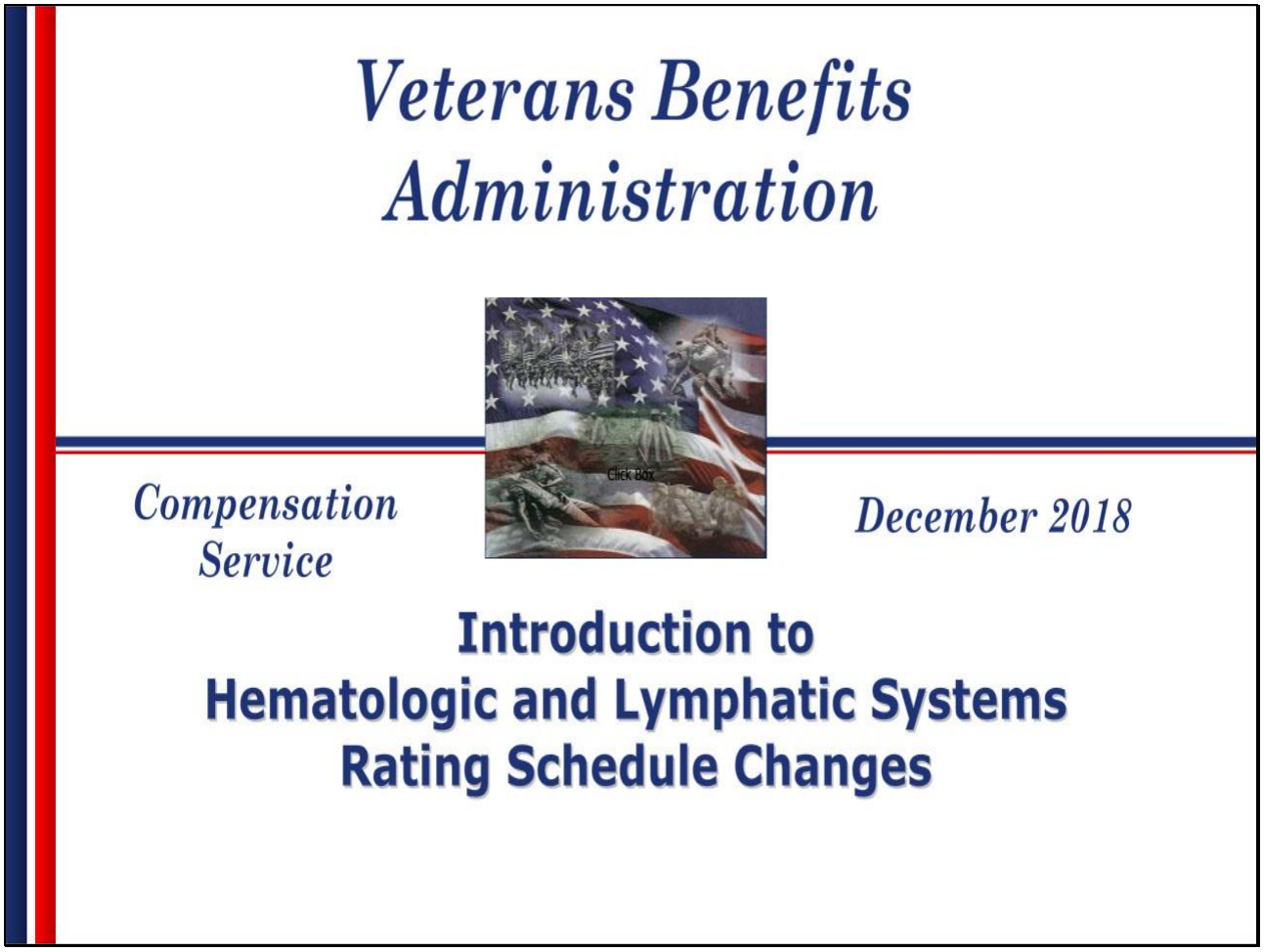
Slide 1 - Slide 1



Slide notes

Hi, this is Lisa Lotts with the Compensation Service Training Staff.

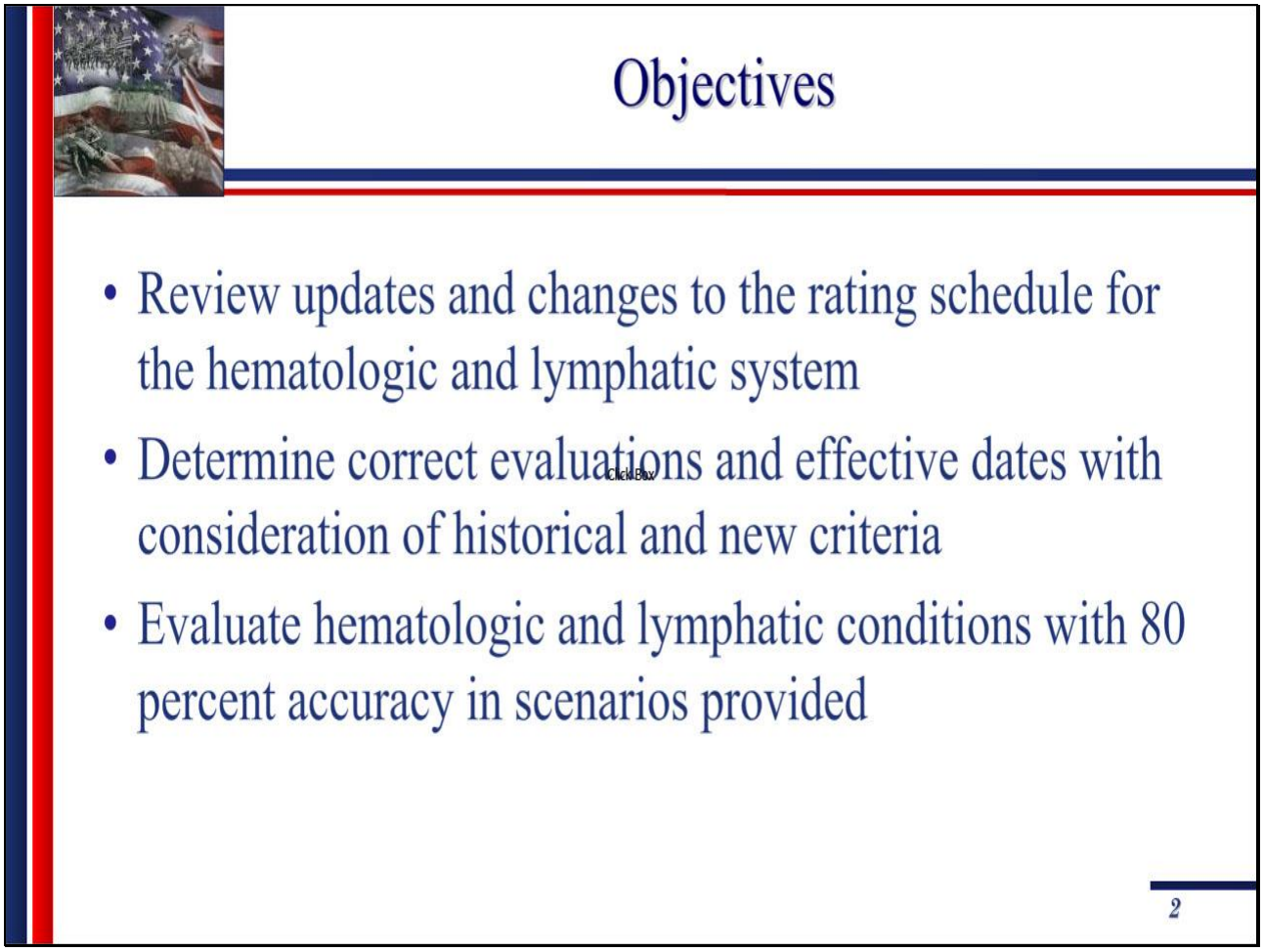
Today, I will be guiding you through the rating schedule changes for the

hematologic and lymphatic system that become effective December 9, 2018.

Please note that these slides will not advance automatically.

After the slide has finished, you will have to click the forward button in order to advance slides.

Slide 2 - Objectives



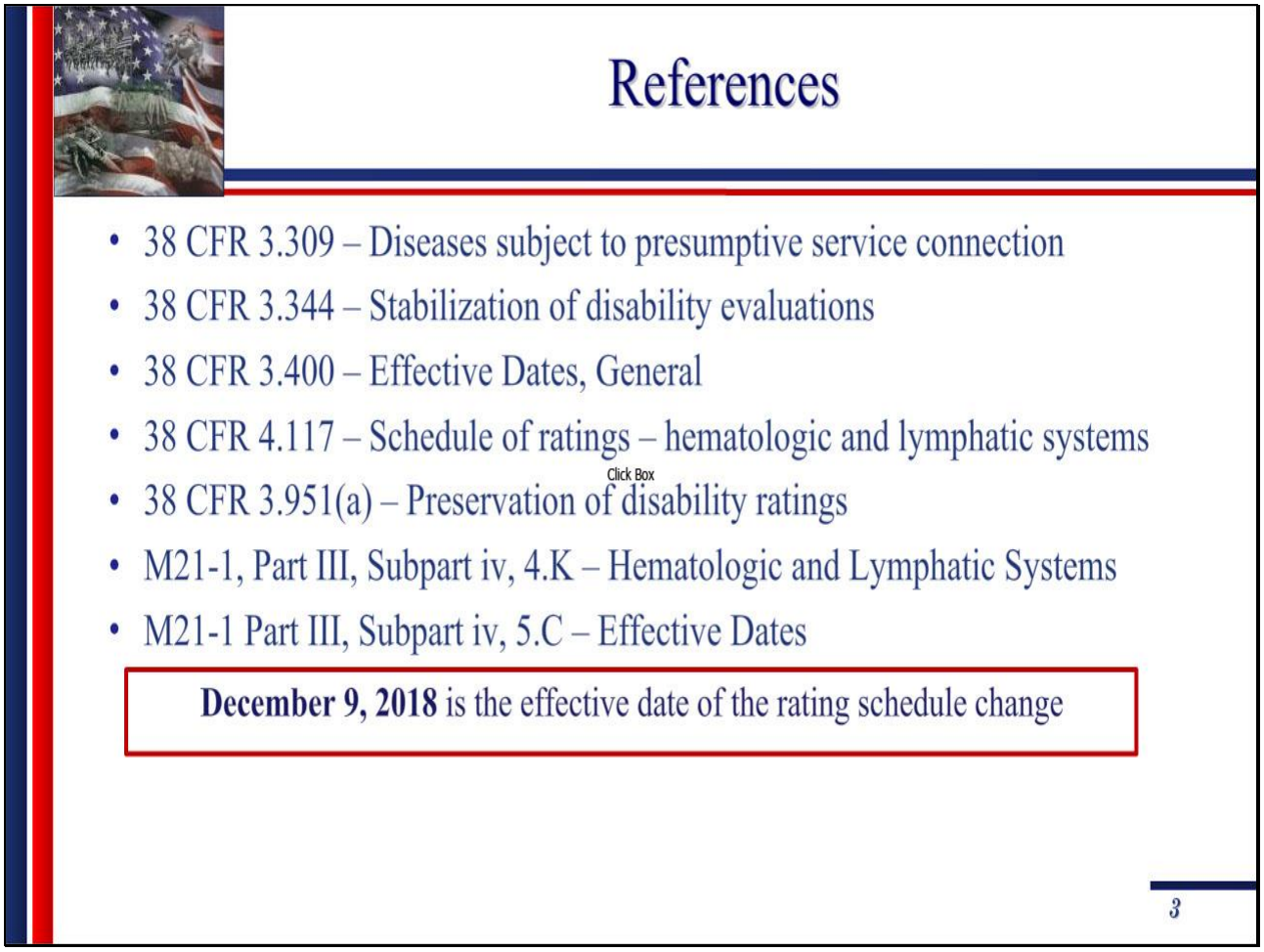
Slide notes

After this lesson, you should be able to identify the changes that occurred to the rating schedule for the hematologic and lymphatic system;

determine the correct evaluations and effective dates, while taking into consideration the historical and new criteria;

and complete the exercise and evaluate the six scenarios provided with 80 percent accuracy.

Slide 3 - References



Slide notes

Our references, provided here, are the guiding force behind our lesson today.

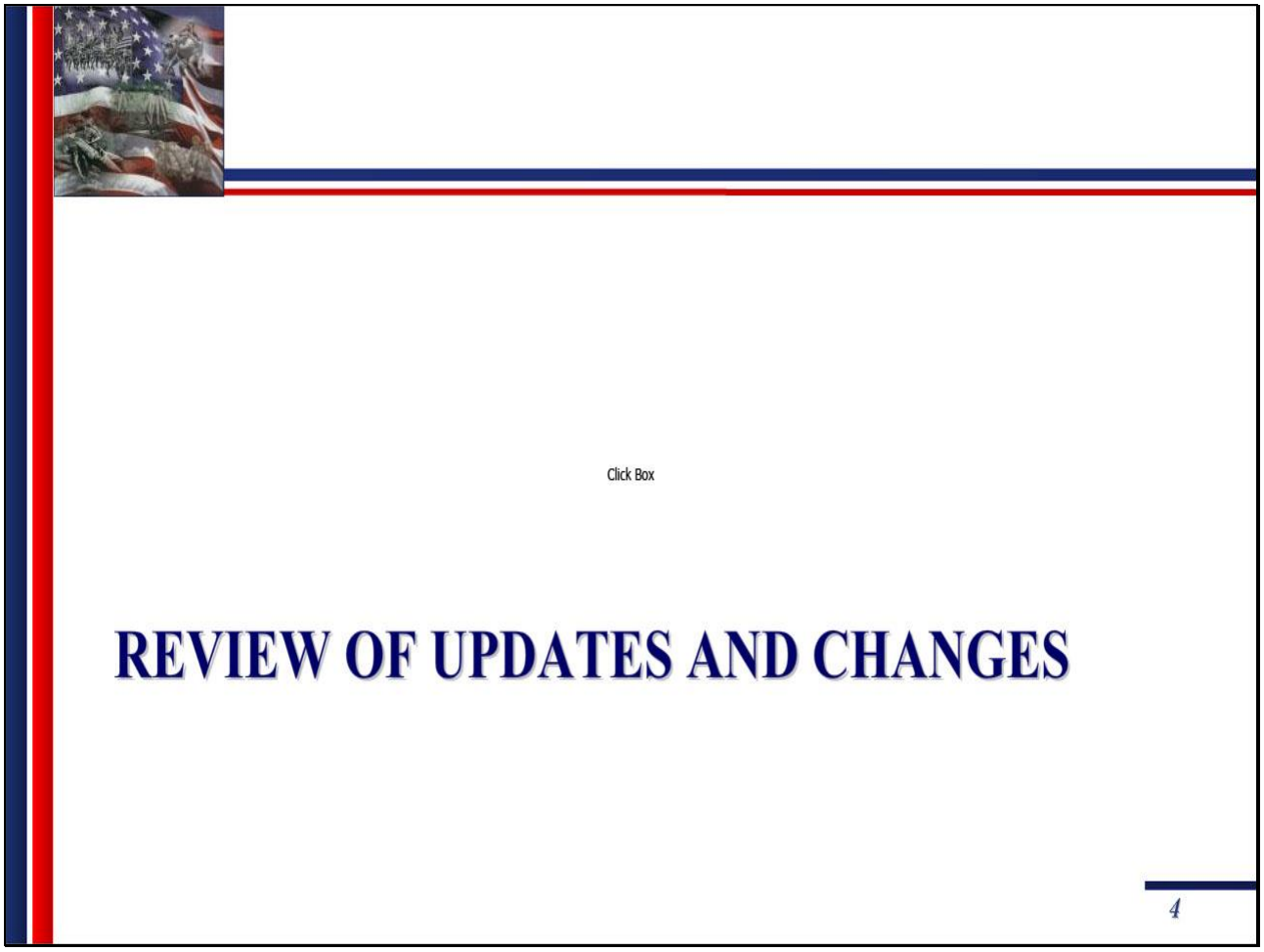
Remember: the effective date of the rating schedule change for

the hematologic and lymphatic system is December 9, 2018.

Just like the other body systems, dental, endocrine, gynecological, eyes,

and skin that were changed prior to this release, this is ***not*** a liberalizing change.

Slide 4 - REVIEW OF UPDATES AND CHANGES



Slide notes

First, we will review the updates and changes of the hematologic and lymphatic rating schedule.

This system has undergone changes in the evaluation criteria for some conditions;

changes in the level of evaluation;

changes in notes applying to certain diagnostic codes;

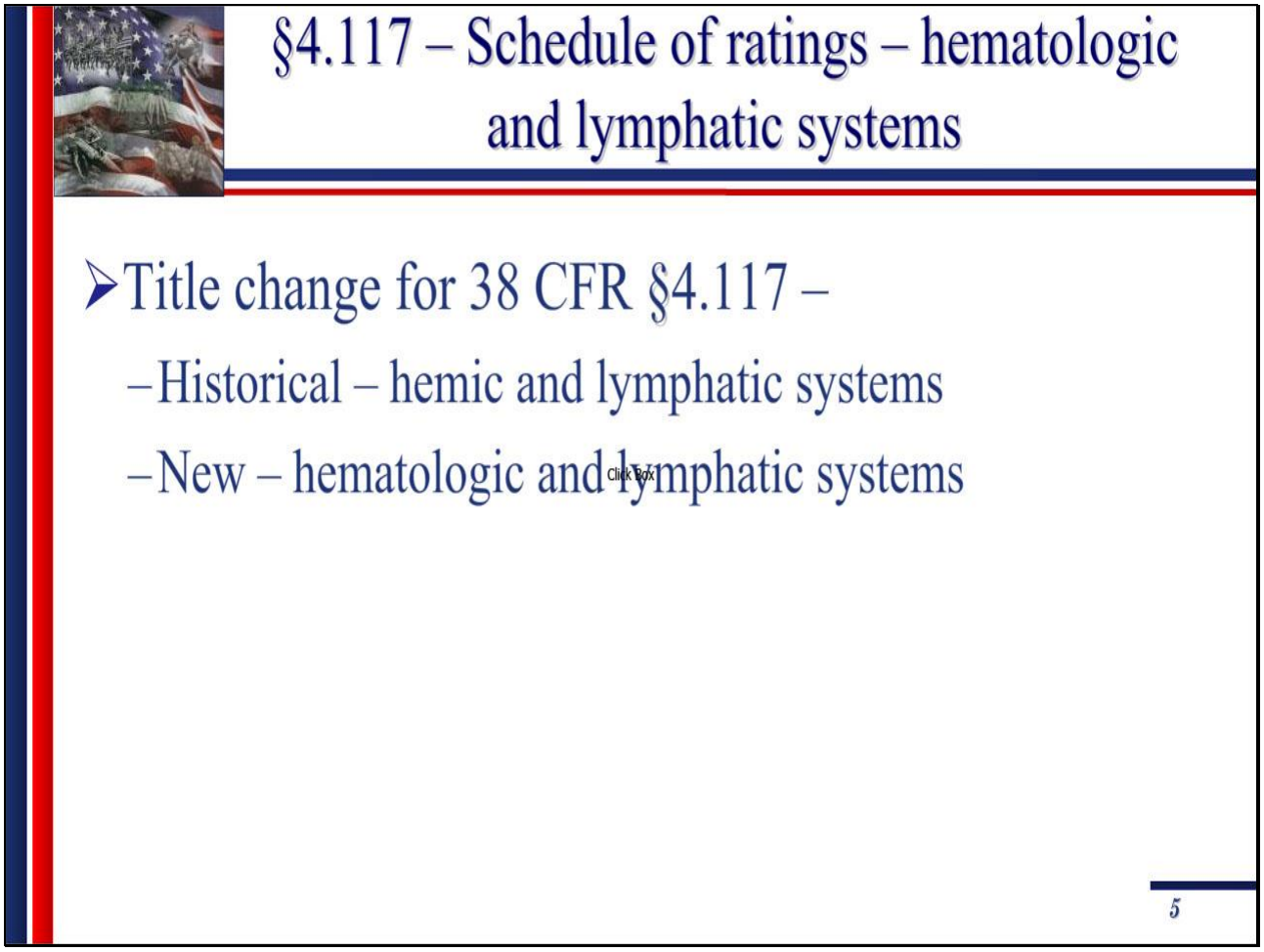
and the addition of nine new diagnostic codes.

We will then discuss important considerations to remember while evaluating these conditions,

and finally, we will practice what you have learned with an exercise and six scenarios.

Let’s get started.

Slide 5 - §4.117 – Schedule of ratings – hematologic and lymphatic systems



Slide notes

For 38 CFR §4.117, there has been a title change

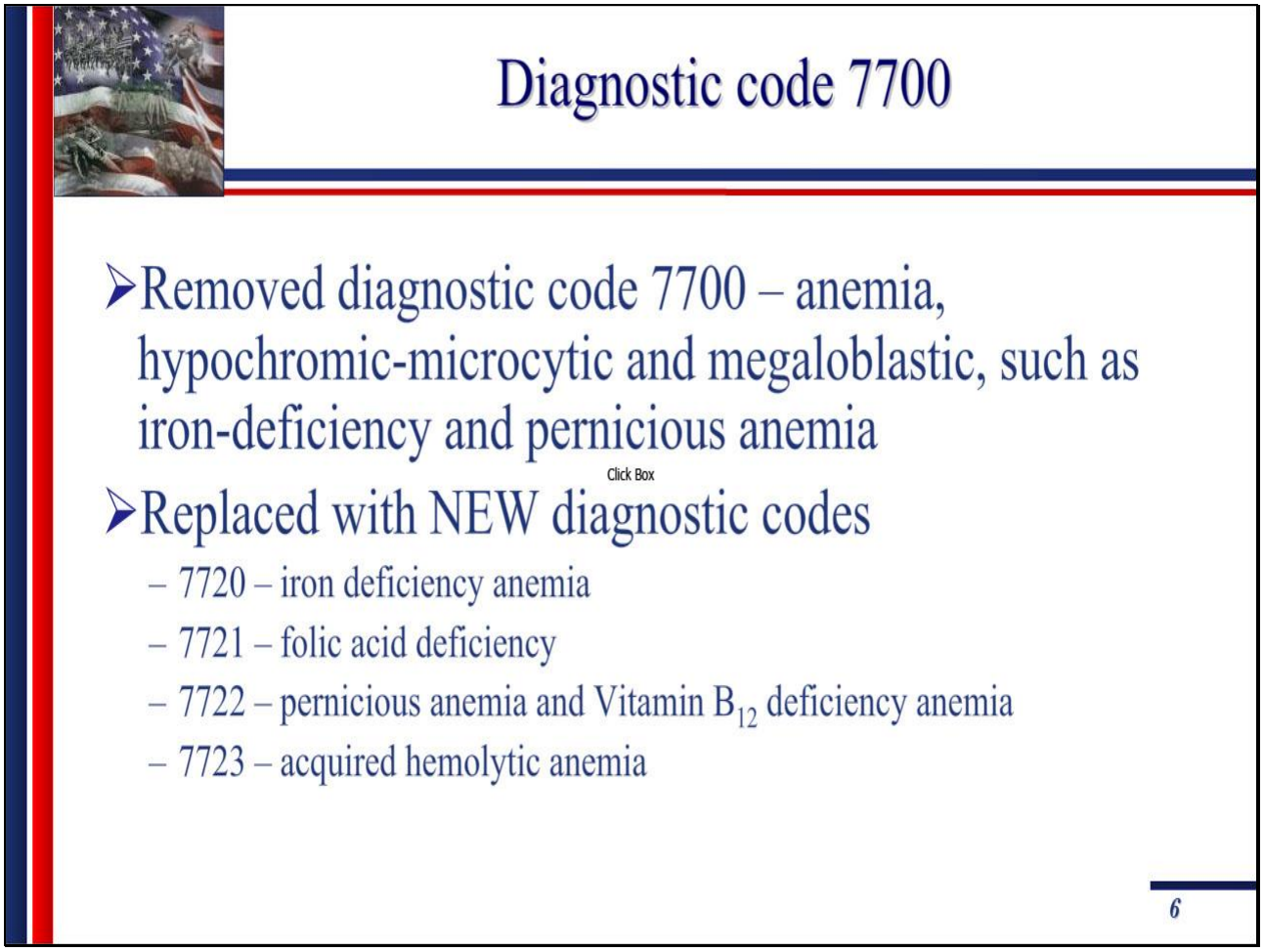
from hemic and lymphatic systems to hematologic and lymphatic systems.

Hemic was an adjective previously used to describe diseases of or related to the blood,

whereas hematologic is the current, more specific medical term

for diseases of the blood or blood-forming organs.

Slide 6 - Diagnostic code 7700



Slide notes

Diagnostic code 7700 for anemia, hypochromic-microcytic and megaloblastic,

such as iron-deficiency and pernicious anemia

has undergone modification and reorganization.

DC 7700 has been deleted and replaced with four new diagnostic codes.

Anemia is predominantly hereditary or secondary to another condition.

Secondary anemia is corrected by treating the underlying condition.

Secondary anemia is most appropriately evaluated as part of

the underlying service-connected disability causing the anemia.

The four new diagnostic codes represent the major anemias that are neither hereditary nor secondary.

This separation also assists decision makers in distinguishing amongst and clarifying the severity of anemias.

The four new diagnostic codes for anemias are:

7720 - iron deficiency anemia

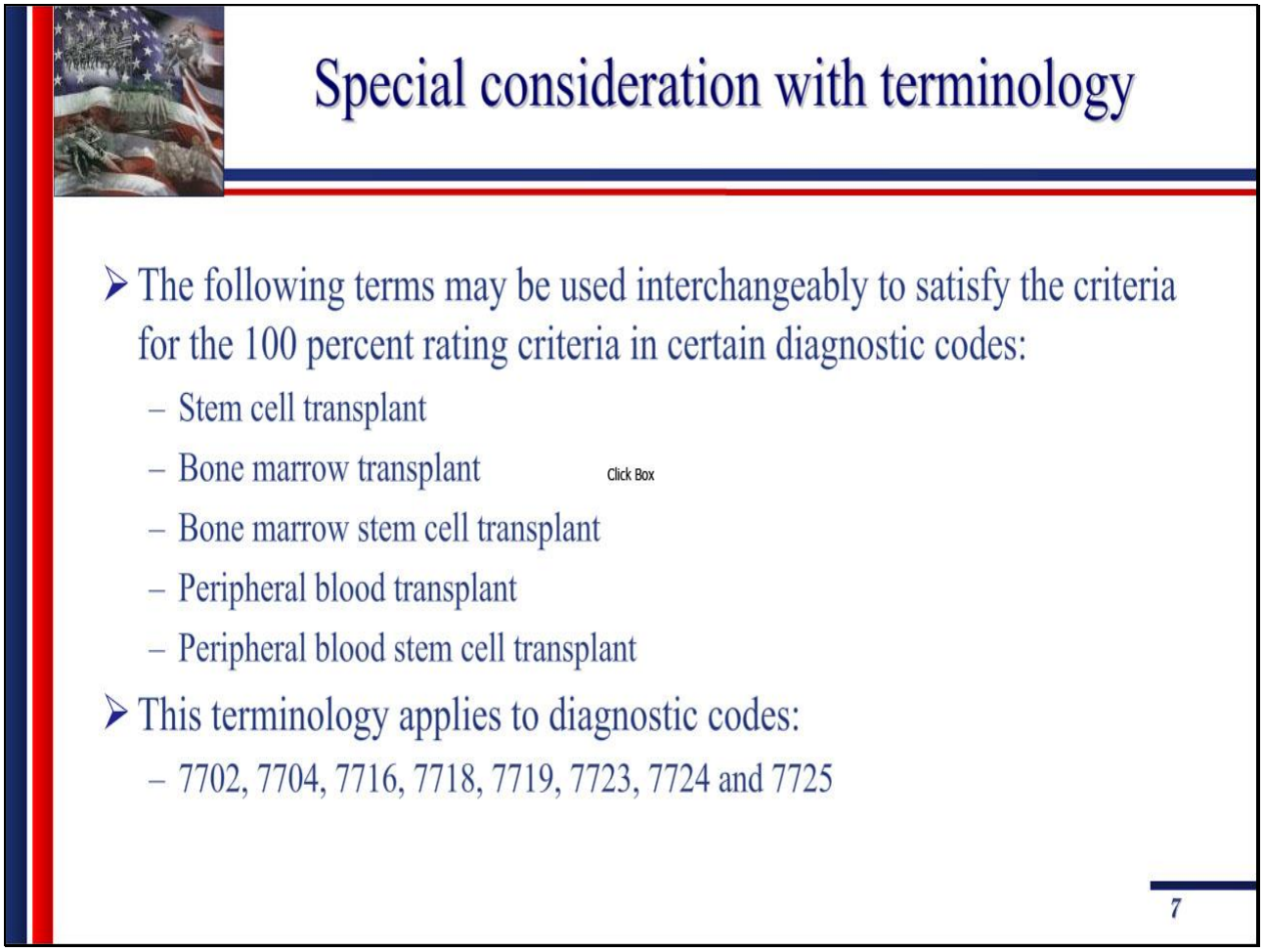
7721 - folic acid deficiency

7722 - pernicious anemia and Vitamin B12 deficiency anemia

and 7723 - acquired hemolytic anemia

These conditions will be discussed later in this presentation.

Slide 7 - Special consideration with terminology



Slide notes

Before moving forward, it is important to talk about terminology that will be used in this presentation.

Many of the hematologic conditions in the rating schedule can be treated with stem cell transplants.

A stem cell transplant, is a procedure used to infuse healthy cells, called stem cells,

into the body to replace damaged or diseased bone marrow.

The cells used in a stem cell transplant can come from bone marrow or peripheral blood.

Therefore, the terms stem cell transplant, bone marrow transplant, bone marrow stem cell transplant

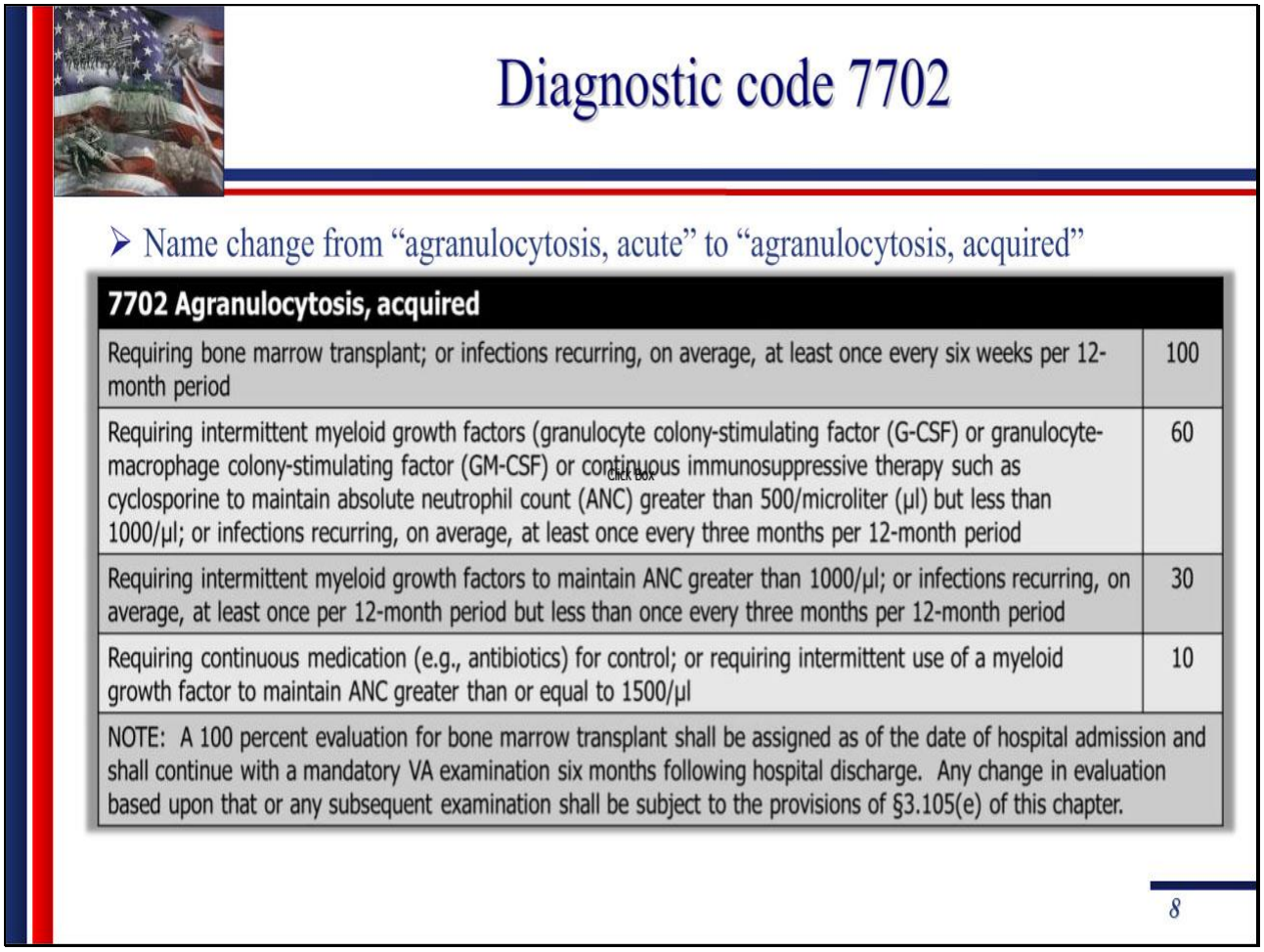
peripheral blood transplant, and peripheral blood stem cell transplant, may be used interchangeably

and all satisfy the criteria for the 100-percent rating criteria.

This interchangeable terminology applies to diagnostic codes

7702, 7704, 7716, 7718, 7719, 7723, 7724, and 7725.

Slide 8 - Diagnostic code 7702



Slide notes

Diagnostic code 7702 for agranulocytosis, acute, has undergone a name change to agranulocytosis, acquired.

Given the advances in pharmacological treatment and shift in standard of care for this condition,

the frequency of transfusions has been removed.

This condition continues to be evaluated as 100, 60, 30 and 10 percent, and the note under this diagnostic code was preserved.

The evaluations are now based on treatment or the average of frequency of episodes of recurring infections.

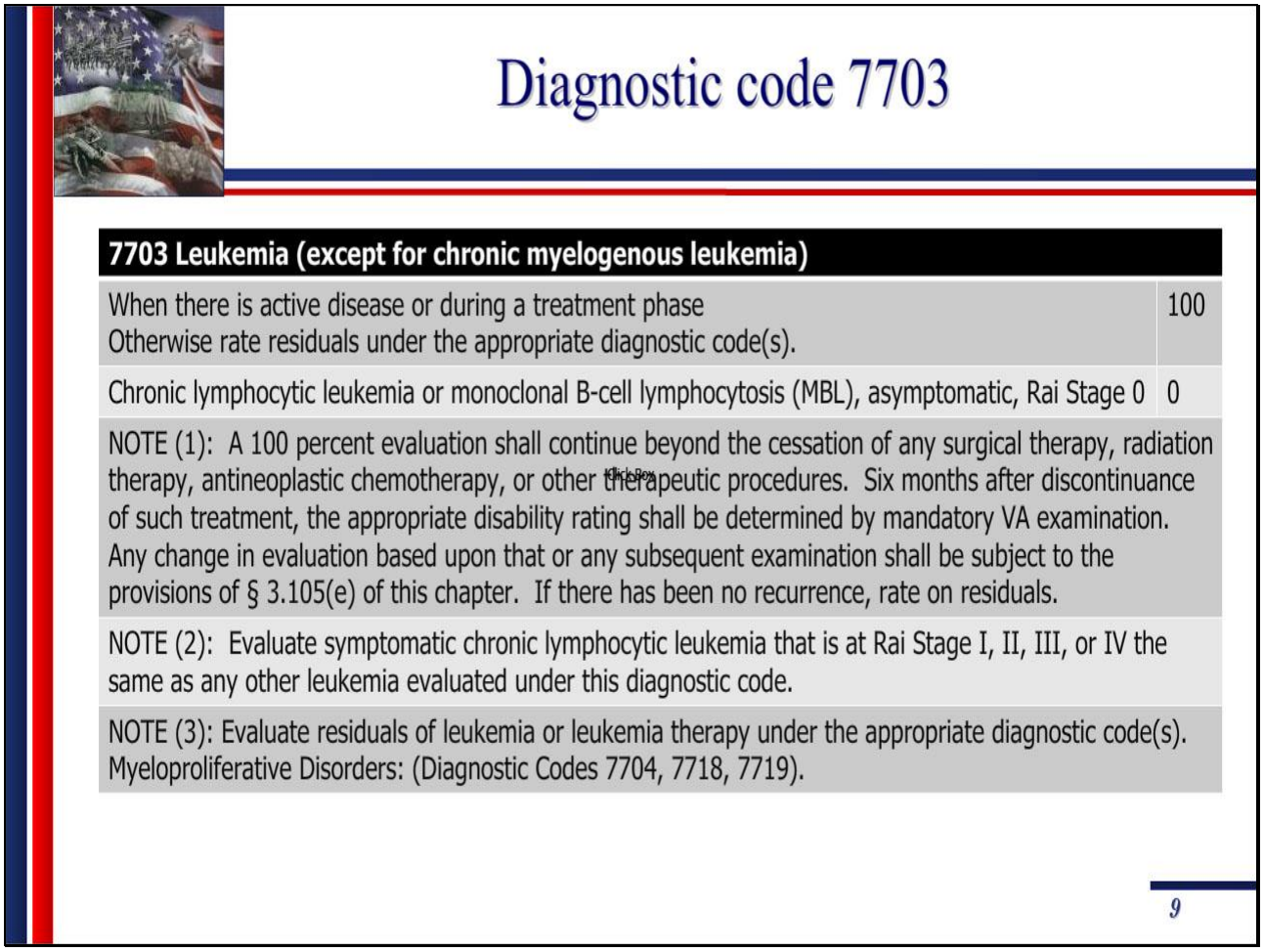
Note 1 was maintained and states that the 100 percent evaluation will be assigned from the date of hospital admission

for bone marrow transplant, and will continue for six months after hospital discharge,

at which time an examination will be completed.

Any reduction is subject to the provisions of 38 CFR 3.105(e). If there has been no recurrence, rate on residuals.

Slide 9 - Diagnostic code 7703



Slide notes

Diagnostic code 7703 is for leukemia, but now indicates it does not include chronic myelogenous leukemia.

This condition has a separate and new diagnostic code that will be discussed later.

The 100 percent evaluation for active disease or during the treatment phase is retained.

Note 1 was also retained and indicates that the 100 percent evaluation will continue for six months after

the cessation of any surgical therapy, radiation therapy, antineoplastic chemotherapy, or

other therapeutic procedures, at which time an examination will be completed and

any reduction is subject to the provisions of 38 CFR 3.105(e).

If there has been no recurrence, rate on residuals.

Since there are many types of residuals associated with leukemia, decision makers are

no longer restricted to anemia or aplastic anemia as a residual.

Note 3 allows for residuals of leukemia or leukemia therapy to be evaluated under the appropriate diagnostic code(s).

Of the four major types of leukemia, chronic lymphocytic leukemia, or CLL, is often diagnosed at the early stages

when the blood lymphocyte count is high, but the patient does not

have enlargement of the spleen, liver, or lymph nodes,

and the red blood cell and platelets are normal or near normal. This early stage is known as Rai Stage 0.

Occasionally patients are diagnosed with monoclonal B-cell lymphocytosis, or MBL.

This diagnosis is in a similar category as Rai Stage 0 CLL.

Unlike other types of leukemia, this early stage of CLL may not progress for many years.

Assigning a 100 percent evaluation would be inappropriate since antineoplastic treatment is not warranted,

and at this early stage, there is little or no effect on a patient's well-being.

Therefore, a noncompensable evaluation is to be assigned for CLL or MBL, asymptomatic, Rai Stage 0.

Patients with lymphocytosis, enlarged lymph nodes and splenomegaly or hepatomegaly

are defined as having intermediate risk for disease progression (Rai Stage I or II).

Patients with hepatomegaly, anemia, or thrombocytopenia are considered to be in the higher risk categories (Rai Stage III or IV).

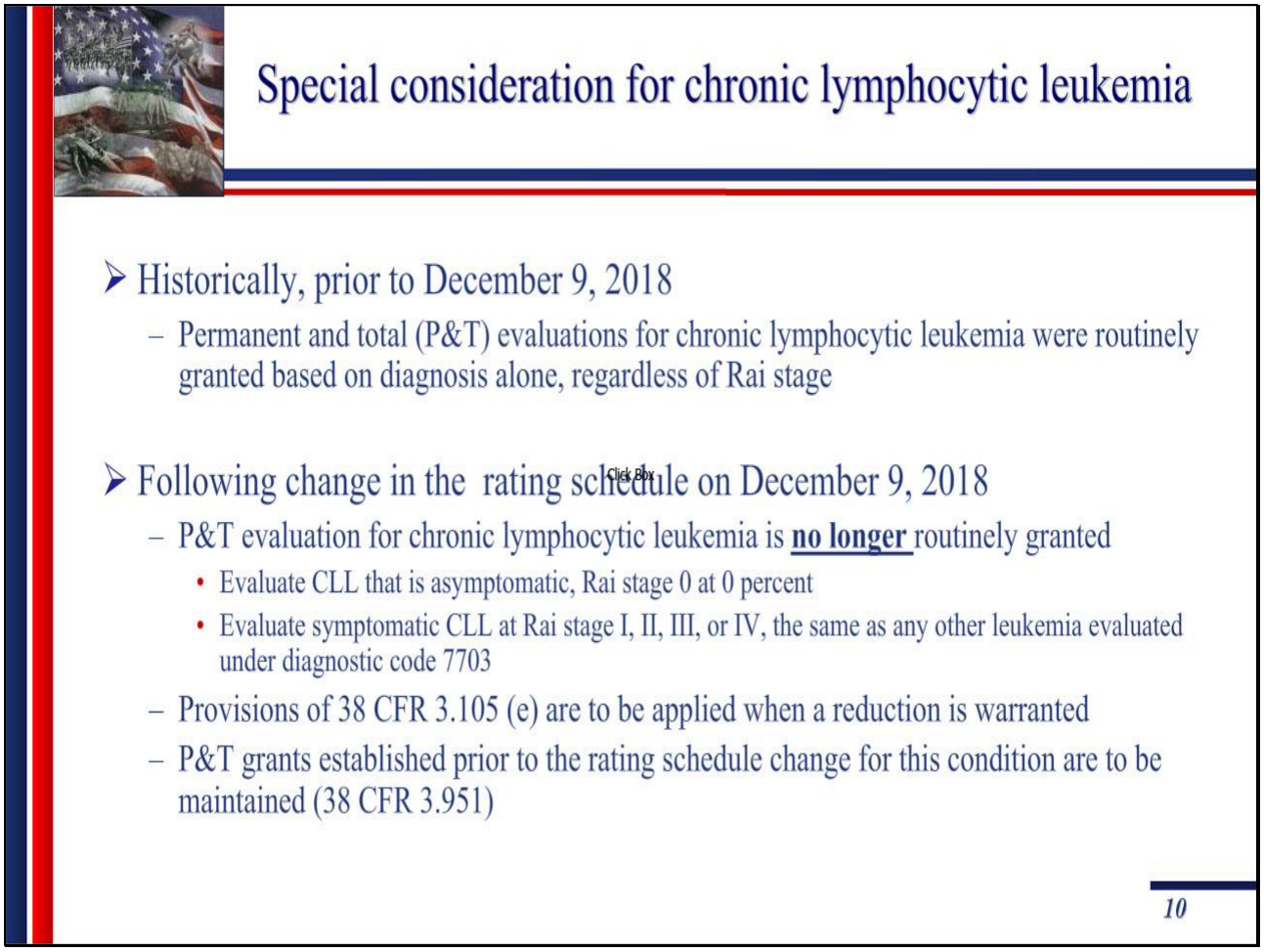
Patients with intermediate risk and high risk are usually started on treatment.

Note 2 of this diagnostic code allows decision makers to evaluate symptomatic CLL

at Rai stage I, II, III, or IV, the same as any other leukemia evaluated under this diagnostic code.

This means the condition will be treated as if it is an active disease.

Slide 10 - Special consideration for chronic lymphocytic leukemia



Slide notes

Prior to the change in the hematologic and lymphatic systems rating schedule on December 9, 2018,

chronic lymphocytic leukemia, or CLL was routinely granted a permanent and total evaluation

based on diagnosis alone, regardless of Rai stage.

This is no longer the case with new claims submitted on or after

December 9, 2018, the date of the rating schedule change.

CLL is to be evaluated based on facts found.

Asymptomatic CLL that is at Rai stage 0 is to be evaluated at 0 percent.

Whereas symptomatic CLL that is at Rai Stage I, II, III, or IV is evaluated the same as any other

leukemia evaluated under this diagnostic code, as stated in Note 2.

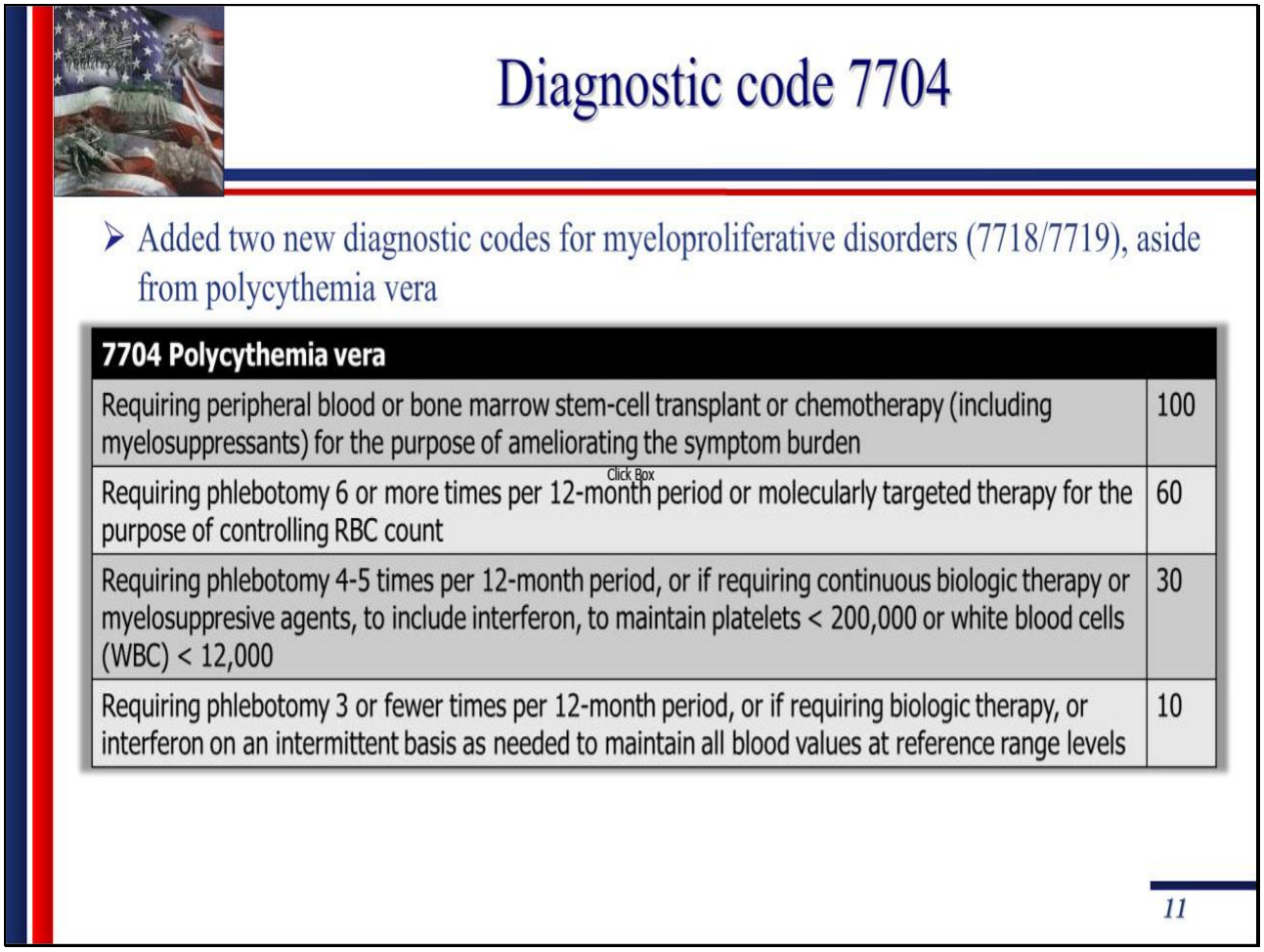
Remember, this means the will be treated as if it is an active disease.

In the event a claim is reviewed where the prior grant is permanent and total, and it was established

prior to December 9, 2018, the evaluation is protected under 38 CFR 3.951,

which provides that a rating schedule change cannot be the basis for reduction.

Slide 11 - Diagnostic code 7704



Slide notes

Polycythemia vera is a type of myeloproliferative disorder that is evaluated under diagnostic code 7704.

Myeloproliferative disorders are a group of slow-growing blood neoplasms in which the bone marrow

produces excess numbers of red blood cells, white blood cells, or platelets.

Polycythemia vera is the only myeloproliferative disorder included on the historical rating schedule.

Two new myeloproliferative disorders have been added to the rating schedule -

essential thrombocythemia and primary myelofibrosis under diagnostic code 7718

and chronic myelogenous leukemia (CML) (chronic myeloid leukemia or chronic granulocytic leukemia)

under diagnostic code 7719. These two conditions will be covered later in this presentation.

First, let’s talk about polycythemia vera.

Polycythemia vera is treated commonly by phlebotomy, which is removal of the blood,

as needed, to reduce the number of blood cells and platelets.

This condition can also be treated similarly to other myeloproliferative disorders

to achieve appropriate levels of cells and to reduce complications.

Examples of treatment include radioactive phosphorus, which suppresses the overproduction of blood cells;

interferon alpha, which boosts the immune system;

chemotherapeutic agents, including myelosuppressants that decrease bone marrow production, and low dose aspirin.

This condition is evaluated as 100, 60, 30, or 10 percent, rather than the historical 100, 40, or 10 percent.

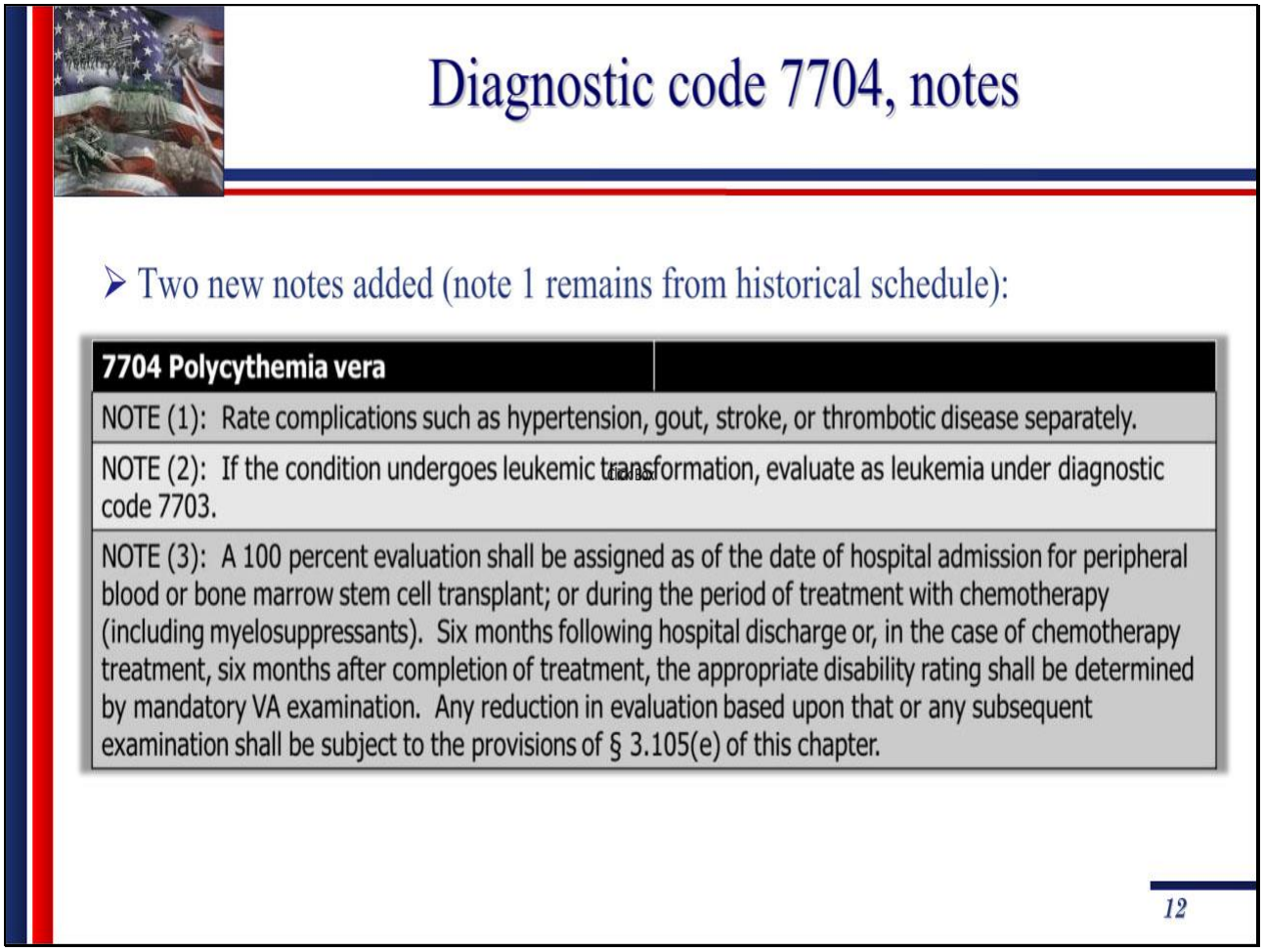
It is important to note that under the 10 percent evaluation, the term “all blood values” is truly inclusive of “all,”

not just platelets or white blood cell counts as noted in the other evaluation levels.

There are now three notes under this diagnostic code.

Polycythemia vera is the only myeloproliferative disorder included on the historical rating schedule.

Slide 12 - Diagnostic code 7704, notes



Slide notes

The note regarding evaluating complications, such as hypertension, gout, stroke,

or thrombotic disease separately has been maintained.

Note 2 indicates that if the condition undergoes a leukemic transformation,

the condition will be evaluated as leukemia under diagnostic code 7703.

Note 3 indicates the 100 percent evaluation will be assigned from the date of hospital admission

for peripheral blood or bone marrow stem cell transplant,

or during the period of treatment with chemotherapy (including myelosuppressants).

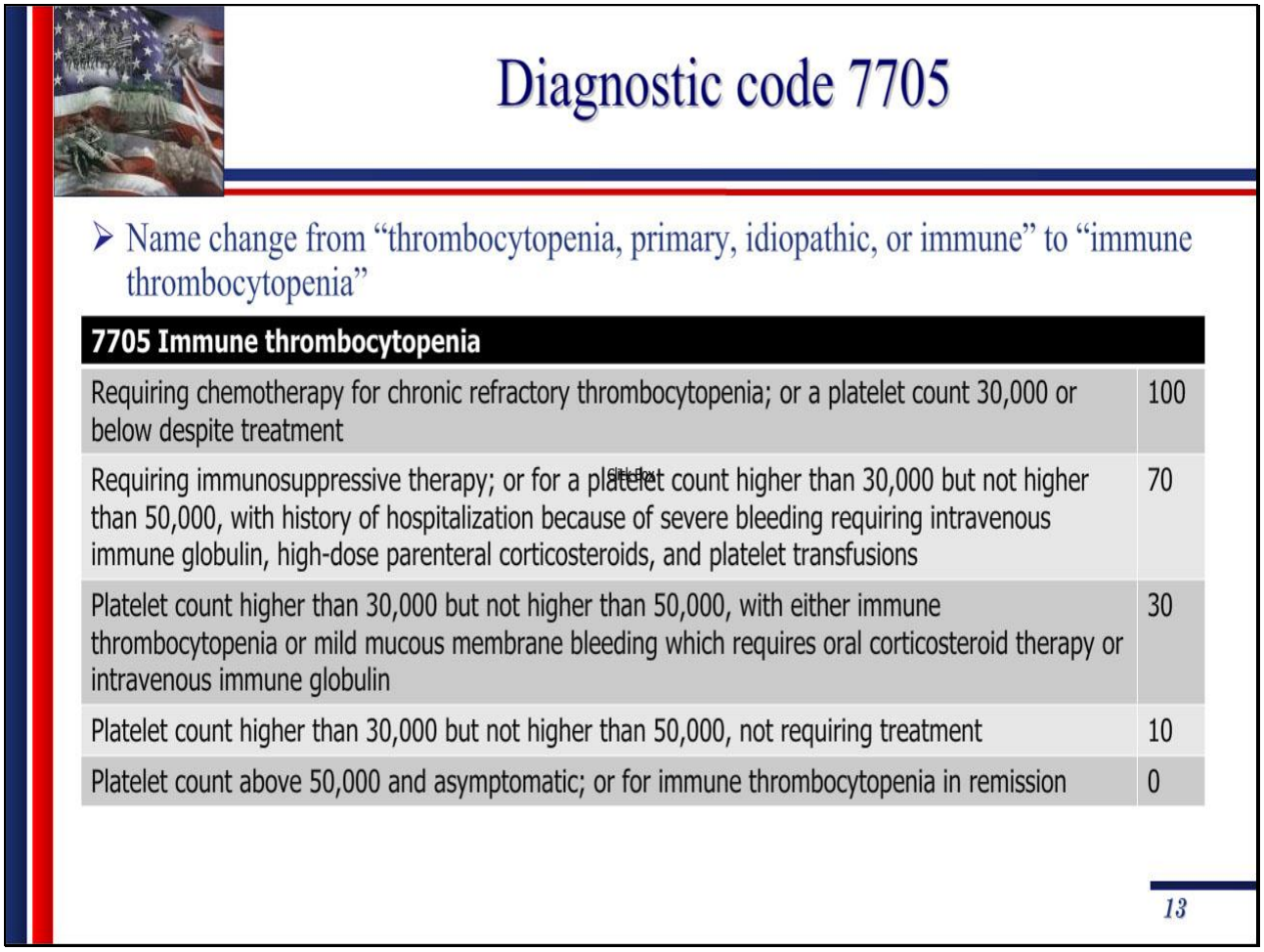
This evaluation will continue for six months after hospital discharge,

or in the case of chemotherapy, six months after cessation of treatment,

at which time an examination will be completed.

Any reduction is subject to the provisions of 38 CFR §3.105(e).

Slide 13 - Diagnostic code 7705



Slide notes

Diagnostic code 7705 has undergone a name

change from "thrombocytopenia, primary, idiopathic, or immune" to "immune thrombocytopenia."

The evaluation criteria has been updated to reflect advances in medical knowledge,

and the new 10 percent level evaluation has been added.

The evaluations are based upon platelet count,

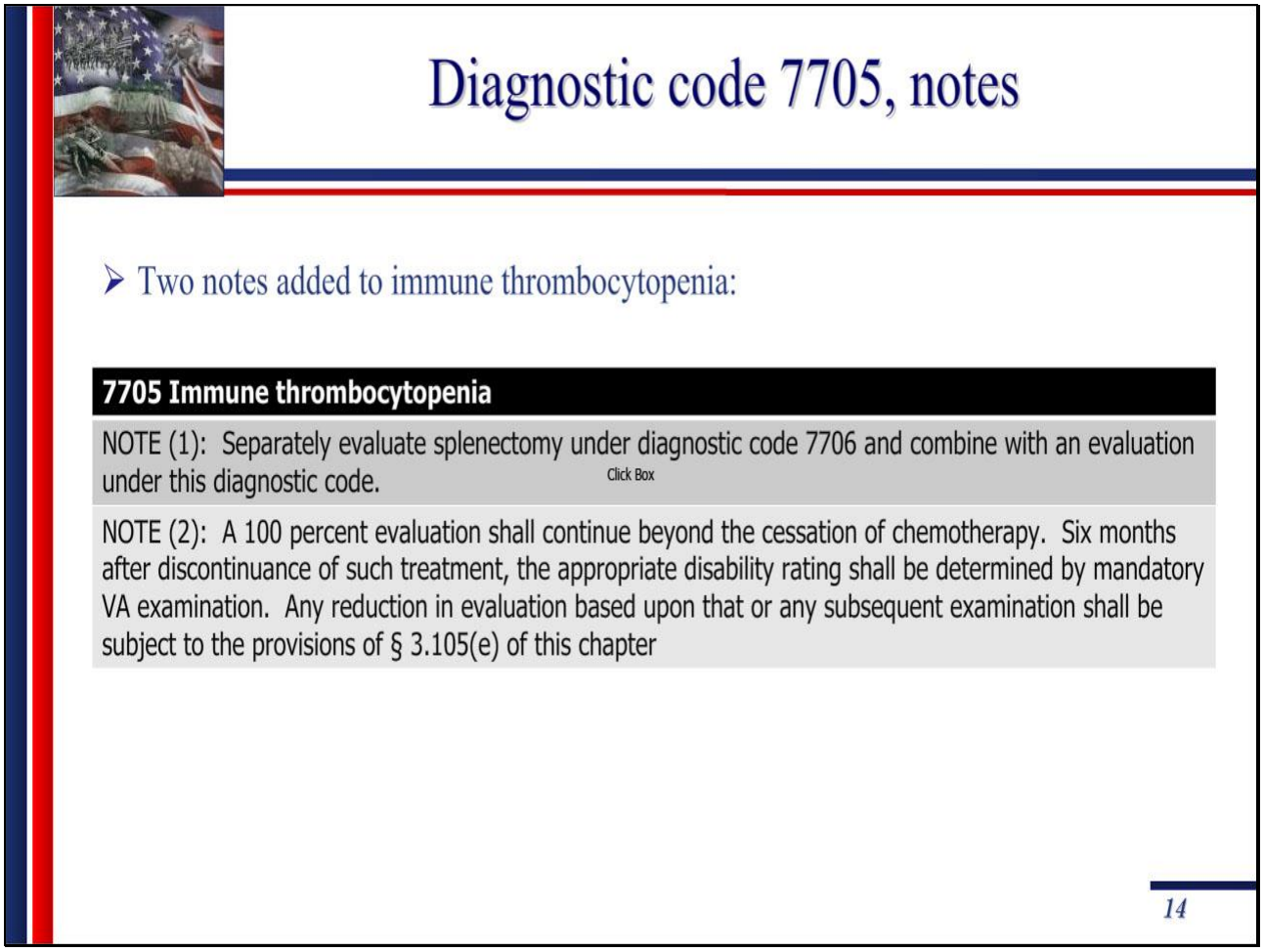
the presence or absence of bleeding episodes, and whether treatment is required.

Examples of treatment include intravenous immune globulin,

high-dose parenteral corticosteroids, platelet transfusions, or oral corticosteroid therapy.

Two notes have also been added under this diagnostic code, which will be discussed on the next slide.

Slide 14 - Diagnostic code 7705, notes



Slide notes

The first note indicates splenectomy under diagnostic code 7706

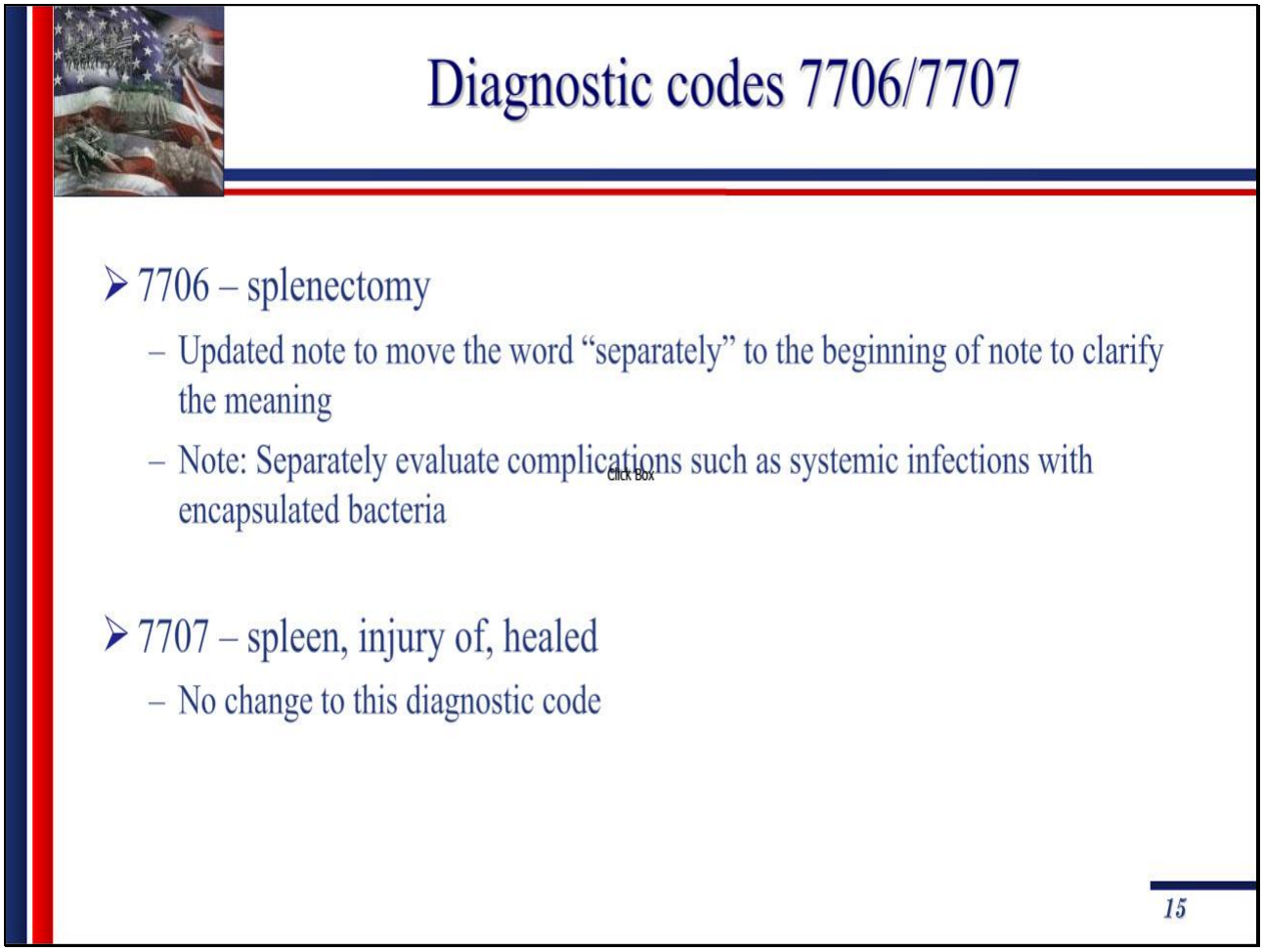
is to be separately evaluated and combined with this diagnostic code under 38 CFR 4.25.

Note 2 indicates that the 100 percent evaluation continues for six months

after the cessation of chemotherapy, at which time an examination will be completed

and any reduction is subject to the provisions of 38 CFR 3.105(e).

Slide 15 - Diagnostic codes 7706/7707



Slide notes

Diagnostic code 7706 for splenectomy underwent a minor update,

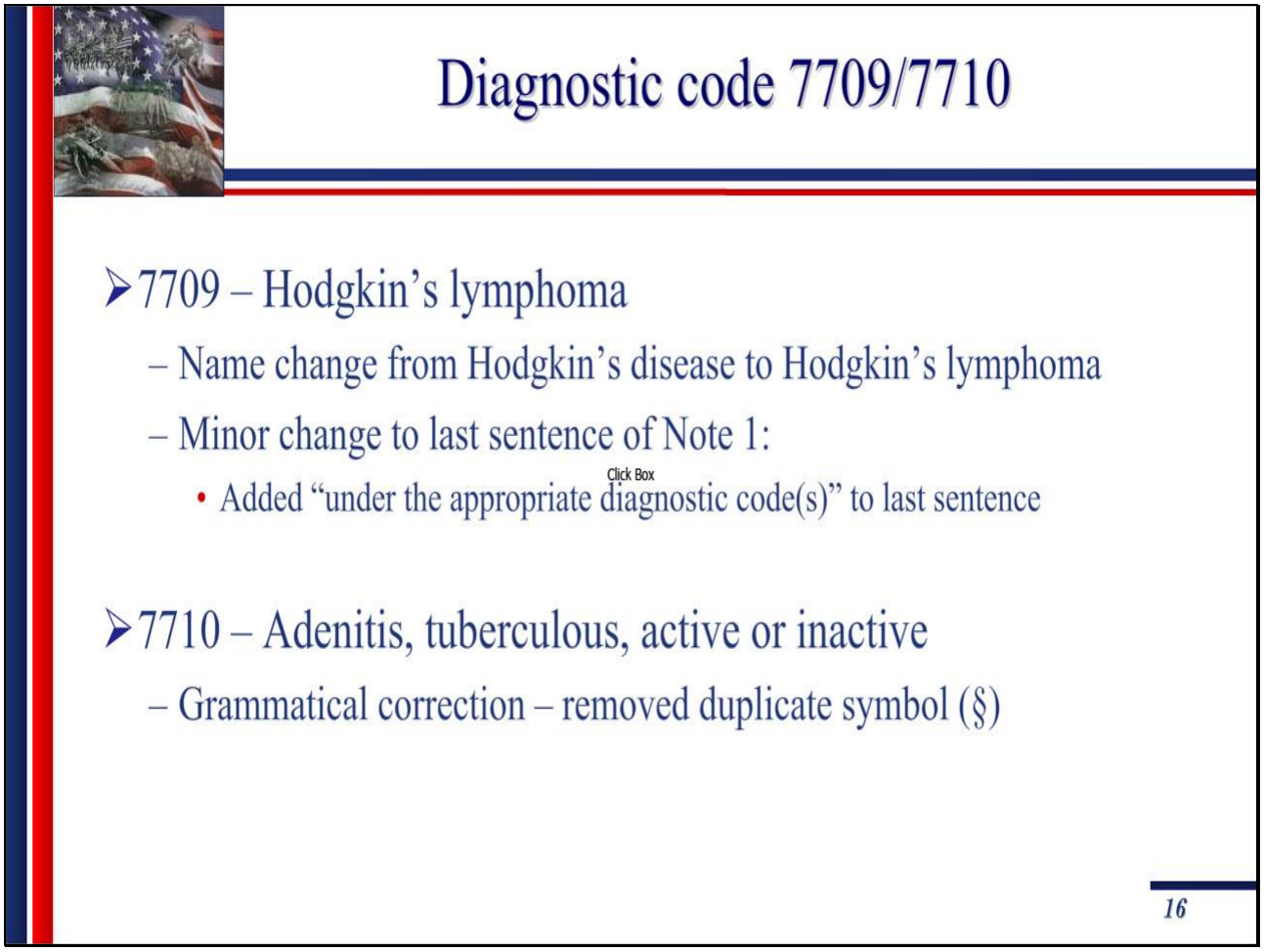
where the word "separately" has been moved to the beginning of the note to add more clarity.

The note now reads:

"Separately evaluate complications such as systemic infections with encapsulated bacteria."

There has been no change to diagnostic code 7707.

Slide 16 - Diagnostic code 7709/7710



Slide notes

Diagnostic code 7709 for Hodgkin's disease underwent a name change

to the more accurate clinical term - Hodgkin's lymphoma.

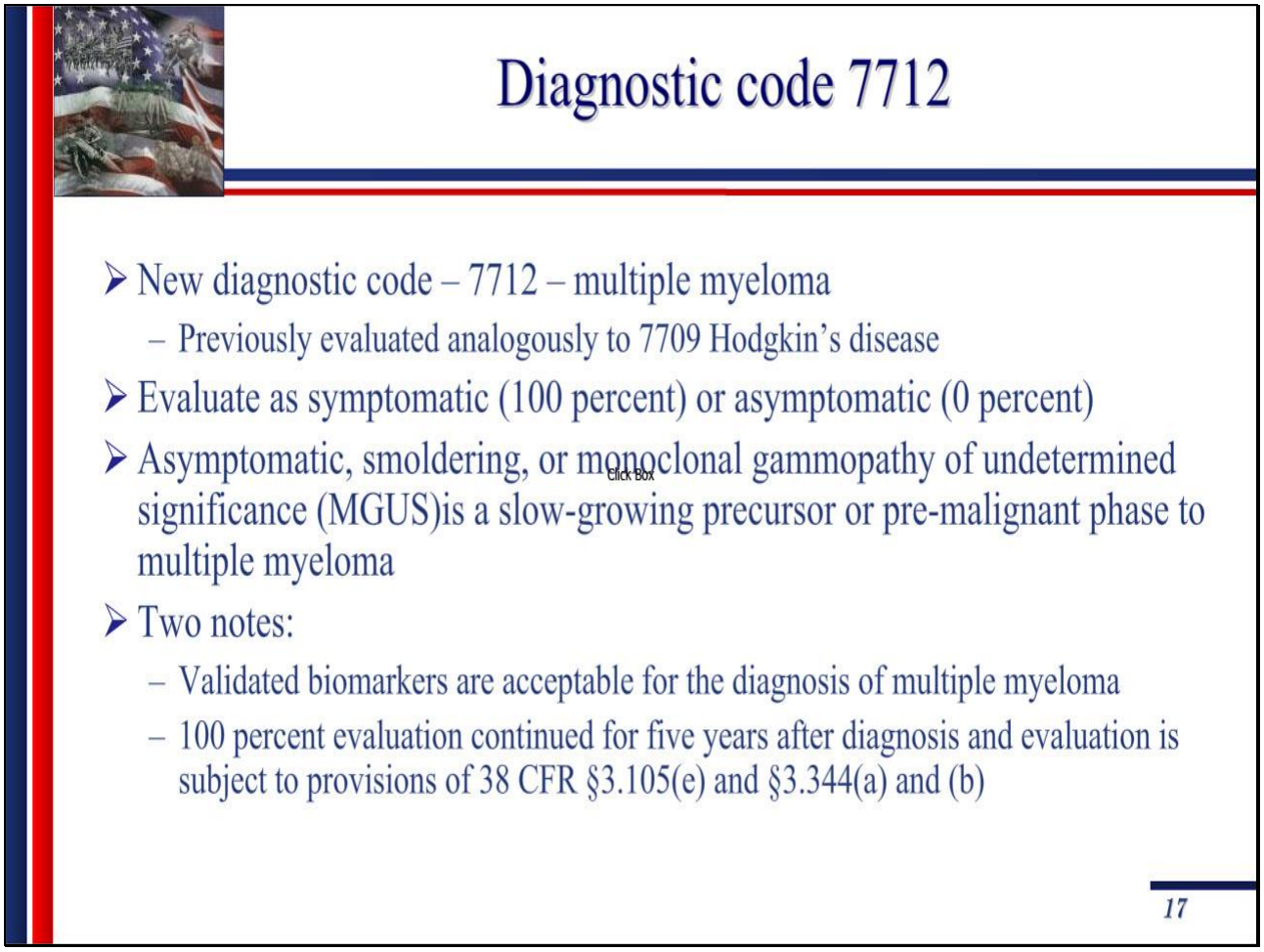
There has been a minor addition to note 1, where "under the appropriate diagnostic code(s)"

has been added to the last sentence. The last sentence now reads as

"If there has been no local recurrence or metastasis, rate on residuals under the appropriate diagnostic code(s)."

Diagnostic code 7710 underwent a minor change where the duplicate symbol for section has been removed.

Slide 17 - Diagnostic code 7712



Slide notes

Diagnostic code 7712, multiple myeloma, has been added to the rating schedule.

Multiple myeloma was previously evaluated analogously to diagnostic code 7709.

An evaluation of 100 or 0 percent is to be assigned based on whether the condition is symptomatic or asymptomatic.

Multiple myeloma has a wide variety of clinical presentations that can vary between asymptomatic and symptomatic.

Asymptomatic (smoldering or indolent) myeloma is a slow-growing, asymptomatic precursor

or pre-malignant phase of multiple myeloma.

It is not usually treated until evidence of end organ damage develops

and it has a high risk of developing into multiple myeloma.

However, since it is not malignant, it's asymptomatic, and does not require treatment,

it would not warrant a compensable evaluation under this diagnostic code.

Even if smoldering multiple myeloma is currently regarded as a pre-malignant state,

there are subsets of patients with different rates of progression towards multiple myeloma.

No single pathological or molecular feature can be used to distinguish between smoldering and pre-malignant

multiple myeloma with clonal plasma cells from those with clonal malignant plasma cells.

A biomarker-based definition that can predict this transformation is needed but is not yet currently available.

Two notes have been added:

Note 1 indicates current validated biomarkers of symptomatic multiple myeloma and asymptomatic multiple myeloma,

smoldering, or monoclonal gammopathy of underdetermined significance (MGUS) are acceptable

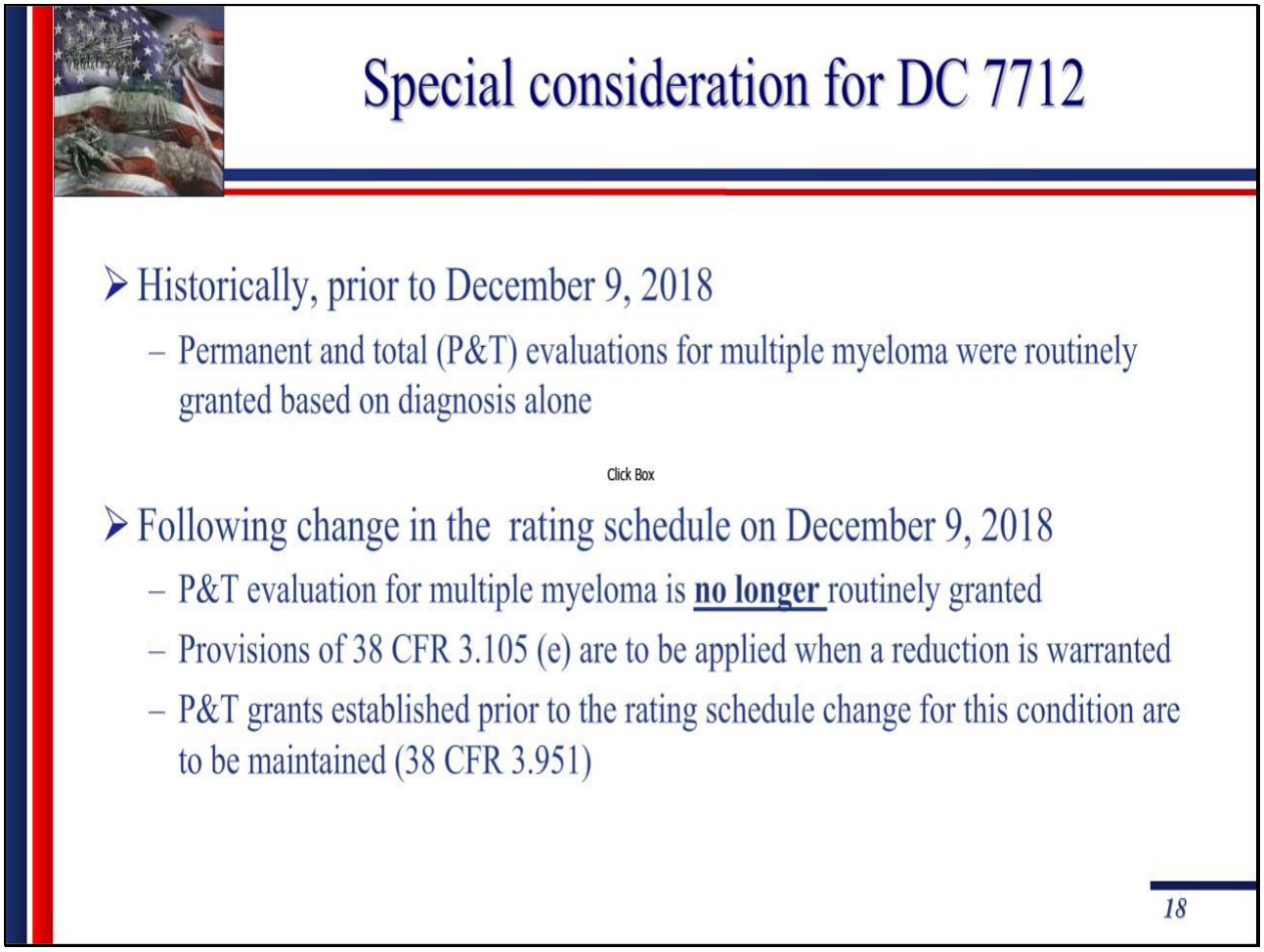
for the diagnosis of multiple myeloma as defined by

the American Society of Hematology (ASH) and International Myeloma Working Group (IMWG).

Note 2 indicates that a review examination is to be completed five years after the diagnosis of symptomatic multiple myeloma.

Any reduction is subject to the provisions of 38 CFR 3.105(e) and 38 CFR 3.344(a) and (b).

Slide 18 - Special consideration for DC 7712



Slide notes

Similar to CLL, prior to the change in the hematologic and lymphatic systems rating schedule on December 9, 2018,

multiple myeloma was routinely granted a permanent and total evaluation based on diagnosis alone.

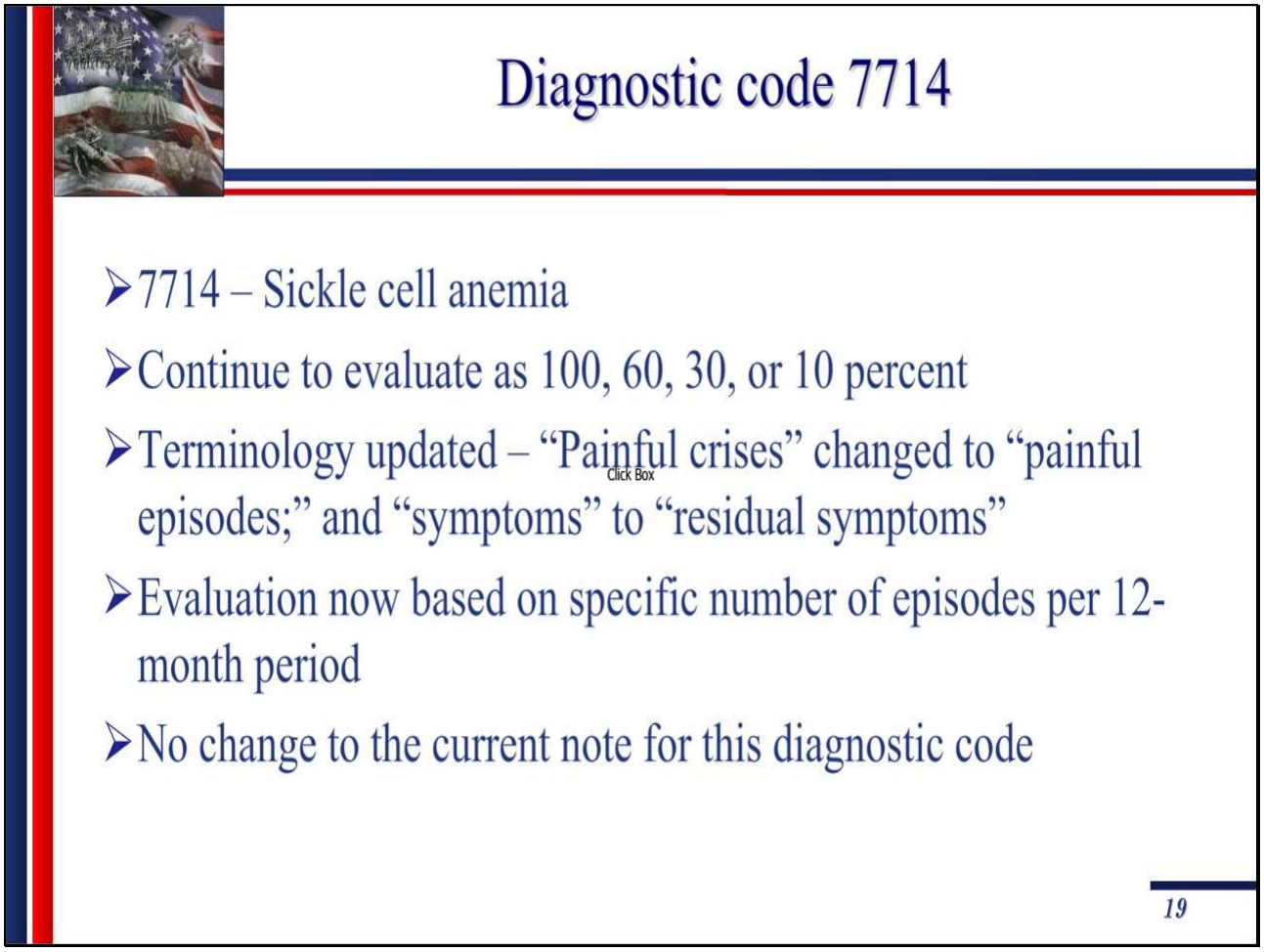
This is no longer the case with new claims submitted on or after December 9, 2018, the date of the rating schedule change.

In the event a claim is reviewed where the prior grant is permanent and total,

and it was established prior to December 9, 2018, the evaluation is

protected under 38 CFR 3.951, which provides that a rating schedule change cannot be the basis for reduction.

Slide 19 - Diagnostic code 7714



Slide notes

Sickle cell anemia underwent minor changes. The term "painful crises" has been replaced with "painful episodes."

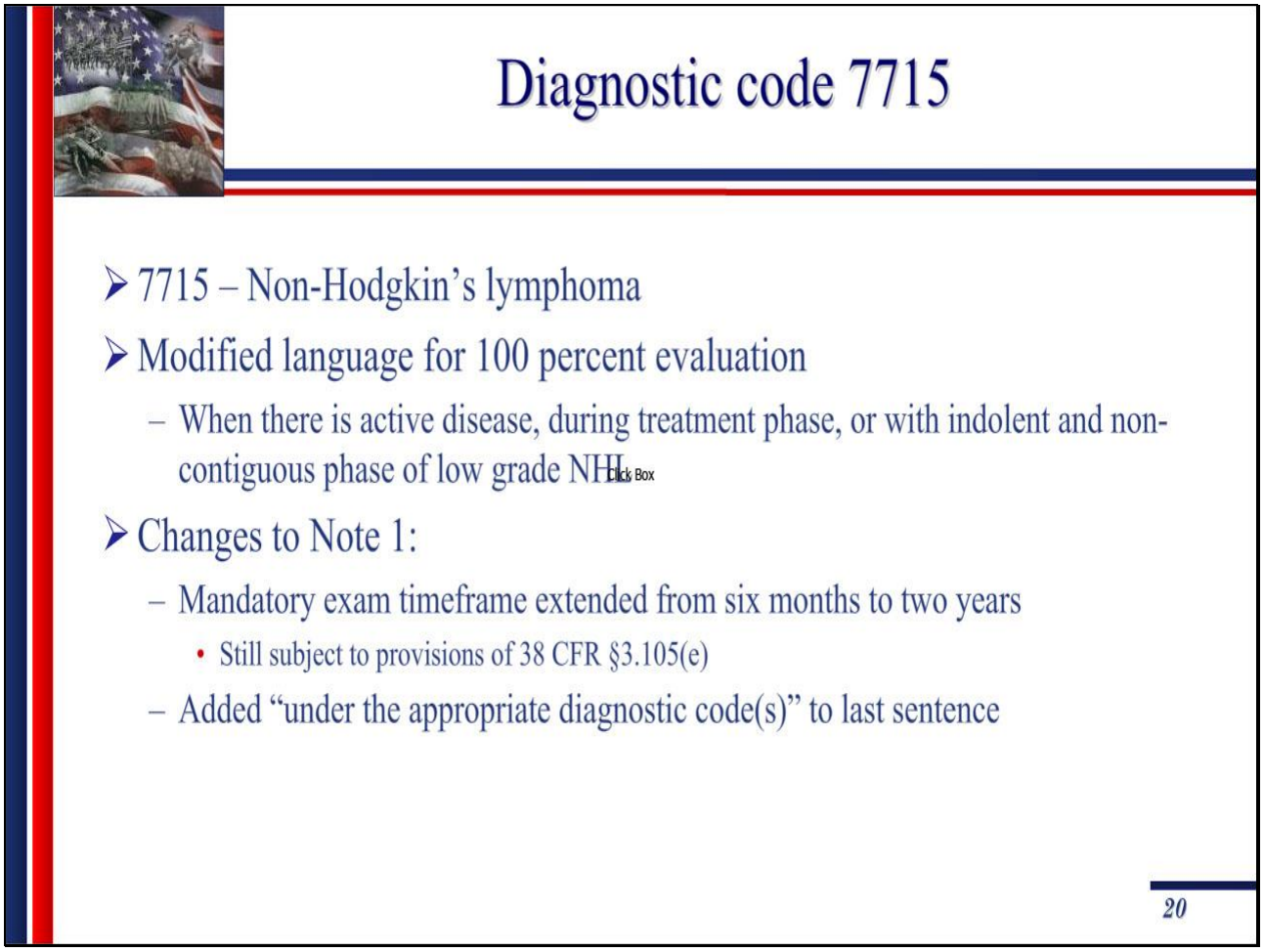
Under the 100 percent evaluation, the term "residual" was added prior to "symptoms;"

and a minor change in punctuation was completed for clarification purposes.

Under the 60 and 30 percent evaluation, the number of painful episodes and timeframe of these episodes has been

more clearly defined to make the criterion less ambiguous and to promote more consistent evaluations.

Slide 20 - Diagnostic code 7715



Slide notes

The criteria for the 100 percent evaluation for non-Hodgkin's lymphoma (NHL) has been modified to "when there is active disease, during treatment phase, or with indolent and non-contiguous phase of low grade NHL."

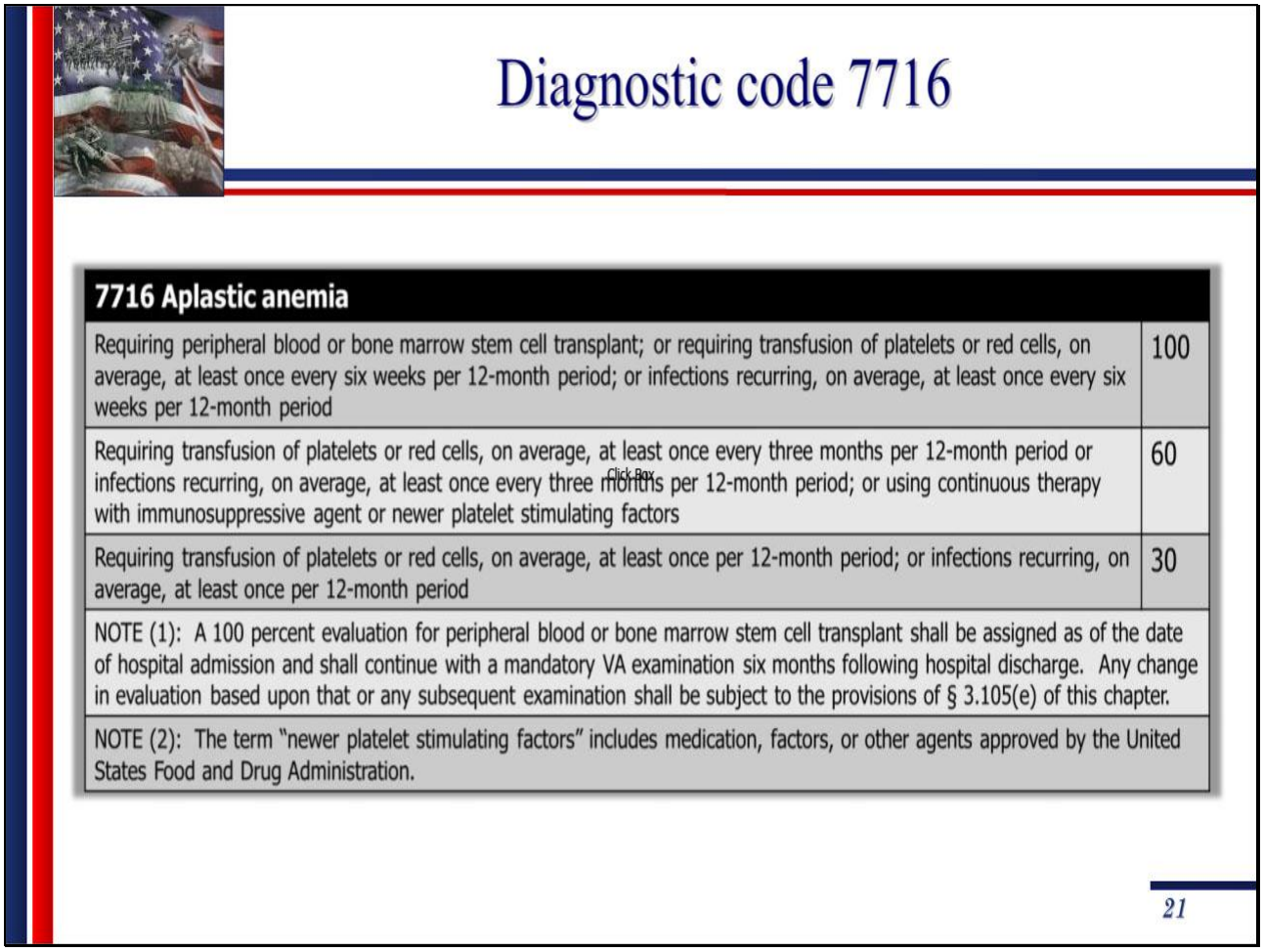
The note for this condition underwent a non-substantive change that extended the allowable time required for mandatory examination from six months to two years.

This change was a result of current medical information that suggests recurrences in NHL is very high, with common tumor recurrences within or after the period that mandates lowering of disability rating for treatment completion or apparent remission of six months.

Lastly, there has been a minor addition to note 1, where "under the appropriate diagnostic code(s)" has been added to the last sentence. The last sentence now reads as

"If there has been no local recurrence or metastasis, rate on residuals under the appropriate diagnostic code(s)."

Slide 21 - Diagnostic code 7716



Slide notes

For the 100, 60, and 30 percent evaluations of aplastic anemia, the phrase "on average" has been added

to the specific numbers of platelet or red blood cell transfusions required and to the frequency of recurring infections.

The phrase "per 12-month period" has also been added to the evaluation criteria to promote consistent evaluations.

The 10 percent evaluation has been deleted,

as the medications used to treat this condition warrant higher levels of evaluation.

The existing note about 100 percent evaluation being assigned and a review examination being completed

six months after hospital discharge, remains the same, however the provisions of 38 CFR 3.105(e)

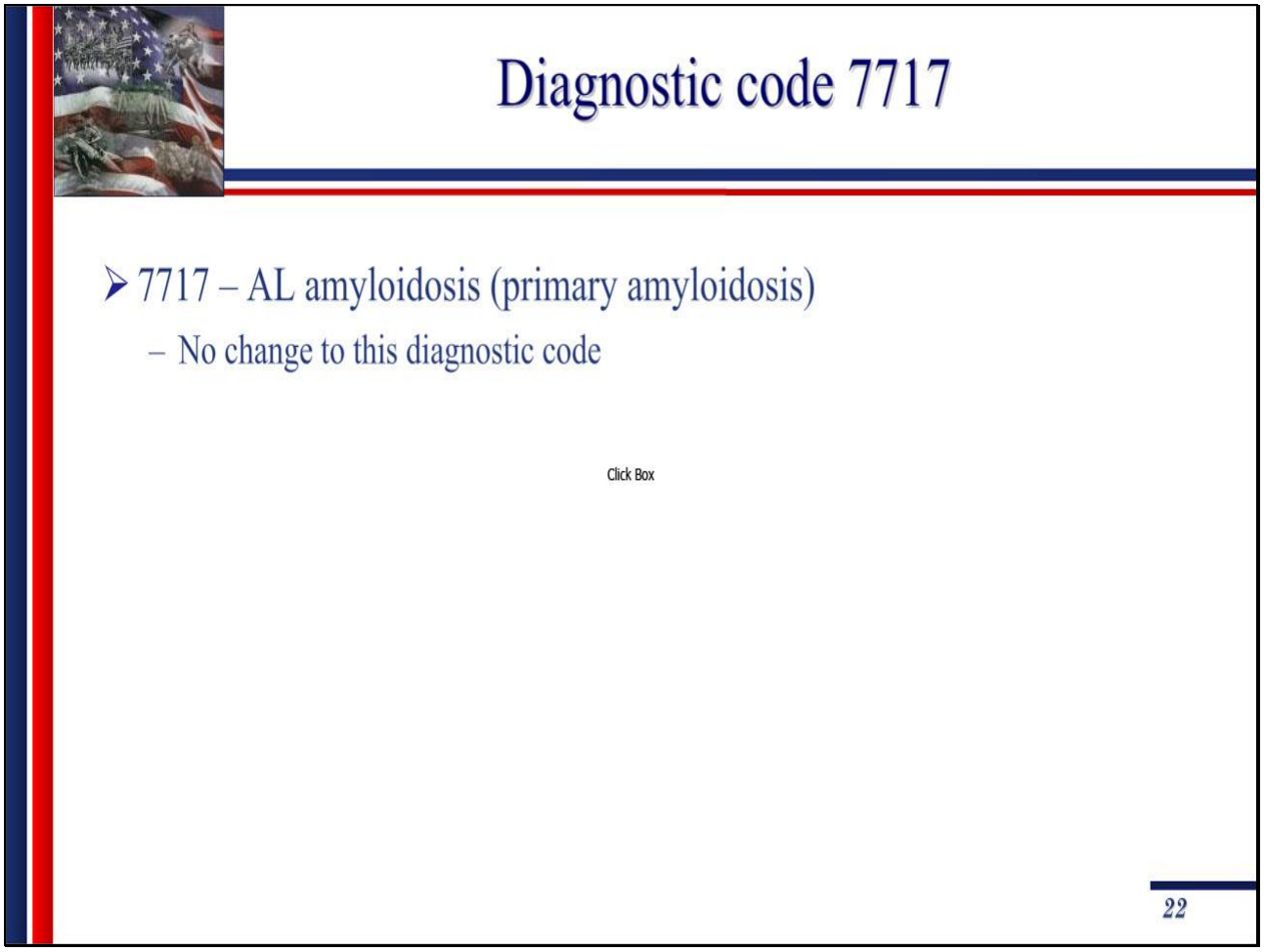
apply when the 100 percent evaluation is assigned

has been expanded from "bone marrow transplant" to "peripheral blood or bone marrow stem cell transplant."

A second note has been added which states the term “newer platelet stimulating factors”

includes medication, factors, or other agents approved by the United States Food and Drug Administration.

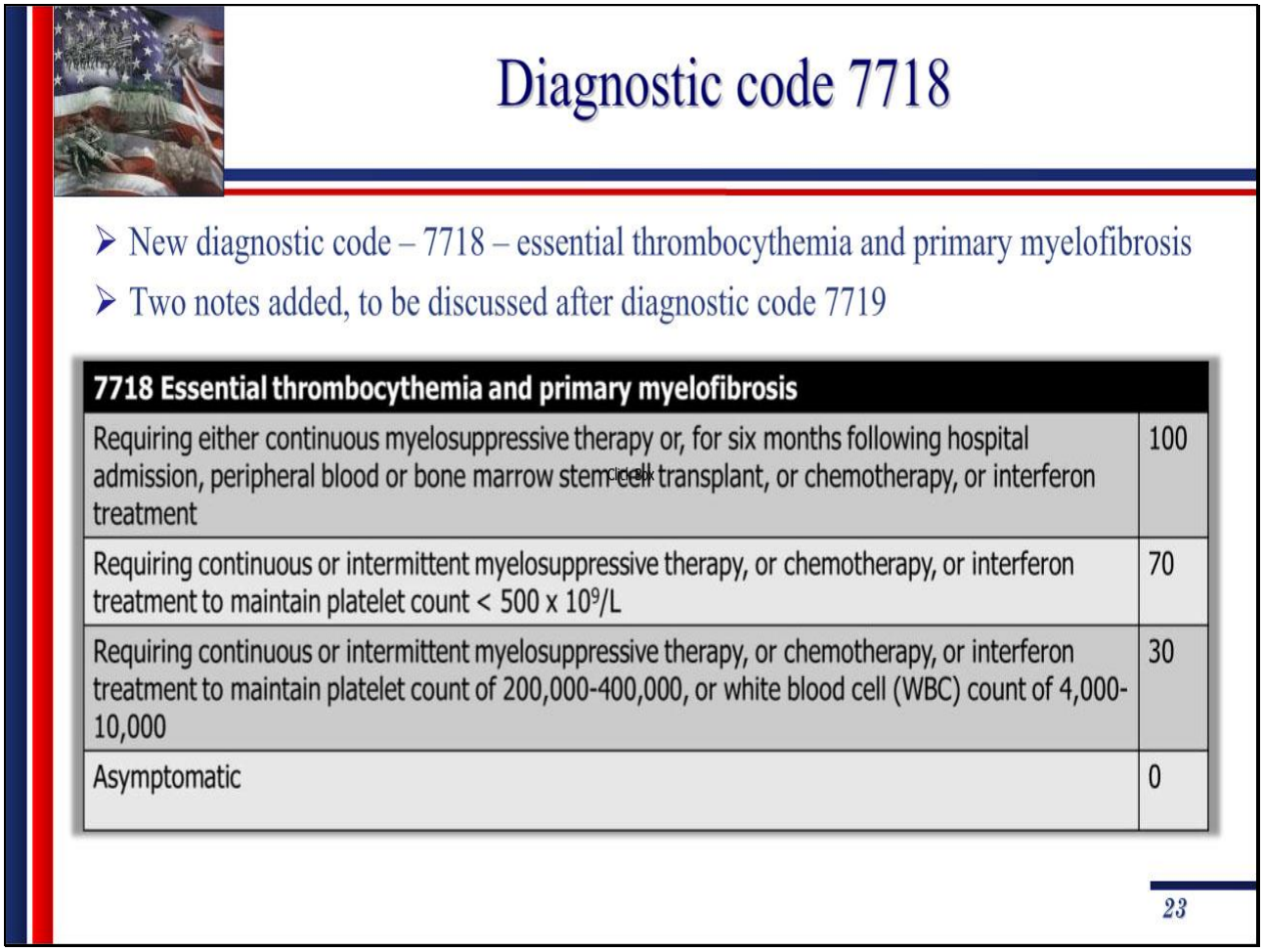
Slide 22 - Diagnostic code 7717



Slide notes

There has been no change to diagnostic code 7717.

Slide 23 - Diagnostic code 7718



Slide notes

Diagnostic code 7718, essential thrombocythemia and primary myelofibrosis,

is one of the new myeloproliferative disorders that has been added to the rating schedule.

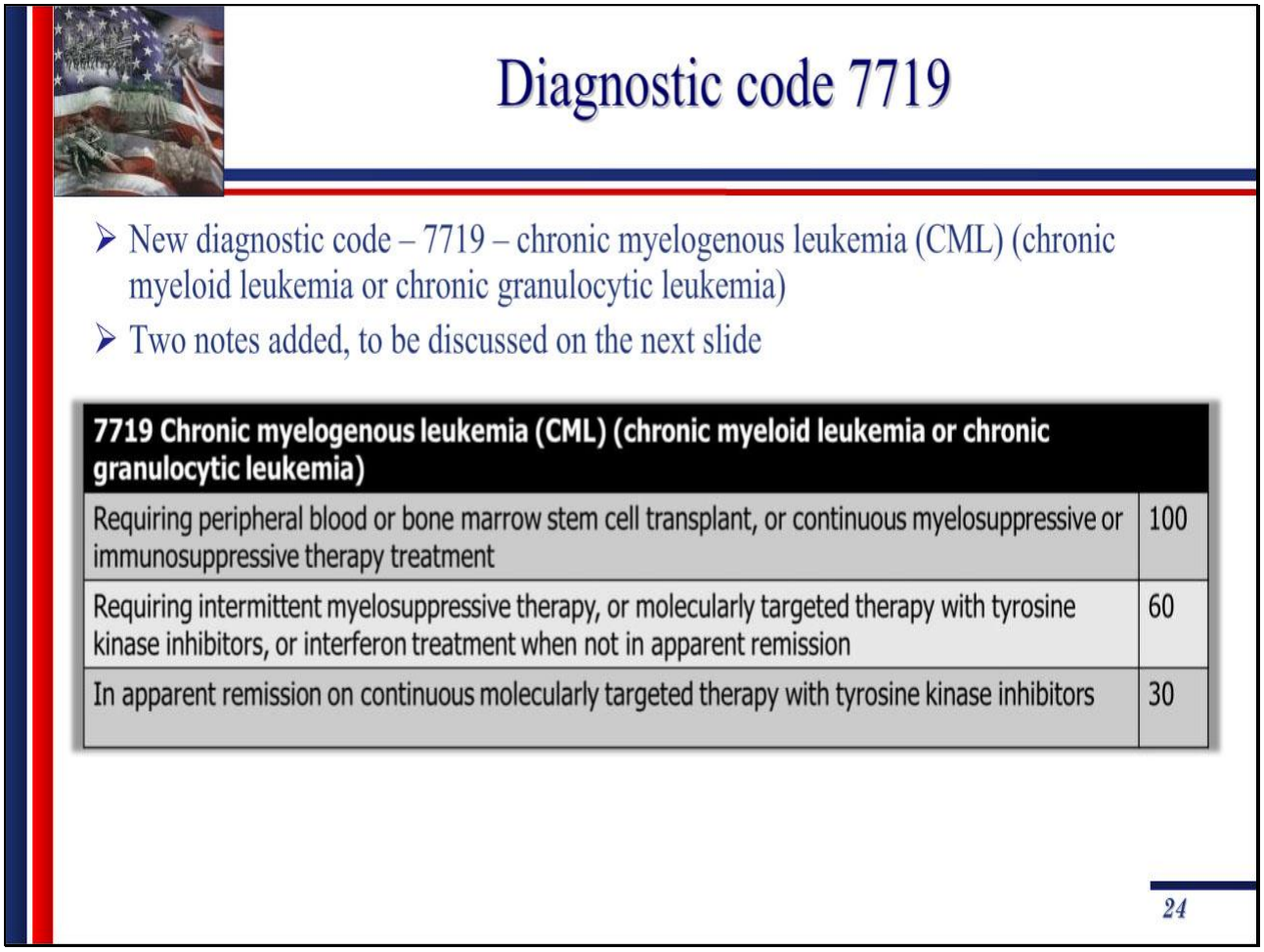
This condition is evaluated at 100, 70, 30, or 0 percent based on treatments to achieve appropriate levels of

platelets or white blood cells. Treatments included in this evaluation include

myelosuppressive therapy, peripheral blood or bone marrow stem cell transplant, chemotherapy, or interferon treatment.

The two notes for this diagnostic code will be discussed after diagnostic code 7719, as they have the same notes.

Slide 24 - Diagnostic code 7719



Slide notes

Diagnostic code 7719 for chronic myelogenous leukemia, or CML,

also known as chronic myeloid leukemia or chronic granulocytic leukemia,

is the second myeloproliferative disorder that has been added to the rating schedule.

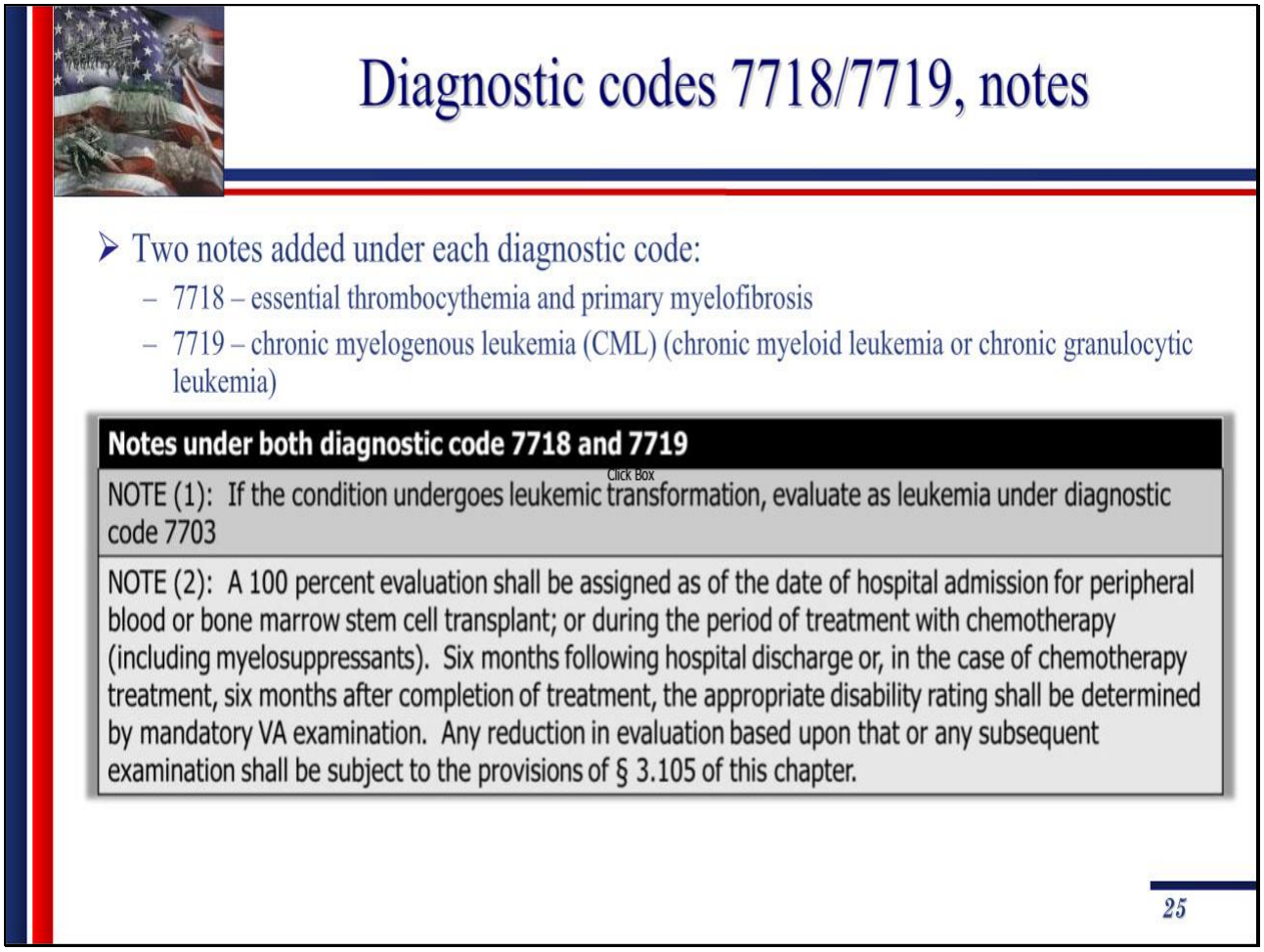
This condition is evaluated at 100, 60, or 30 percent, based upon treatment,

Treatment included in these evaluations include peripheral blood or bone marrow stem cell transplant,

myelosuppressive or immunosuppressive therapy,

molecularly targeted therapy with tyrosine kinase inhibitors, or interferon treatment.

Slide 25 - Diagnostic codes 7718/7719, notes



Slide notes

The two notes here are to be applied under diagnostic code 7718 and 7719.

Note 1 indicates that if the condition undergoes a leukemic transformation,

the condition will be evaluated as leukemia under diagnostic code 7703.

Note 2 indicates that the 100 percent evaluation will be assigned from the date of hospital admission for

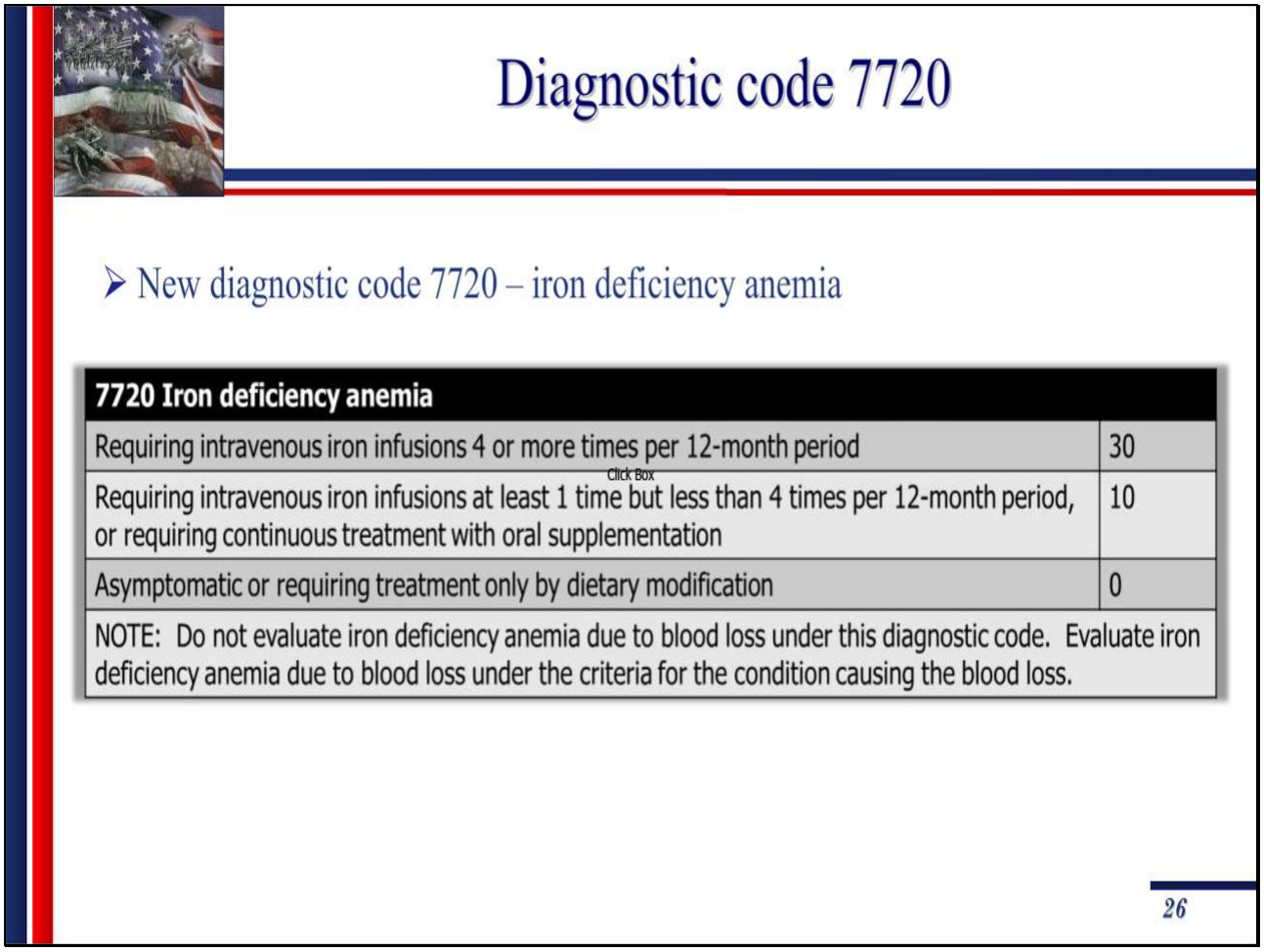
peripheral blood or bone marrow stem cell transplant, or during the period of treatment with

chemotherapy (including myelosuppressants). This evaluation will continue

for six months after hospital discharge, or in the case of chemotherapy, six months after cessation of treatment,

at which time an examination will be completed. Any reduction is subject to the provisions of 38 CFR 3.105(e).

Slide 26 - Diagnostic code 7720



Slide notes

As mentioned earlier, diagnostic code 7700 for anemia, hypochromic-microcytic and megaloblastic,

such as iron-deficiency and pernicious anemia, has been deleted and replaced with four new diagnostic codes -

7720, 7721, 7722, and 7723. We will now talk about these new diagnostic codes for anemia.

Iron deficiency anemia is defined as a decrease in total body iron content and is now evaluated under diagnostic code 7720.

Total body iron content is regulated through the balance of iron absorption and loss.

Iron deficiency anemia is most commonly due to blood loss, post-hemorrhagic anemia.

Iron deficiency anemia due to blood loss would be evaluated under the criteria

for the causative condition (e.g. duodenal ulcers). Evaluating iron deficiency anemia

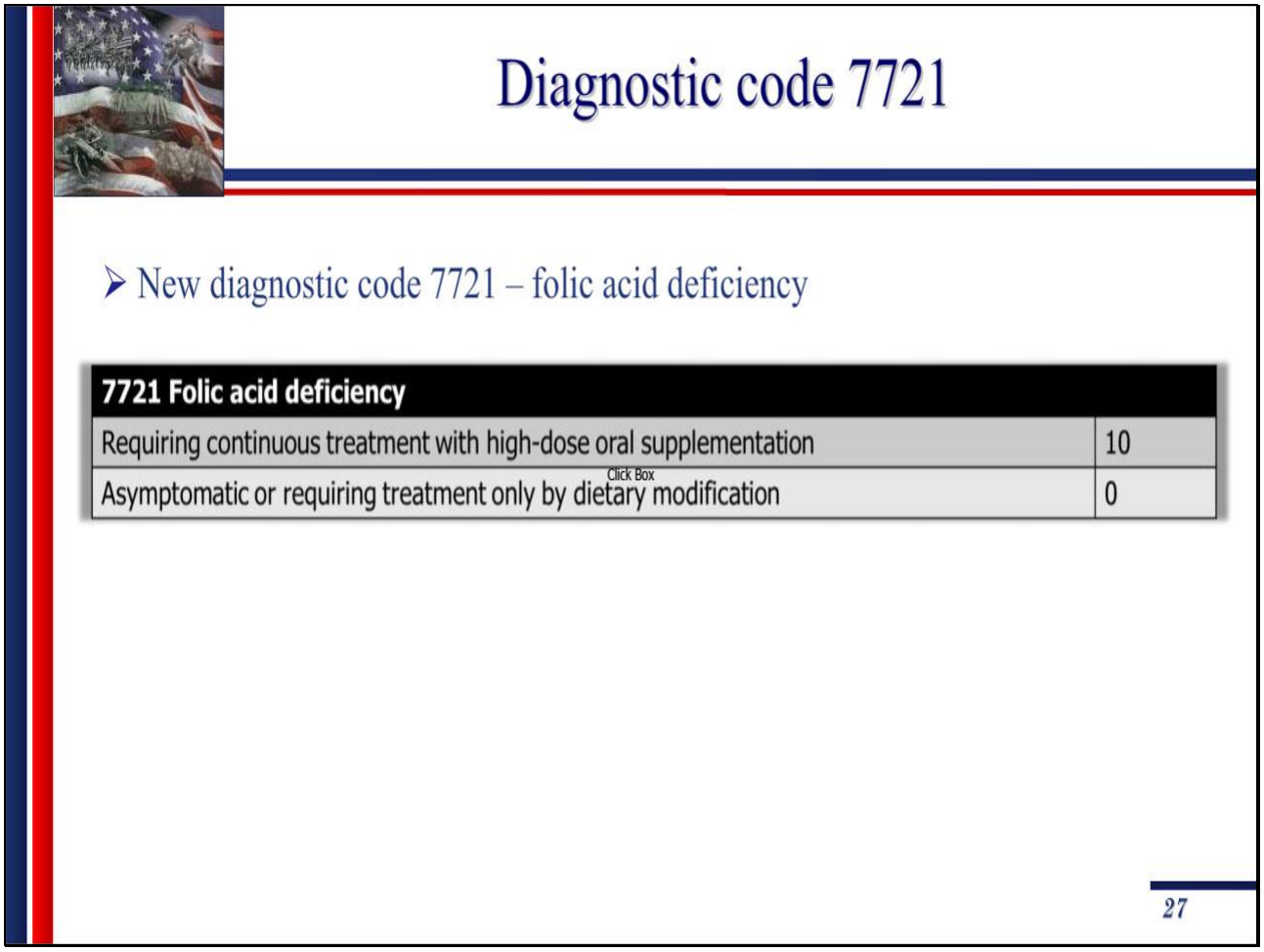
due to blood loss is to be avoided, and has been clarified in a note under this diagnostic code.

Iron deficiency anemia can be readily treated by diet or dietary supplements and

is ordinarily short term with mild symptoms and responds to treatment.

An evaluation of 30, 10, or 0 percent can be assigned based on the type and frequency of treatment.

Slide 27 - Diagnostic code 7721



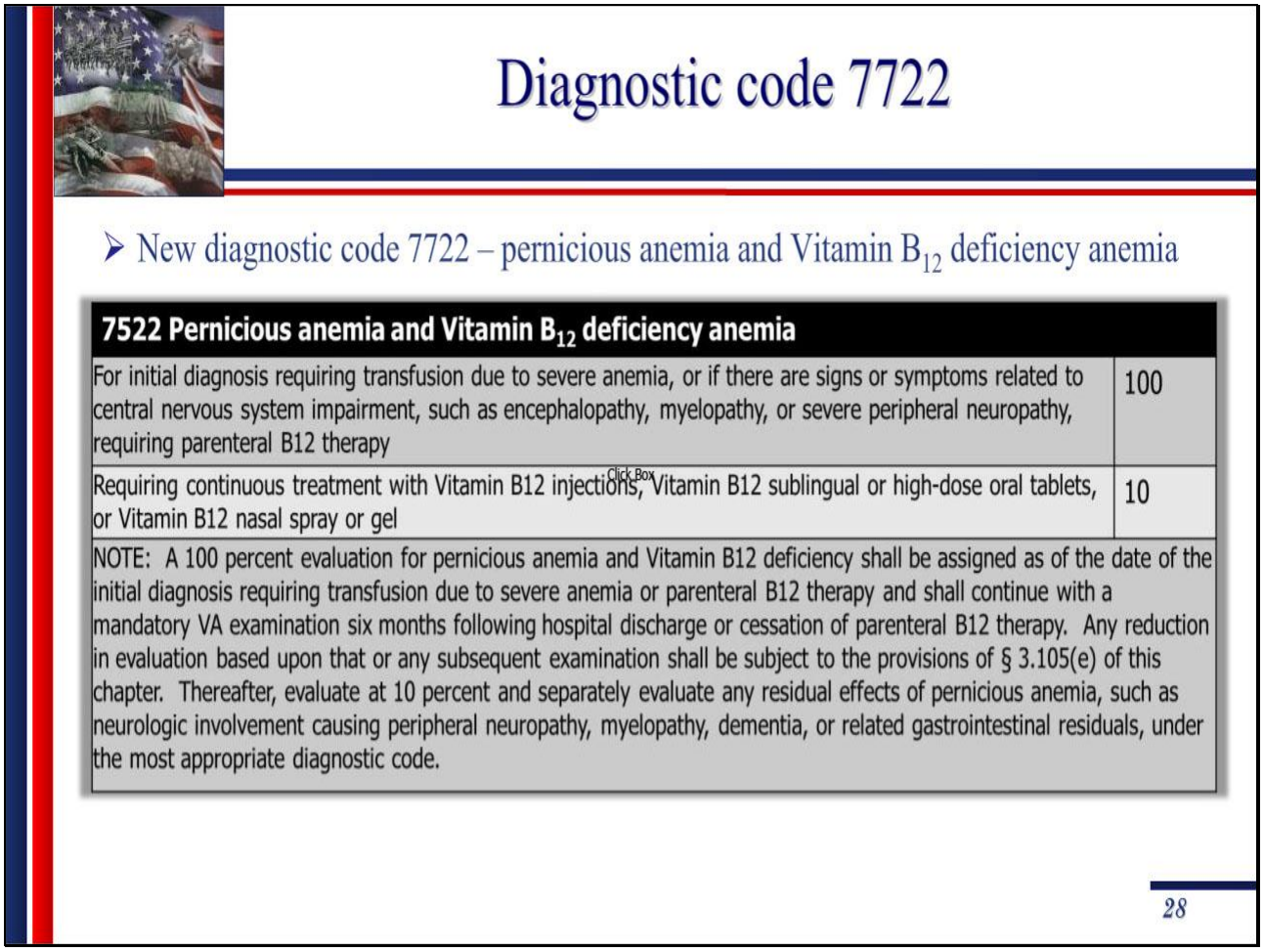
Slide notes

Folic acid deficiency is evaluated under diagnostic code 7721.

An evaluation of 10 or 0 percent is assigned based on continuous treatment

with oral supplements or dietary modification, respectively.

Slide 28 - Diagnostic code 7722



Slide notes

Pernicious anemia and vitamin B12 deficiency are evaluated under diagnostic code 7722.

Pernicious anemia is the most severe form of vitamin B12 deficiency

and is caused by a lack of intrinsic factor, or a glycoprotein, that is necessary for absorption of vitamin B12.

Other causes of B12 deficiency include dietary avoidance, such as vegetarianism, malabsorption,

gastrectomy or gastric bypass, inflammatory bowel disease,

pancreatic insufficiency, use of histamine 2-blockers, and proton pump inhibitors.

Pernicious anemia requires lifelong treatment with vitamin B12 supplementation.

Since disabilities from nutritional vitamin B12 deficiency are consistent with pernicious anemia,

nutritional B12 deficiency would be evaluated under the same diagnostic code as pernicious anemia.

The 100 percent evaluation is assigned following the initial diagnosis requiring transfusion, or if there

are signs and symptoms related to central nervous system impairment requiring parenteral B12 therapy.

A mandatory examination is scheduled six months following hospital discharge or cessation of parenteral B12 therapy.

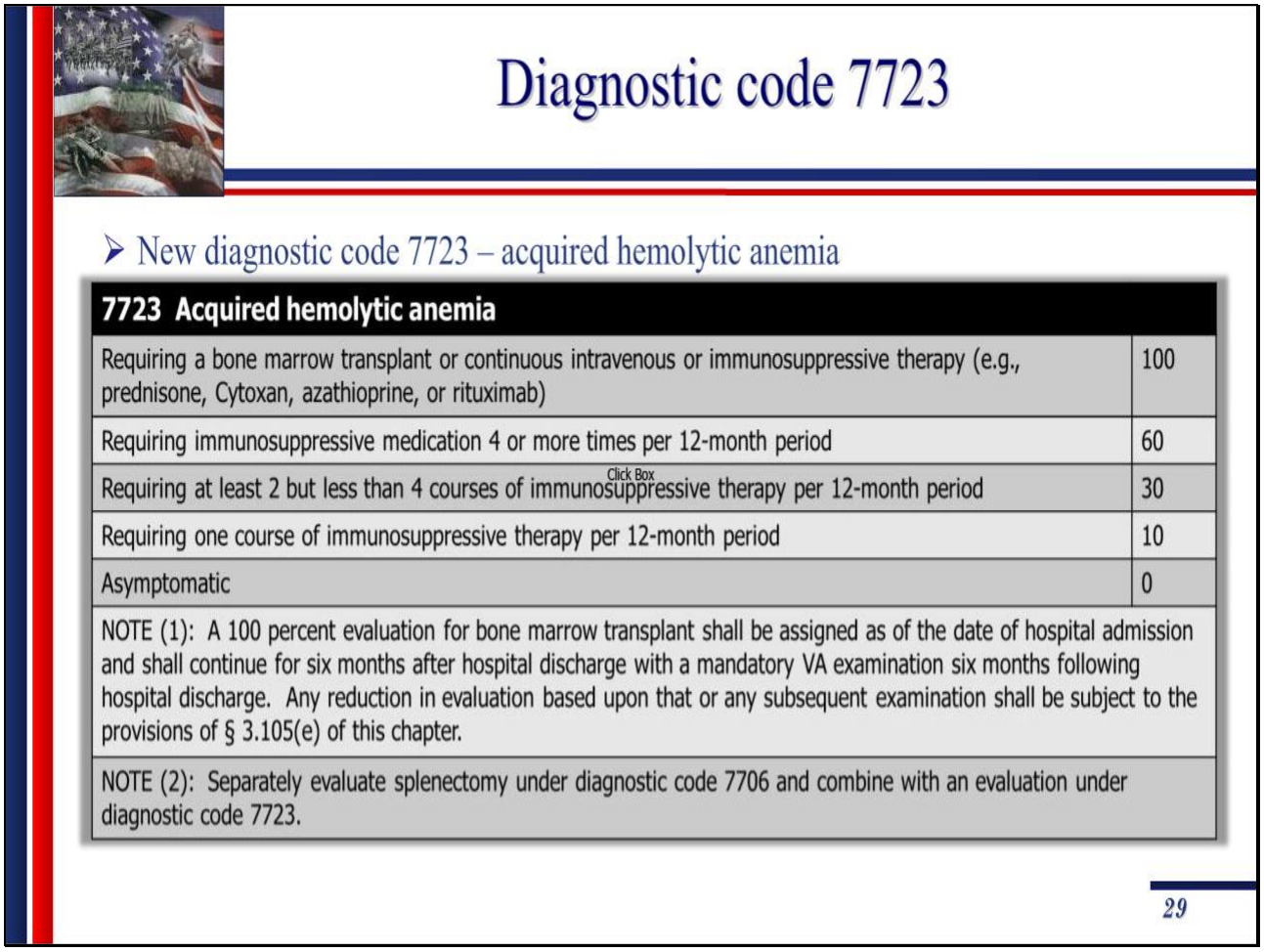
Any reduction is subject to the provisions of 38 CFR 3.105(e).

Thereafter, a 10 percent evaluation is provided with residual conditions being evaluated separately.

An evaluation of 10 percent is warranted for continuous treatment with Vitamin B12 supplements,

regardless of how they are taken.

Slide 29 - Diagnostic code 7723



Slide notes

Acquired hemolytic anemia is evaluated under diagnostic code 7723.

This condition has over 200 causes, including immune disorders, toxic chemicals, medications,

physical damage (such as may occur with prosthetic heart valves), and infections.

Treatment can include intermittent corticosteroids, immunosuppressive drugs, immune globulin,

monoclonal antibody therapy, erythropoiesis stimulating agent, plasmapheresis, blood transfusions,

or peripheral blood and bone marrow stem cell transplantation.

An evaluation of 100, 60, 30, 10, or 0 percent is warranted for this condition.

The 100 percent evaluation is assigned for bone marrow transplant or continuous intravenous

or immunosuppressive therapy. The remaining evaluations

are based on the frequency of immunosuppressive therapy, or whether the condition is asymptomatic.

Note 1 indicates that the 100 percent evaluation will be assigned from the date of hospital admission

for bone marrow transplant, or during the period of treatment with chemotherapy.

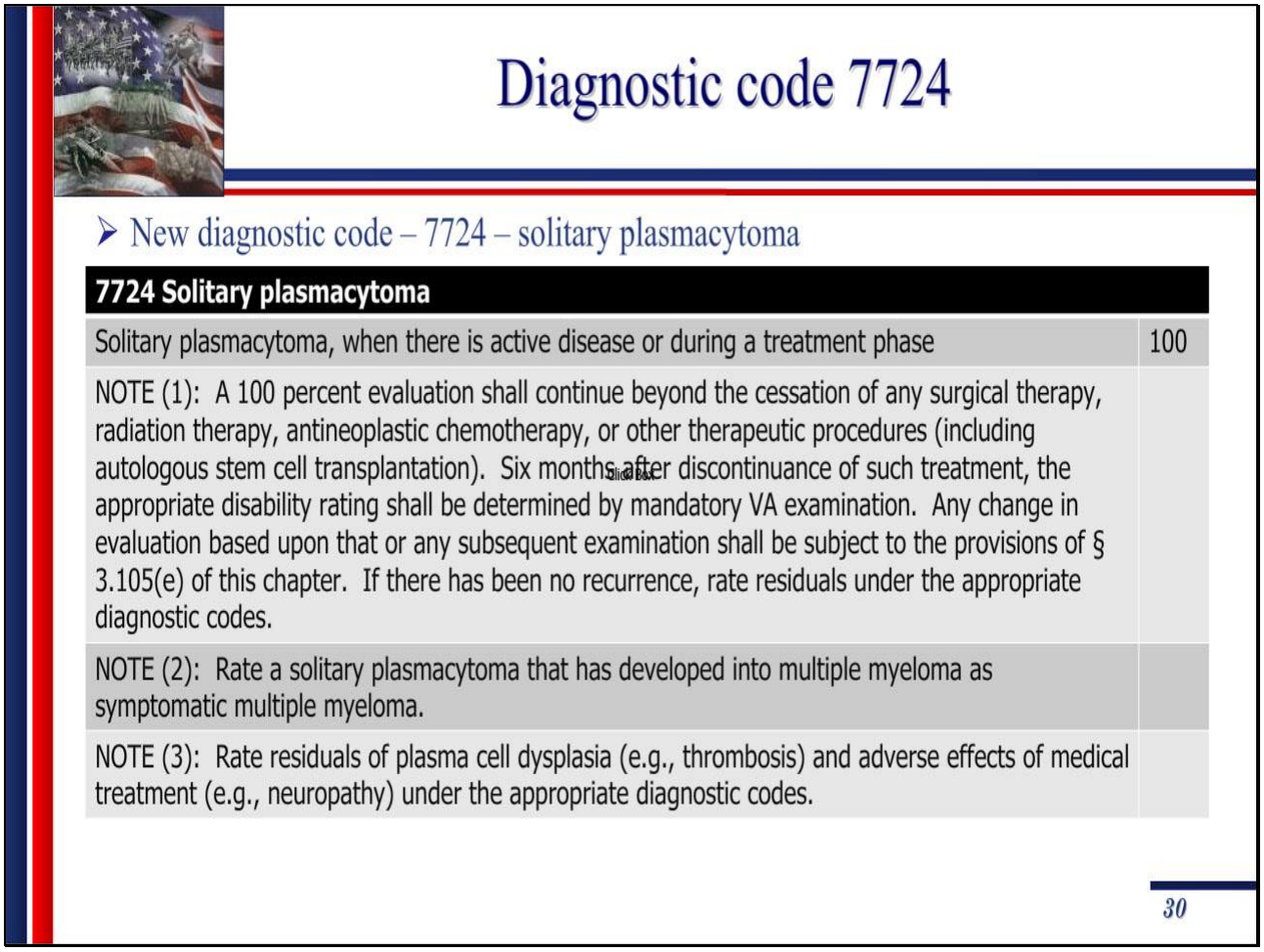
This evaluation will for six months after hospital discharge, or in the case of chemotherapy,

six months after cessation of treatment, at which time an examination will be completed.

Any reduction is subject to the provisions of 38 CFR 3.105(e).

Note 2 indicates a splenectomy is to be evaluated separately and combined with this diagnostic code.

Slide 30 - Diagnostic code 7724



Slide notes

Diagnostic code 7724, solitary plasmacytoma, has been added to the rating schedule.

Solitary plasmacytoma was previously evaluated analogously to diagnostic code 7709.

Solitary bone or extramedullary, which occurrs in soft tissue outside of the bone marrow, plasmacytomas

are malignant plasma cell neoplasms that are closely related to multiple myeloma.

Solitary bone plasmacytoma develops into multiple myeloma in about 50-60 percent of cases,

and into extramedullary plasmacytoma in 10 to 30 percent of cases.

A solitary plasmacytoma that remains solitary has a better prognosis than multiple myeloma and may be curable.

Therefore, this condition will be evaluated similarly to other malignant neoplasms that are potentially curable.

This condition is to be evaluated at 100 percent when there is active disease or during a treatment phase.

Three notes have been added:

The first note indicates that the 100 percent evaluation will be assigned for six months after the

cessation of any surgical therapy, radiation therapy, antineoplastic chemotherapy, or

or other therapeutic procedures (including autologous stem cell transplantation),

at which time an examination will be completed. Any reduction is subject to the provisions of 38 CFR 3.105(e).

If there has been no recurrence, rate on residuals under the appropriate diagnostic code.

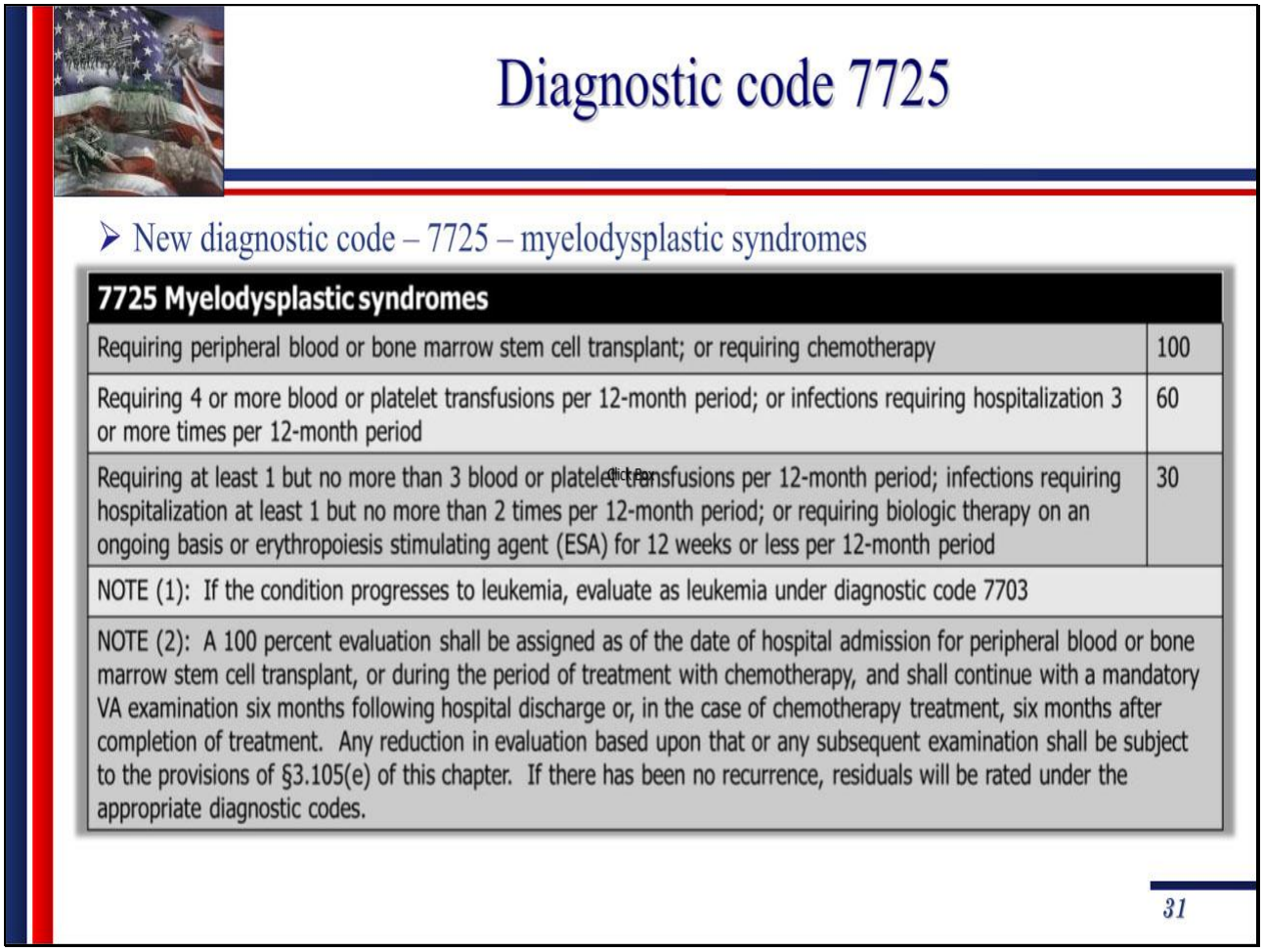
The second note indicates that solitary plasmacytoma that has developed into multiple myeloma

is to be evaluated as symptomatic multiple myeloma.

The last note indicates that residuals of plasma cell dysplasia, for example, thrombosis,

and the adverse effects of treatment, for example, neuropathy, are to be evaluated under the appropriate diagnostic codes.

Slide 31 - Diagnostic code 7725



Slide notes

Diagnostic code 7725, myelodysplastic syndromes, has been added to the rating schedule.

Myelodysplastic syndromes are a group of disorders associated with bone marrow dysfunction

in which healthy, mature red blood cells, white blood cells, and platelets are not produced.

Therefore, there may be a deficiency of any type of blood cell.

This condition is to be evaluated at either 100, 60, or 30 percent

based on type and frequency of treatment and number of infections per 12-month period.

Treatment depends on the type of disorder but can include peripheral blood

or bone marrow stem cell transplant, chemotherapy, blood or platelet transfusions, biologic therapy,

which is either interferon alpha or erythropoiesis-stimulating agent (ESA).

Two notes have been added:

The first note indicates if the condition progresses to leukemia to evaluate it as such, under diagnostic code 7703.

The second note indicates that the 100 percent evaluation will be assigned from the date of hospital admission

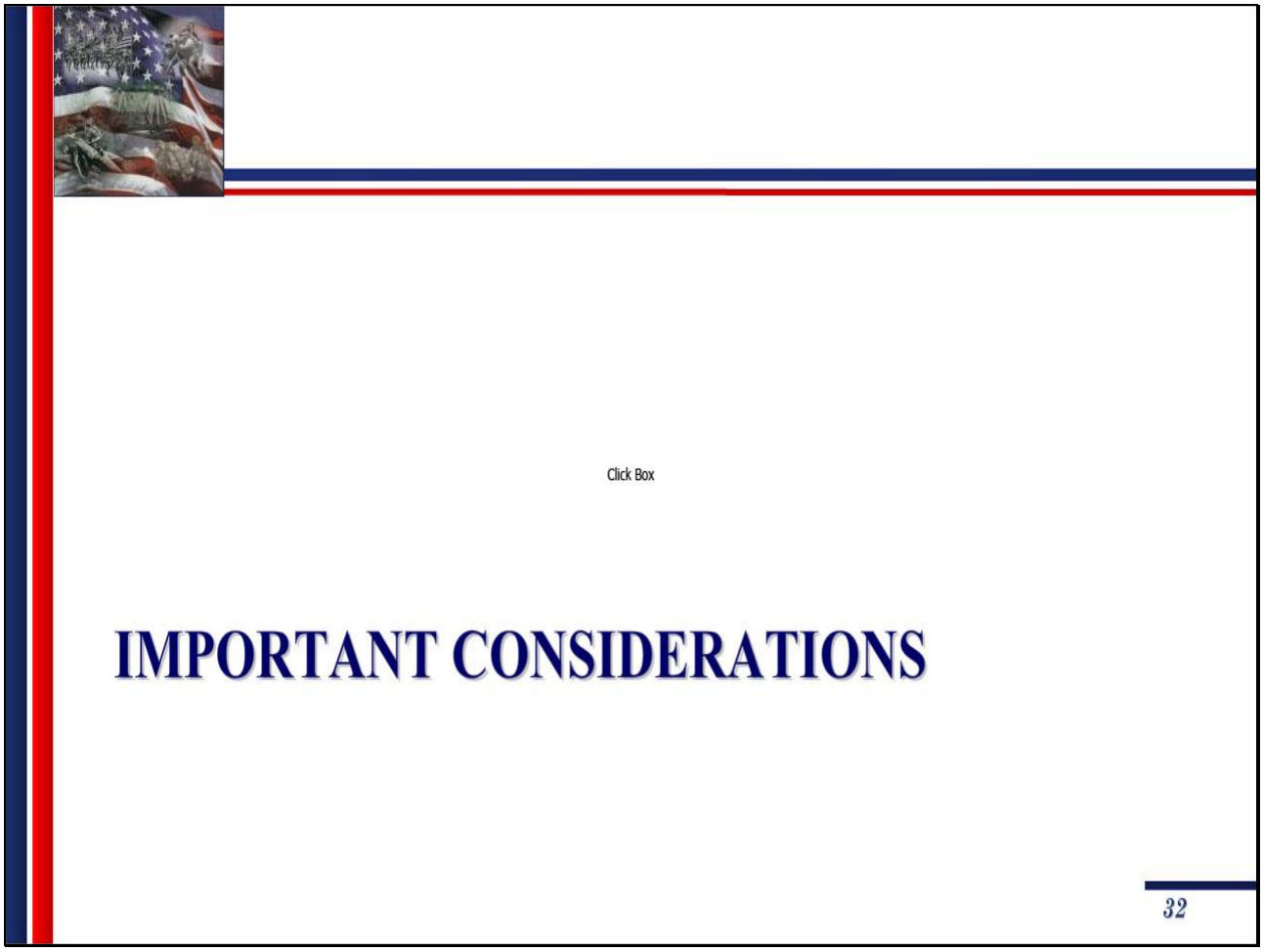
for peripheral blood or bone marrow stem cell transplant, or during the period of treatment with chemotherapy.

This evaluation will continue for six months after hospital discharge, or in the case of chemotherapy,

six months after cessation of treatment, at which time an examination will be completed.

Any reduction is subject to the provisions of 38 CFR 3.105(e).

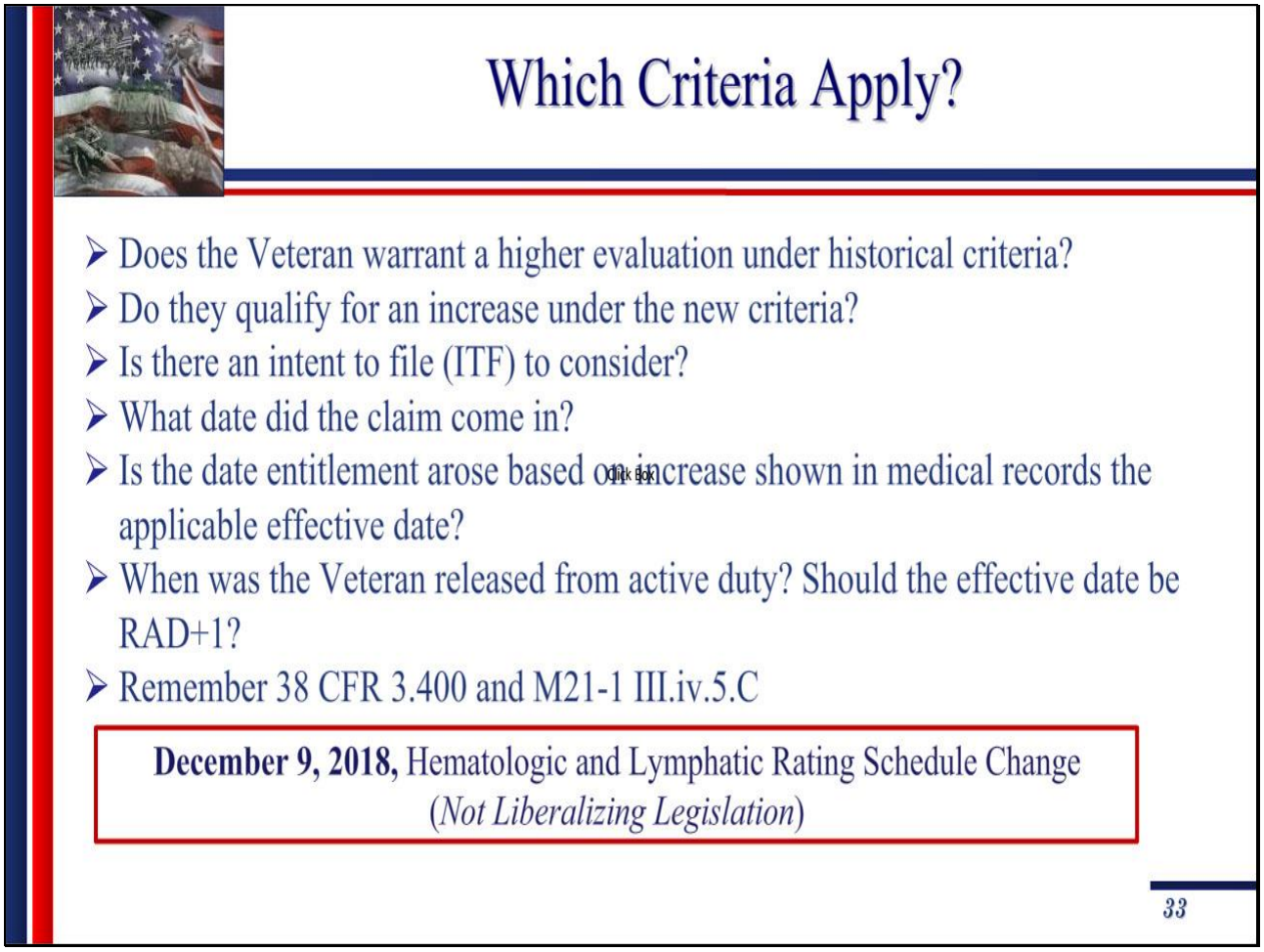
Slide 32 - IMPORTANT CONSIDERATIONS



Slide notes

Now that we have covered the changes for the rating schedule as it pertains to the hematologic and lymphatic system, let’s discuss important considerations you must bear in mind when evaluating these disabilities.

Slide 33 - Which Criteria Apply?



Slide notes

For the first few years after a change in the rating schedule, it is important to consider which criteria applies.

If a claim was pending at the time of the rating schedule change,

does the Veteran warrant a higher evaluation under the historical criteria?

Does a staged rating need to be completed, evaluating under the historical criteria and then the new criteria?

If a Veteran was previously service connected under the historic criteria and claims an increase after the

rating schedule change, should they retain that evaluation under the historic criteria?

Remember, under 38 CFR 3.951, unless the symptoms actually improve under historical criteria

a rating schedule change cannot be used to reduce an evaluation.

Also remember, this is **not** a liberalizing change.

Liberalizing law is essentially a law that allows for a grant of benefit that was not allowed before.

Changes to the hematologic and lymphatic rating schedule,

which only adjusts the way evaluations are assigned, do **not** qualify as liberalizing.

So 38 CFR 3.114a, in conjunction with the rating schedule change,

cannot be used to support a potential earlier effective date for a hematologic and lymphatic condition.

That said, general effective date rules must be considered. Is there an intent to file (ITF) to consider?

Is the date of claim appropriate?

Is the date of ascertainable increase shown in medical records the applicable effective date?

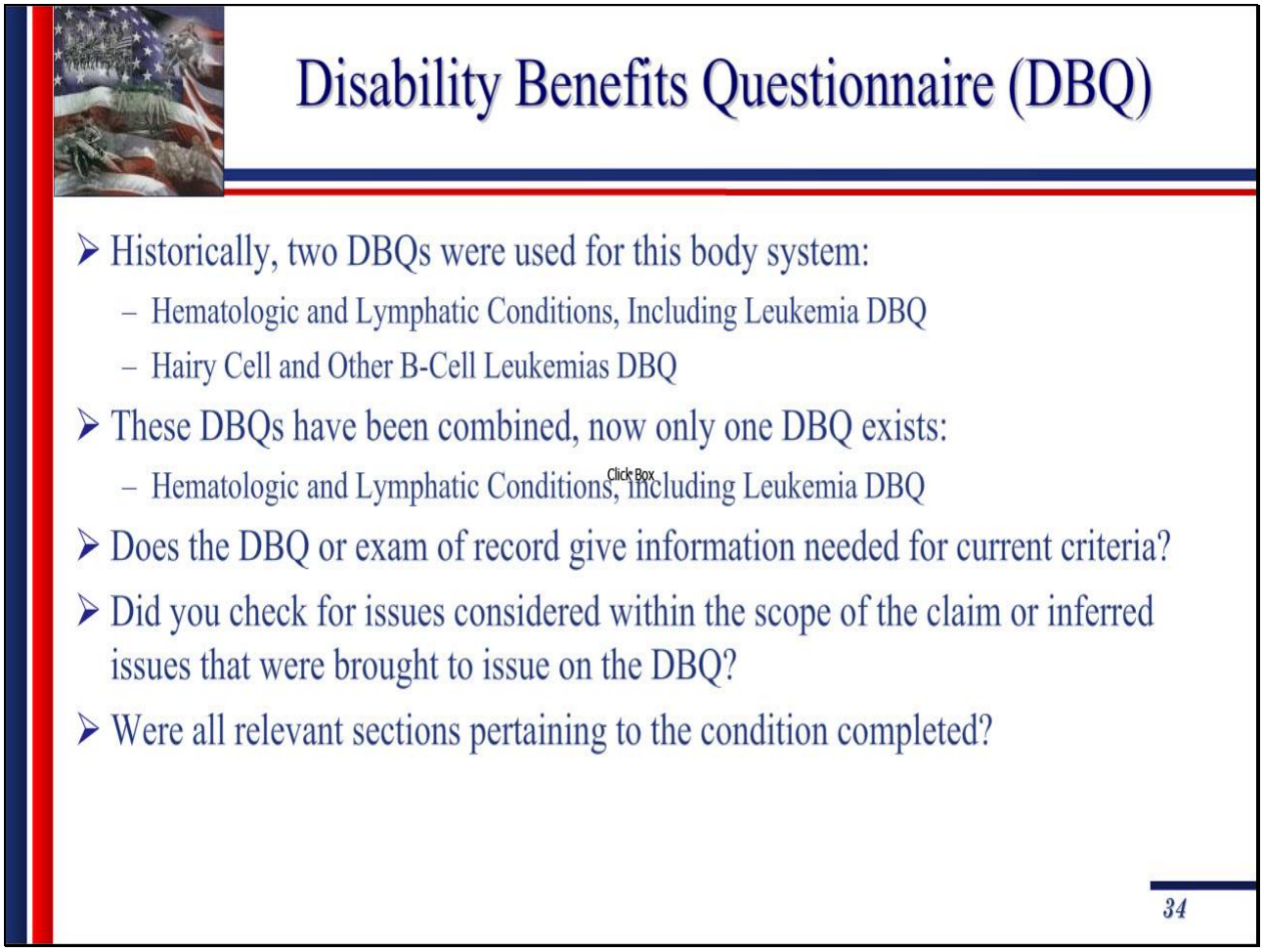
Remember, an increase based on new criteria cannot be granted prior to the date of the rating schedule change.

When was the Veteran released from active duty?

Should the effective date be the first day following the date of discharge, commonly referred to as RAD +1?

Remember to think critically as you assign an effective date.

Slide 34 - Disability Benefits Questionnaire (DBQ)



Slide notes

Previously, the hematologic and lymphatic body system had two Disability Benefits Questionnaires, or DBQs,

that could be used - the Hematologic and Lymphatic Conditions, Including Leukemia DBQ,

and the Hairy Cell and Other B-Cell Leukemias DBQ.

These historic DBQs have been combined and updated to reflect new rating criteria, and now only

one DBQ is available for use for the hematologic and lymphatic body system.

This DBQ is titled “hematologic and lymphatic conditions, including leukemia.”

You may still see older versions of the DBQ in the file.

After reviewing the DBQ in the file, determine if you can grant any benefit right away

or if clarification is needed to establish the correct evaluation.

As always, watch for issues that might be considered within the scope of the claim,

such as scars associated with the condition or special monthly compensation.

Lastly, it is important to ensure the examination is sufficient for rating purposes before making your decision.

Failure to do so could result in an error and may cause an incorrect payment for the Veteran.

Slide 35 - Historical Rating Schedules Available in the Knowledge Management Portal

Slide notes

As mentioned, during the first few years after a change in rating schedule,

it is important to consider which criteria apply.

The new rating schedule can be found under the eCFR for Part 4.

The historical schedule is available under the eCFRs that are accessed through the Knowledge Management Portal.

After selecting the schedule of ratings for the hematologic and lymphatic conditions, scroll down to the bottom and

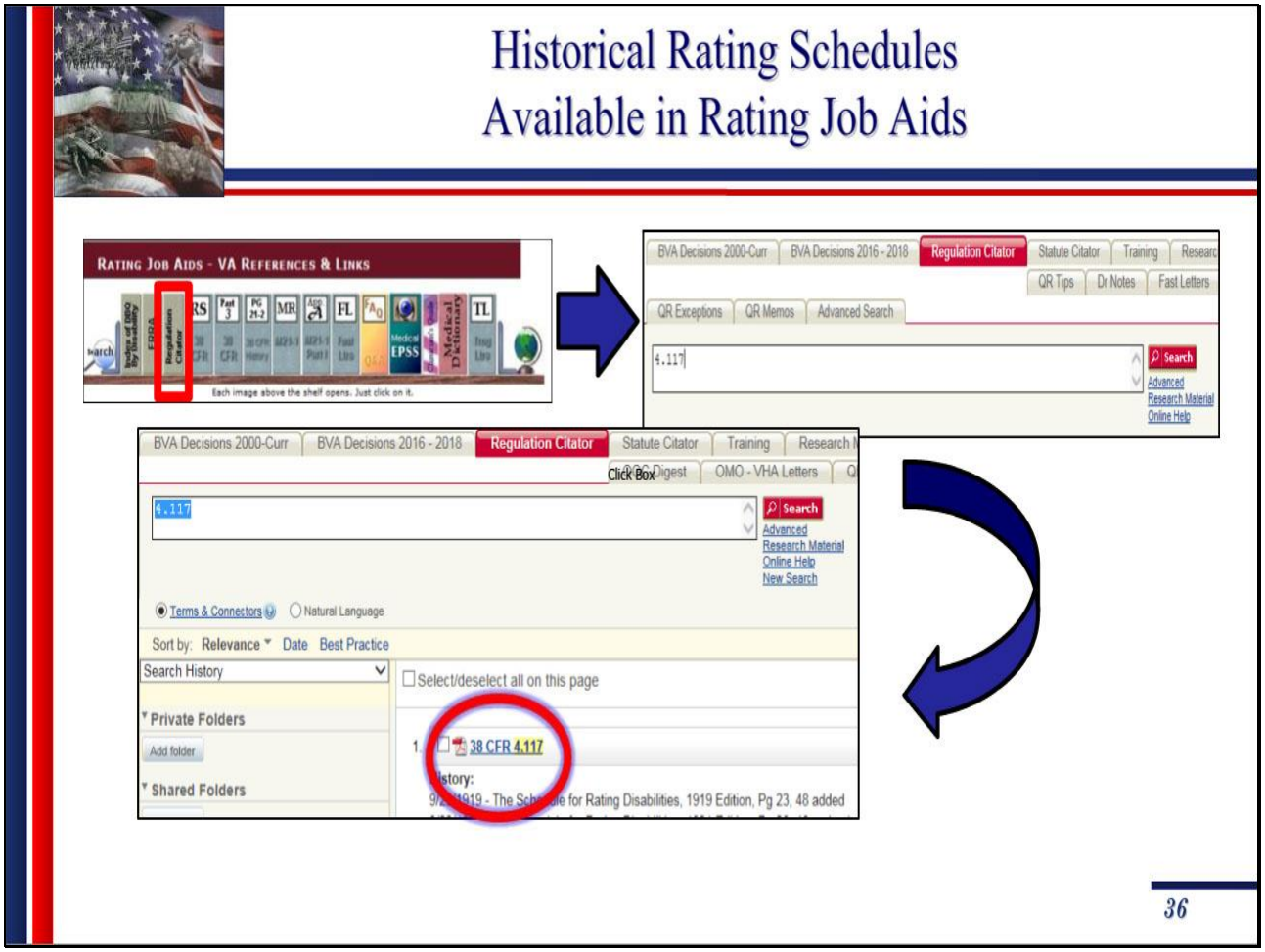
under attachments, you will see the pdf for the historical 4.117.

This is where you can locate all of the historical rating schedules for this body system.

The same instruction holds true for all historical schedules for each body system.

Each body system's historical rating schedule can be found this way.

Slide 36 - Historical Rating Schedules Available in Rating Job Aids



Slide notes

The historical rating schedule can also be found through Rating Job Aids.

From the bookshelf, you would select regulation citator.

The next page defaults to the regulation citator tab,

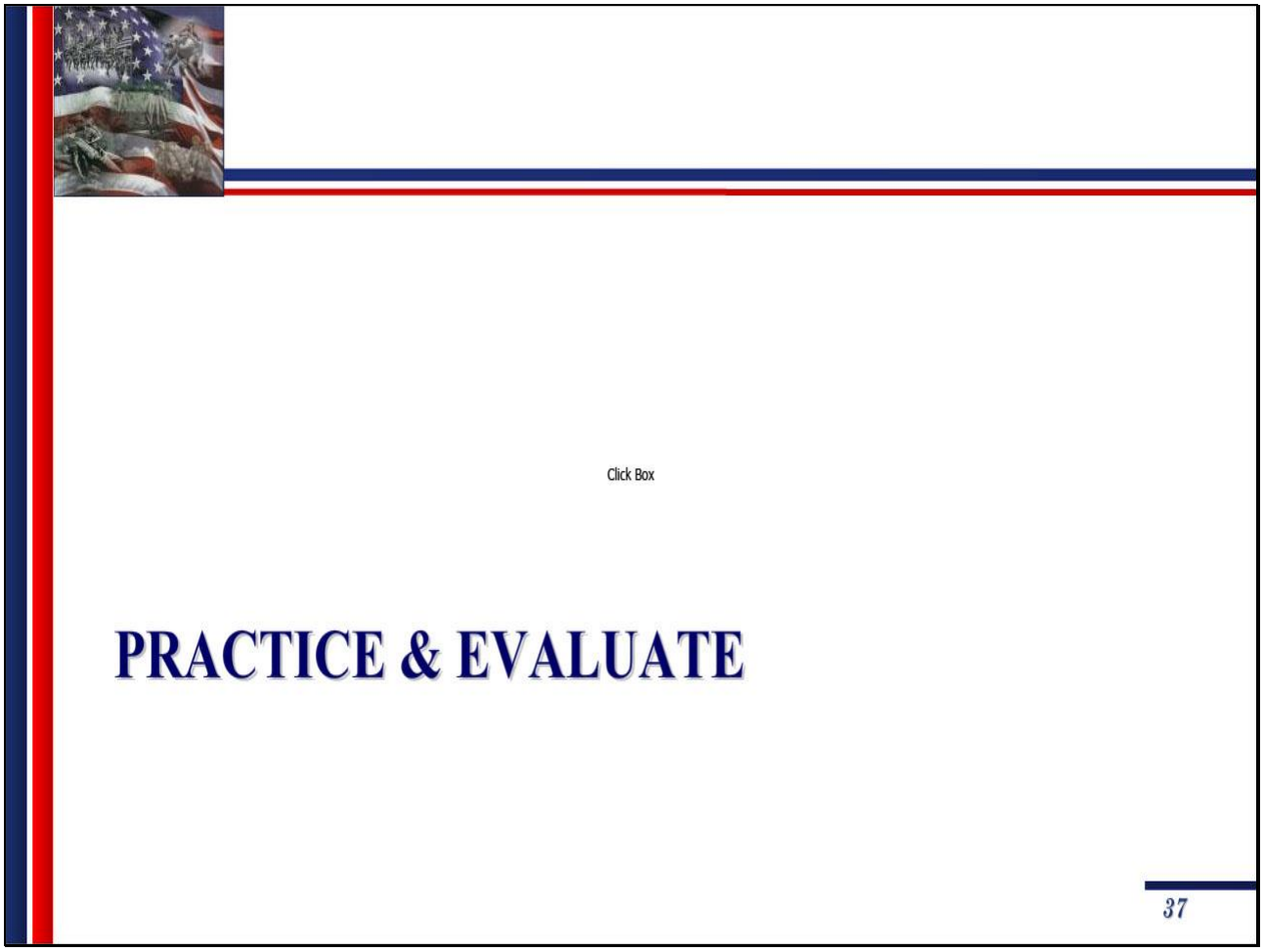
where you would type the regulation for hematologic and lymphatic system,

4.117, and select search.

The first find in the search would be the regulation you typed in the search.

Select that pdf document and you have the historical rating criteria.

Slide 37 - PRACTICE & EVALUATE



Slide notes

Now that we have reminded you of some important considerations,

let’s work through some scenarios for practical application.

Please work the scenario and submit your answer. Once you have completed the scenario, we will review it.

Slide 38 - Slide 38

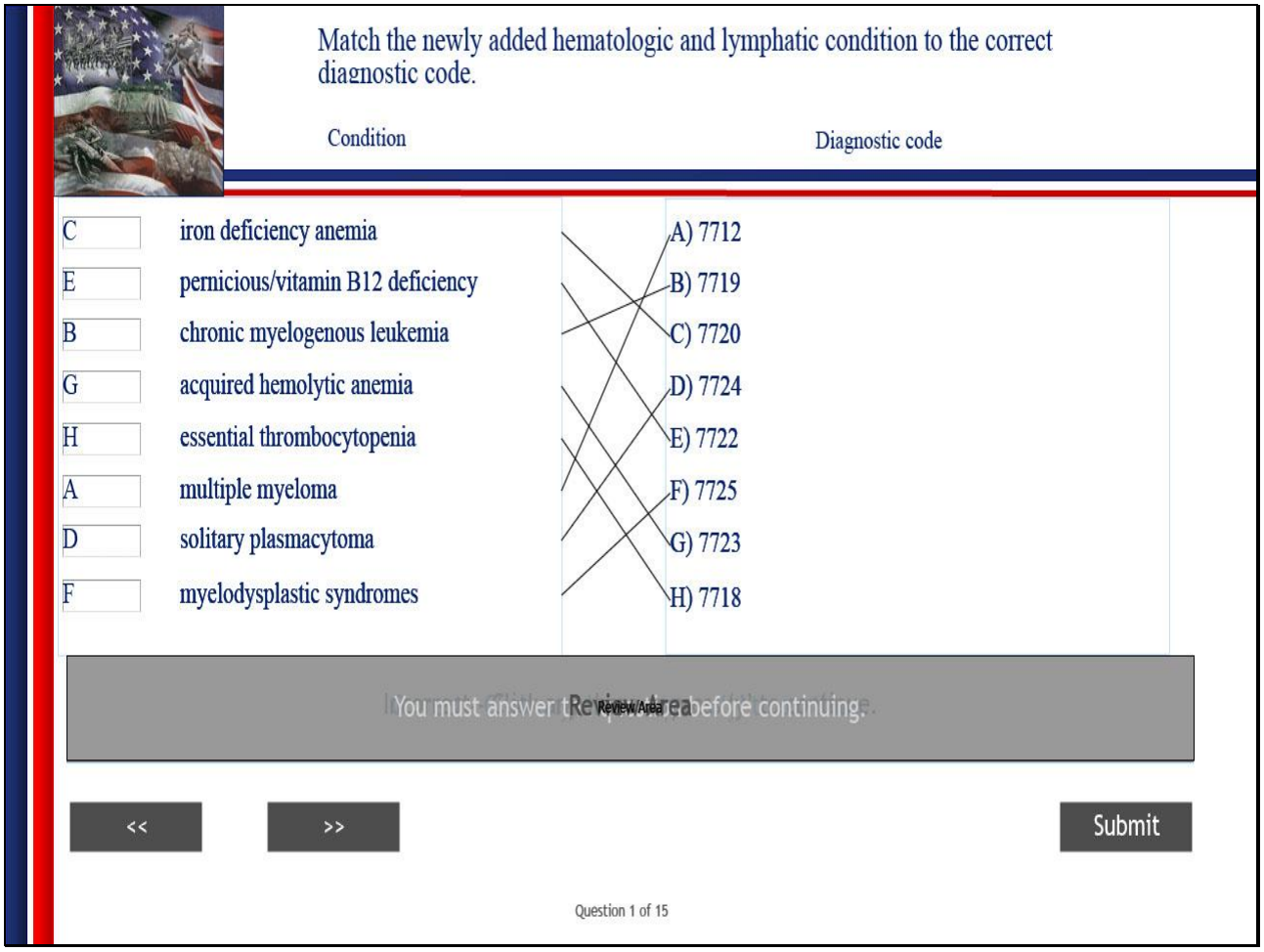
Slide notes

As a reminder, the effective date of the rating schedule change for the hematologic and

lymphatic system is December 9, 2018.

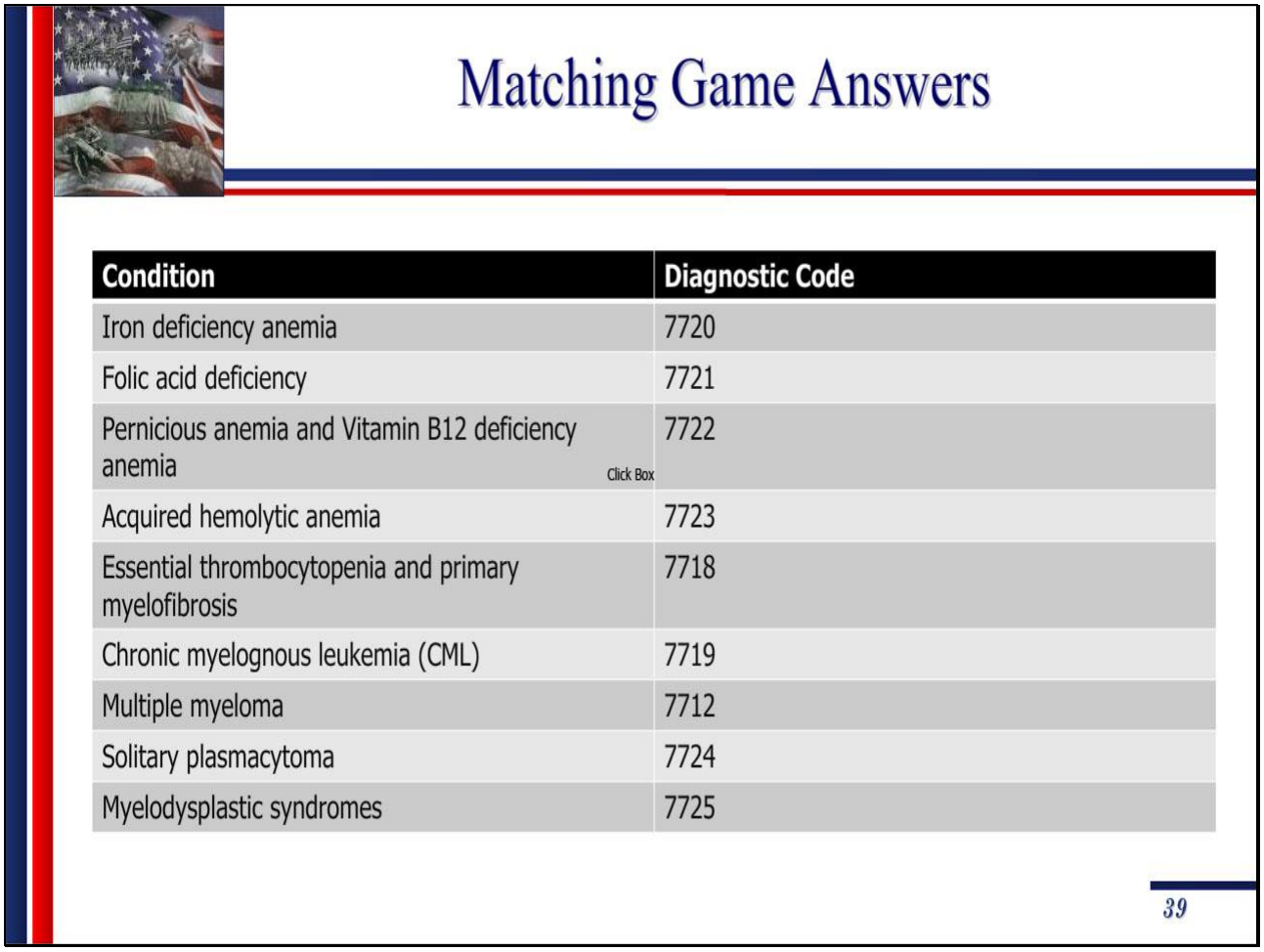
Again, this rating schedule change does **not** fall under liberalizing legislation.

Slide 39 - Slide 39



Slide notes

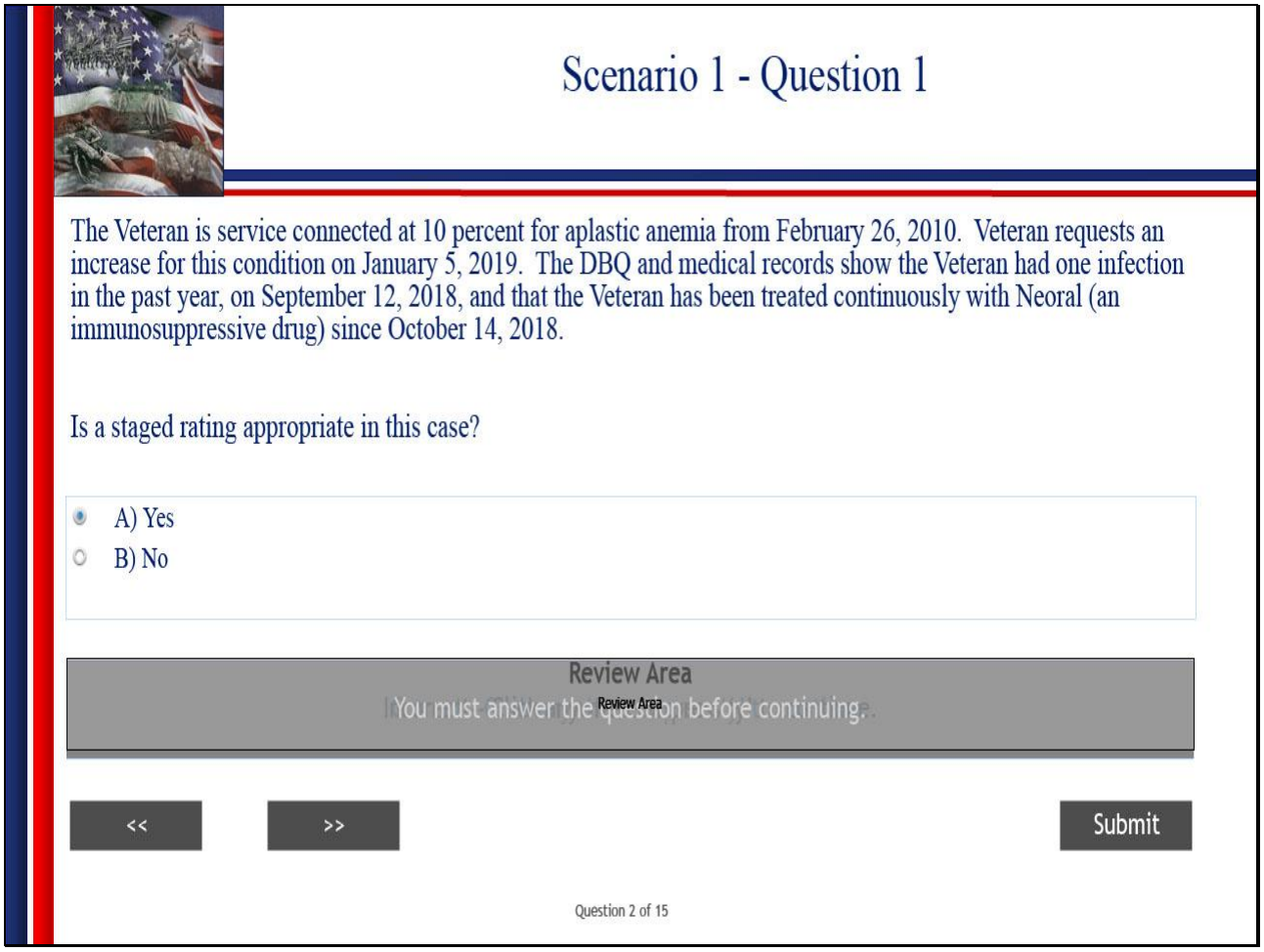
Slide 40 - Matching Game Answers



Slide notes

Please take a moment to review the correct answers.

Slide 41 - Slide 41

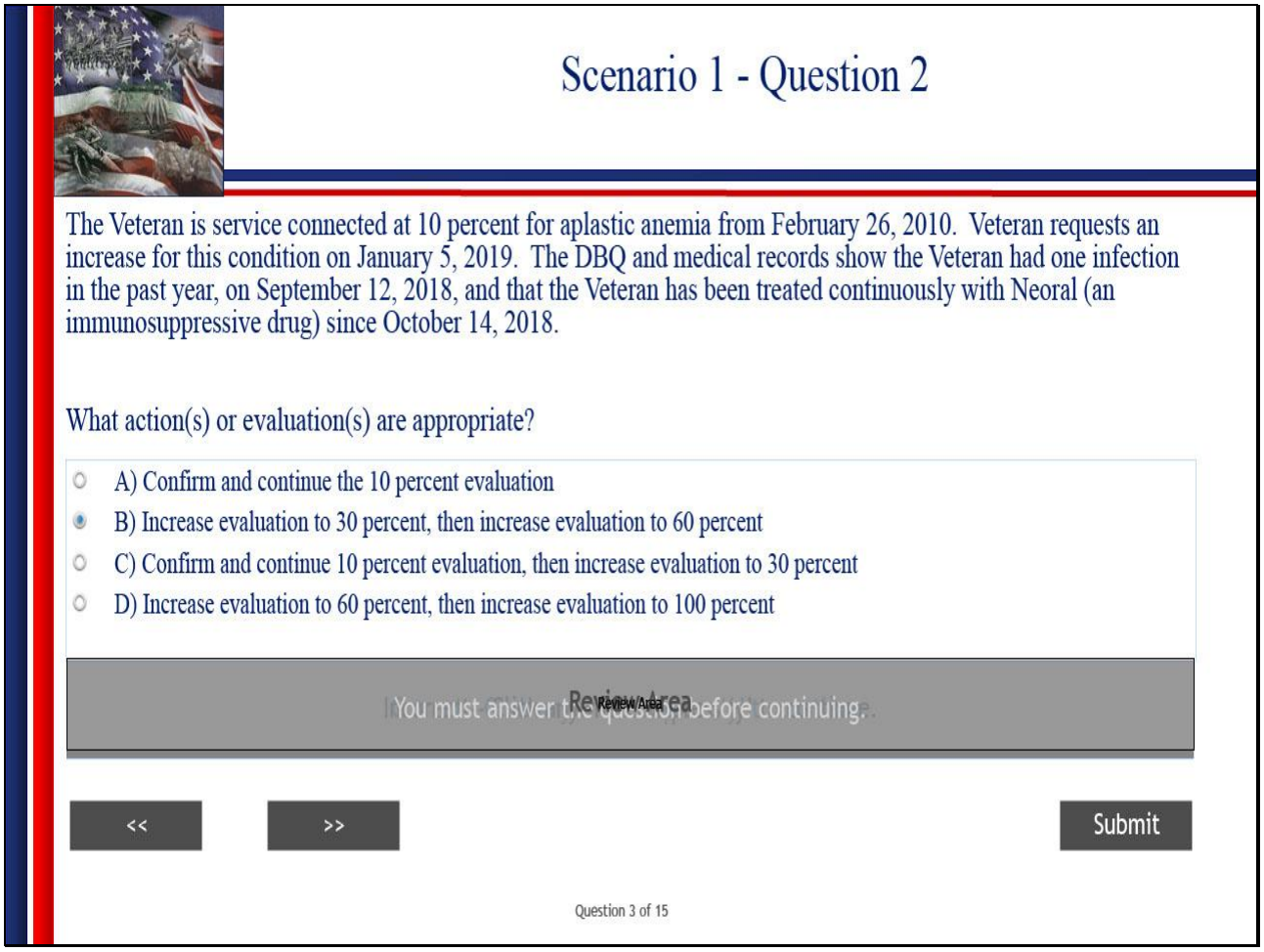


Slide notes

Scenario 1 has three questions. Each slide will have a different question.

<<<reading scenario and question>>>

Slide 42 - Slide 42

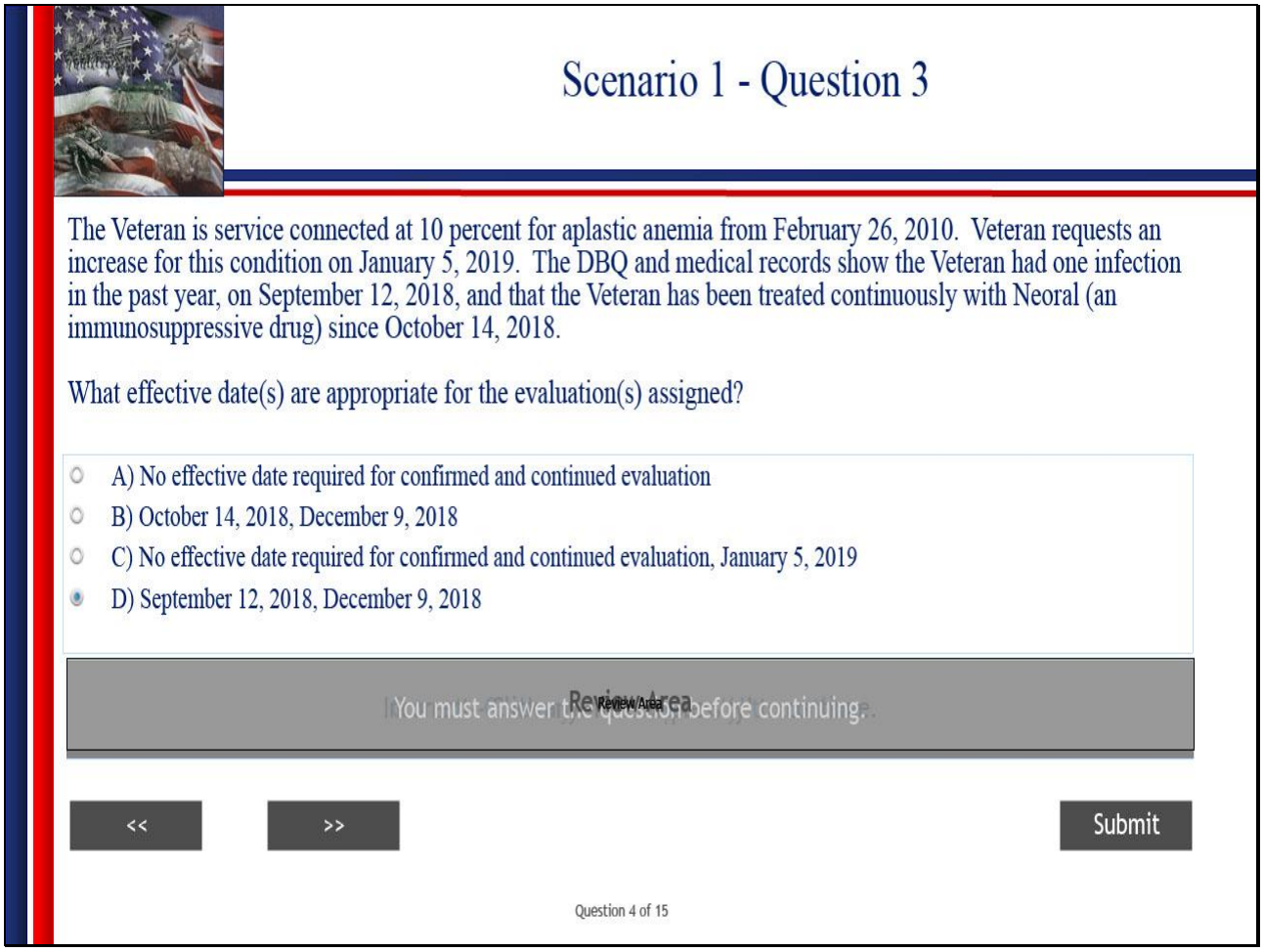


Slide notes

Using the same scenario, answer question 2.

<<<reading scenario and question>>>

Slide 43 - Slide 43

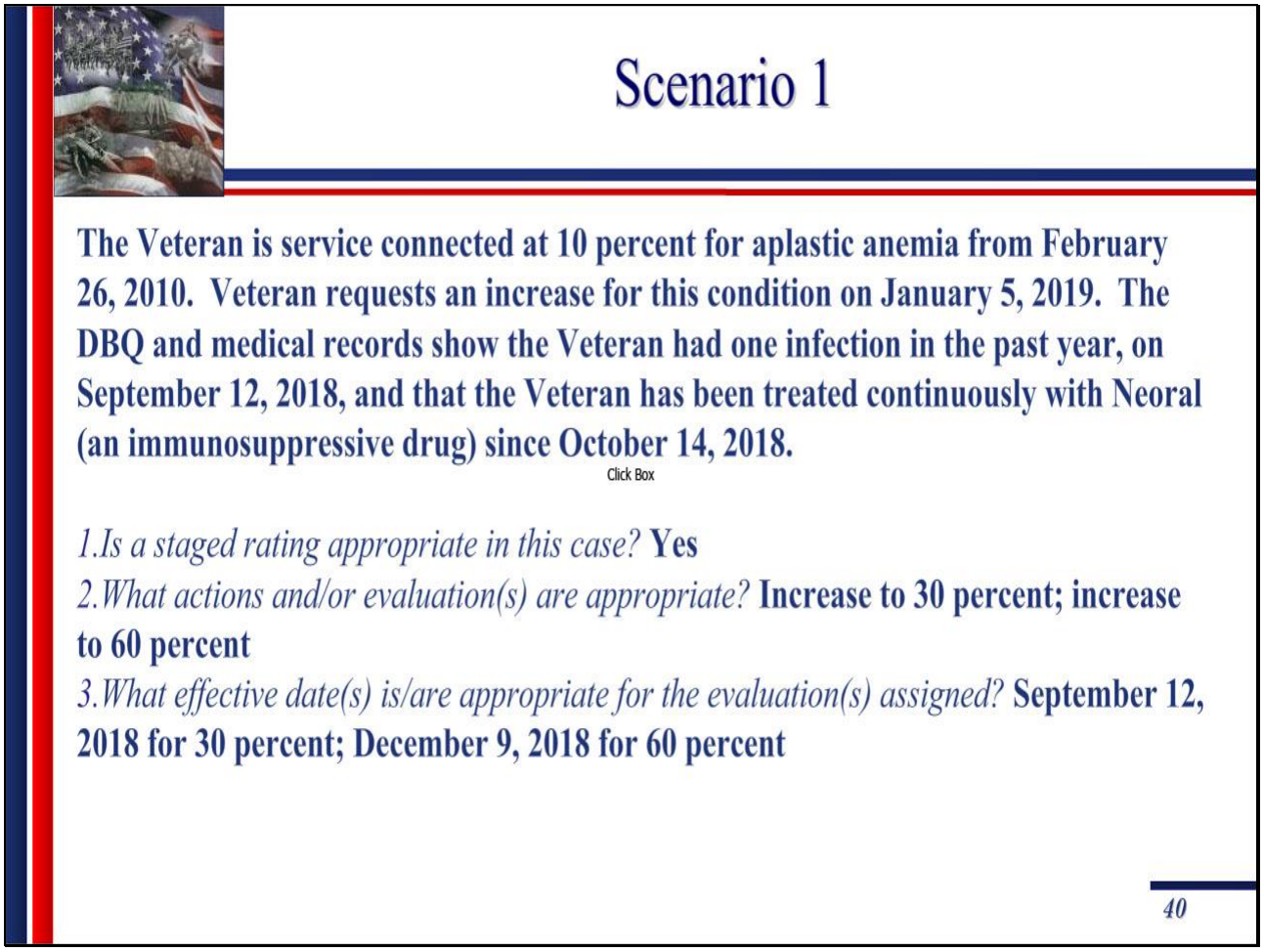


Slide notes

Using the same scenario, answer question 3.

<<<reading scenarion and question>>>

Slide 44 - Scenario 1



Slide notes

A staged rating would be appropriate in this case, because the Veteran warrants a higher evaluation under

the historical criteria, as well as a higher evaluation under the new criteria.

Since the Veteran submitted the claim prior to the date of the rating schedule change, we would have to consider

an increase under the historical criteria first.

An evaluation of 30 percent, under the historical criteria would be assigned from September 12, 2018,

the date of the last infection the Veteran had, as we received the claim within one year of the ascertainable increase.

An evaluation of 60 percent would be assigned based on the continuous use of Neoral,

which is an immunosuppressive drug to treat the condition.

This evaluation would be assigned from December 9, 2018,

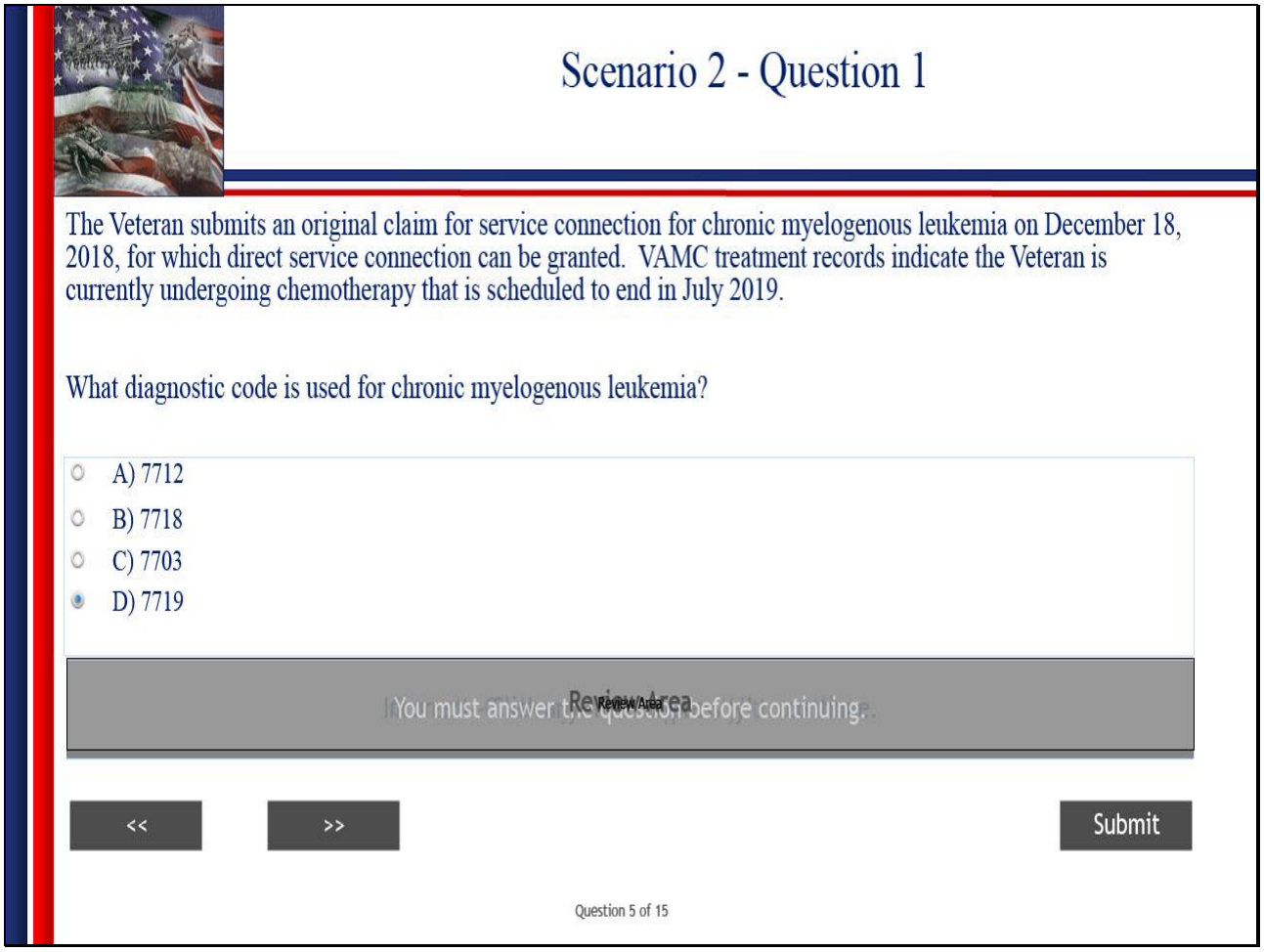
the date of the rating schedule change, because the Veteran

met the evaluation criteria under the new schedule at the time of the rating schedule change,

the claim was pending at the time of the rating schedule change,

and the change in the rating schedule is not liberalizing legislation.

Slide 45 - Slide 45

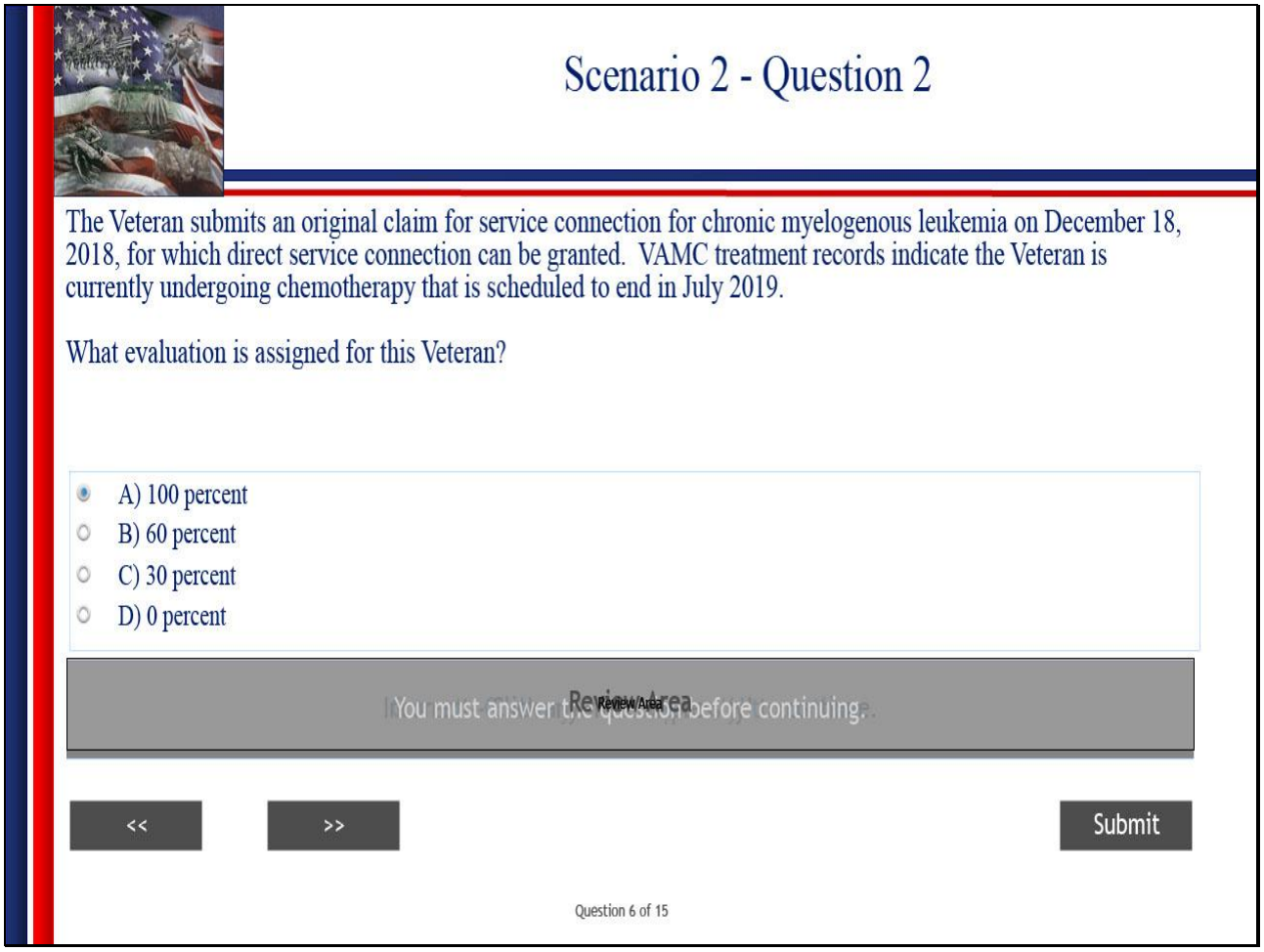


Slide notes

Scenario 2 has three questions. Each slide will have a different question.

<<<reading scenario and question>>>

Slide 46 - Slide 46

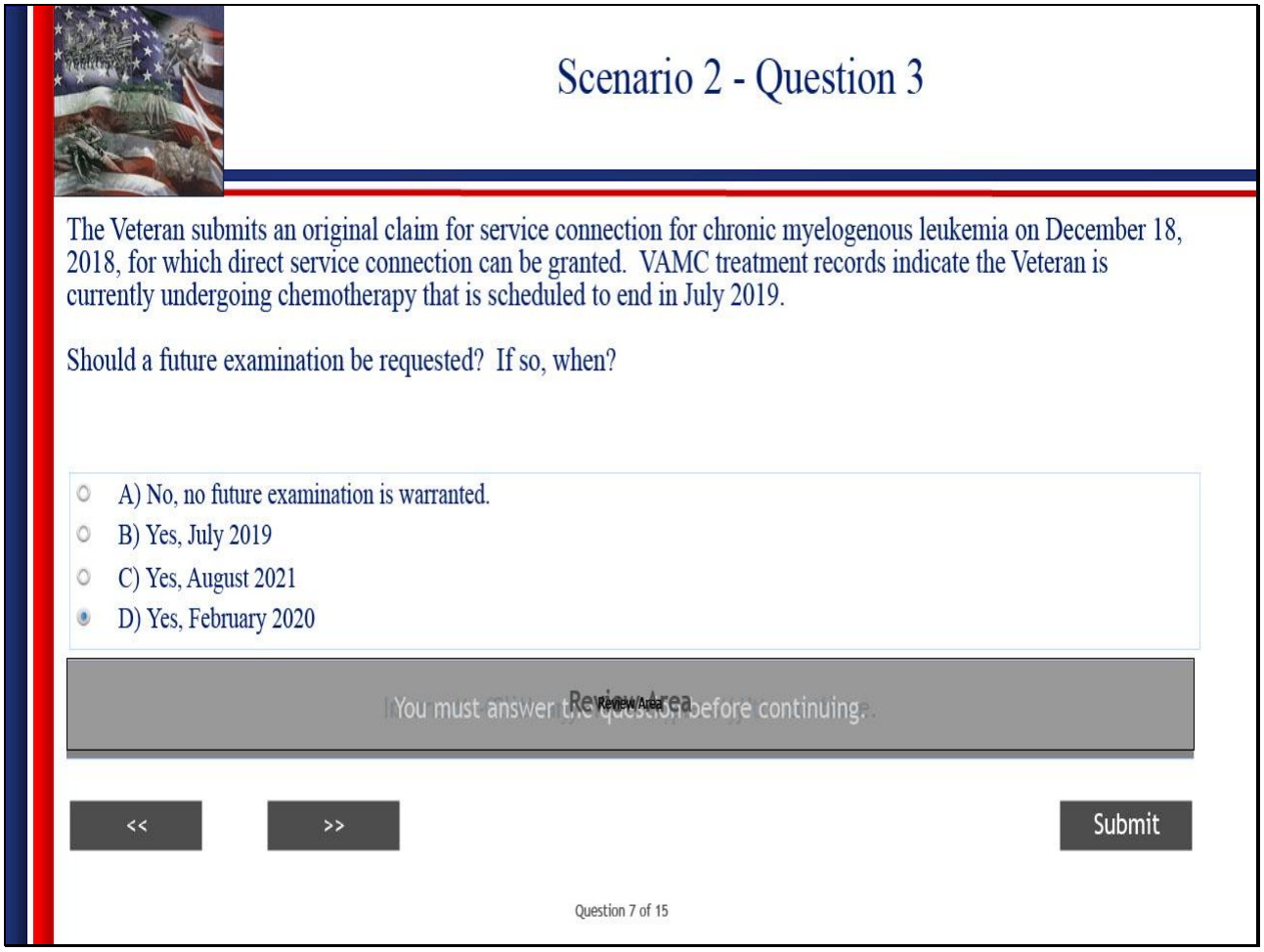


Slide notes

Scenario 2, question 2

<<<reading scenario and question>>>

Slide 47 - Slide 47

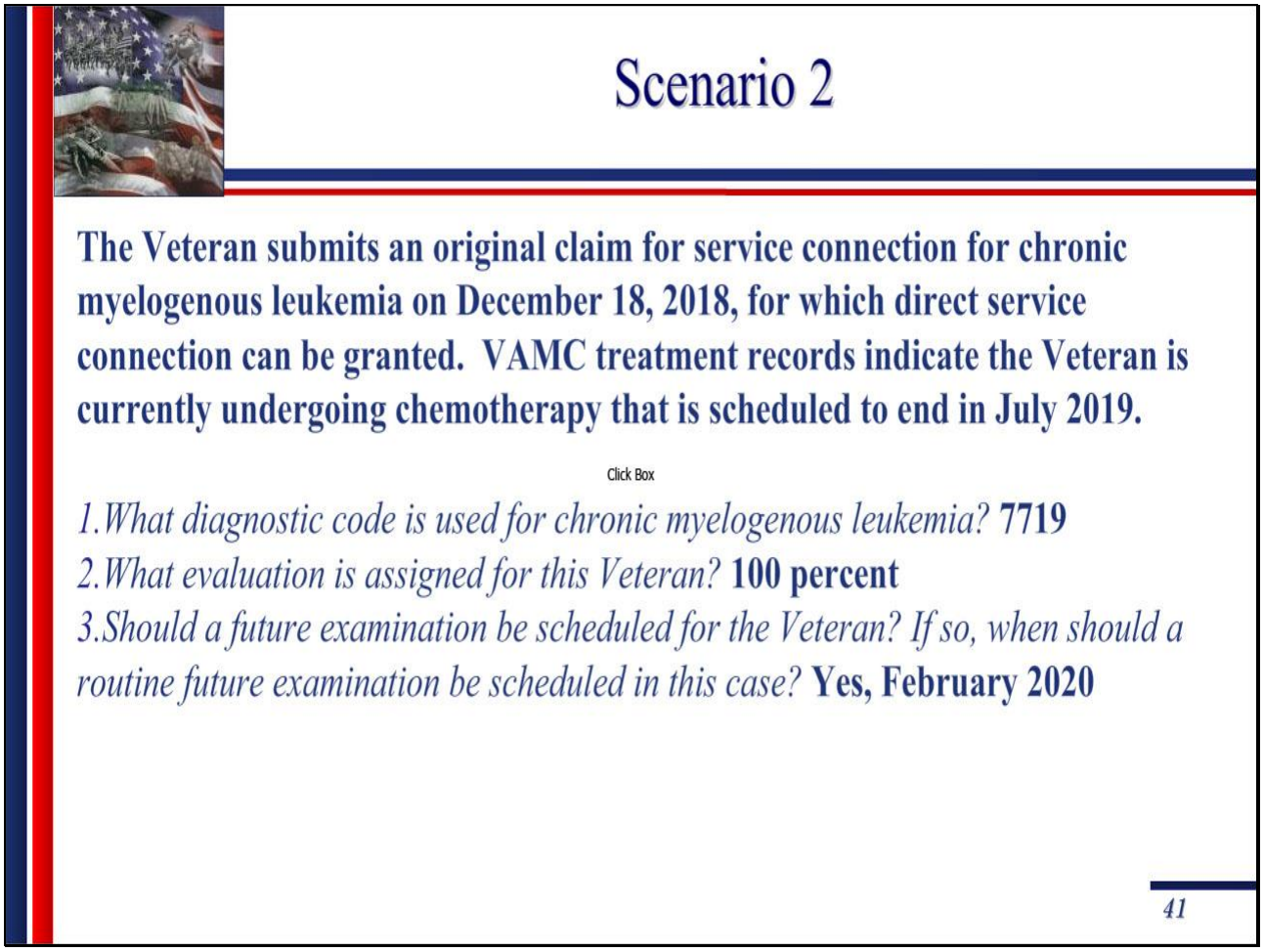


Slide notes

Scenario 2, question 3

<<<reading scenario and question>>>

Slide 48 - Scenario 2



Slide notes

Chronic myelogenous leukemia is now evaluated under diagnostic code 7719.

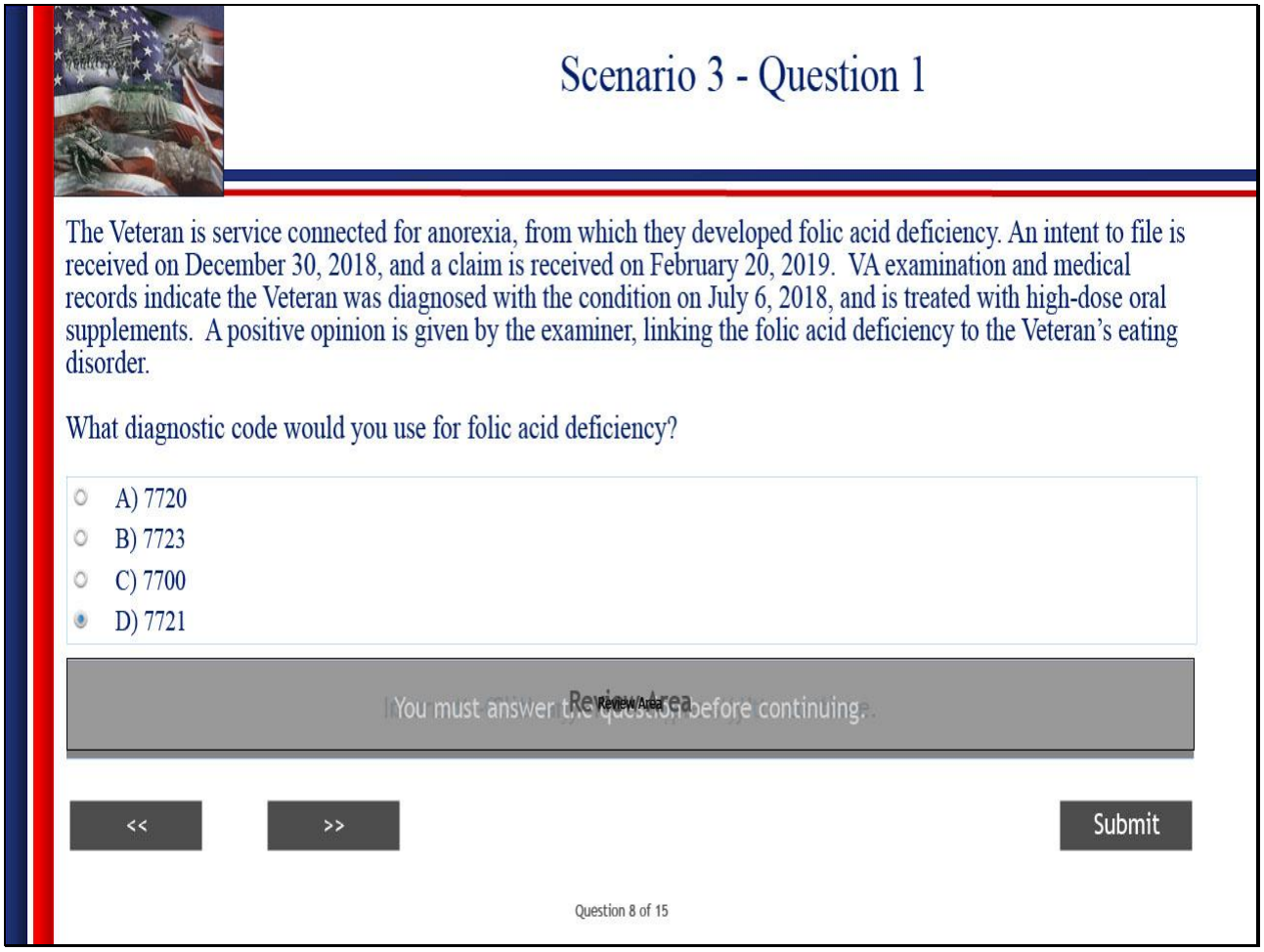
Since the Veteran is undergoing radiation therapy for treatment, a 100 percent evaluation is in order.

Note 2 of diagnostic code 7719 indicates an examination is required six months after completion of treatment.

Since the Veteran's treatment is scheduled to stop in July 2019,

a future examination would be warranted in February 2020.

Slide 49 - Slide 49

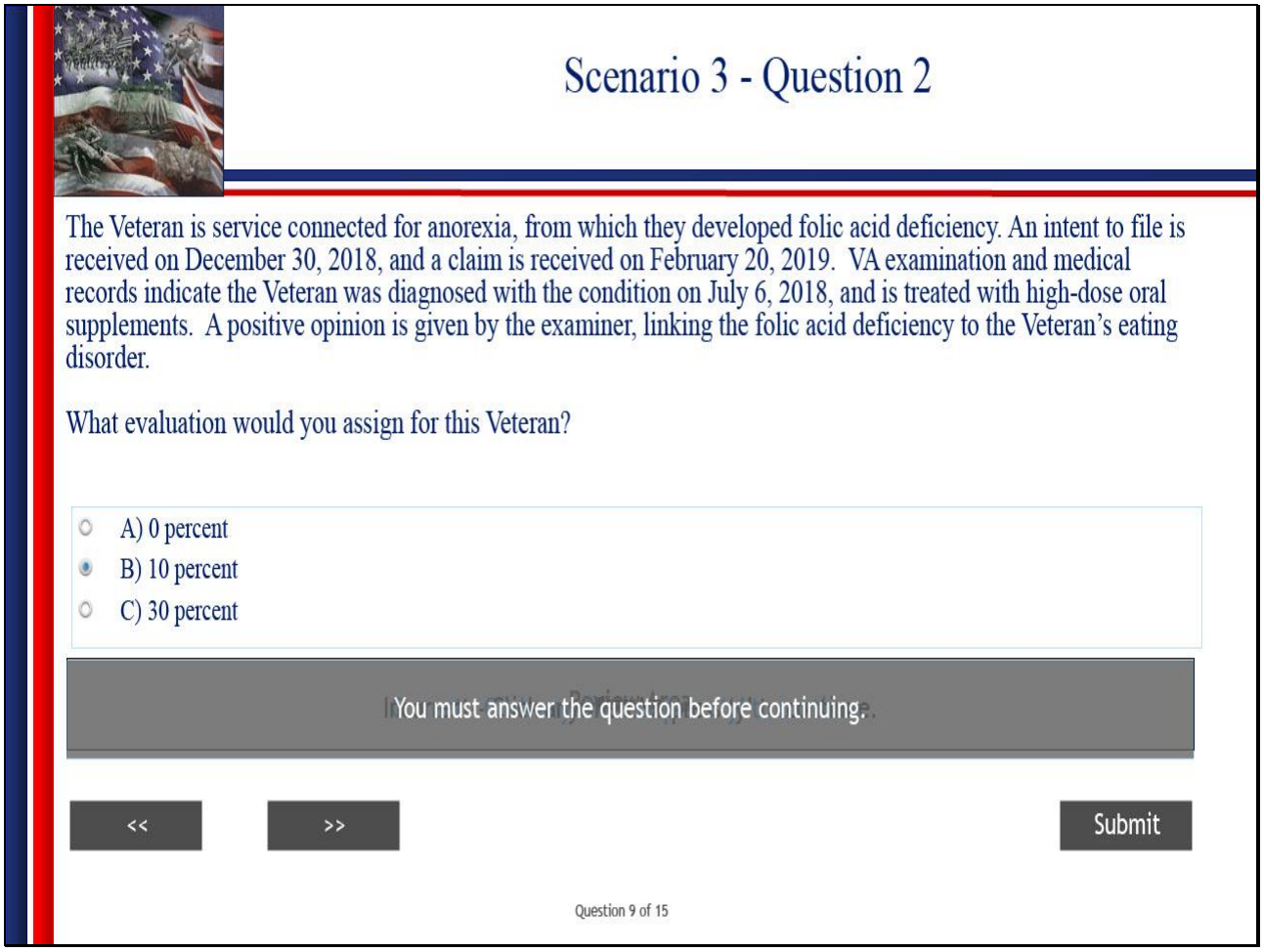


Slide notes

Scenario 3 has three questions. Each slide will have a different question.

<<<reading scenario and question>>>

Slide 50 - Slide 50

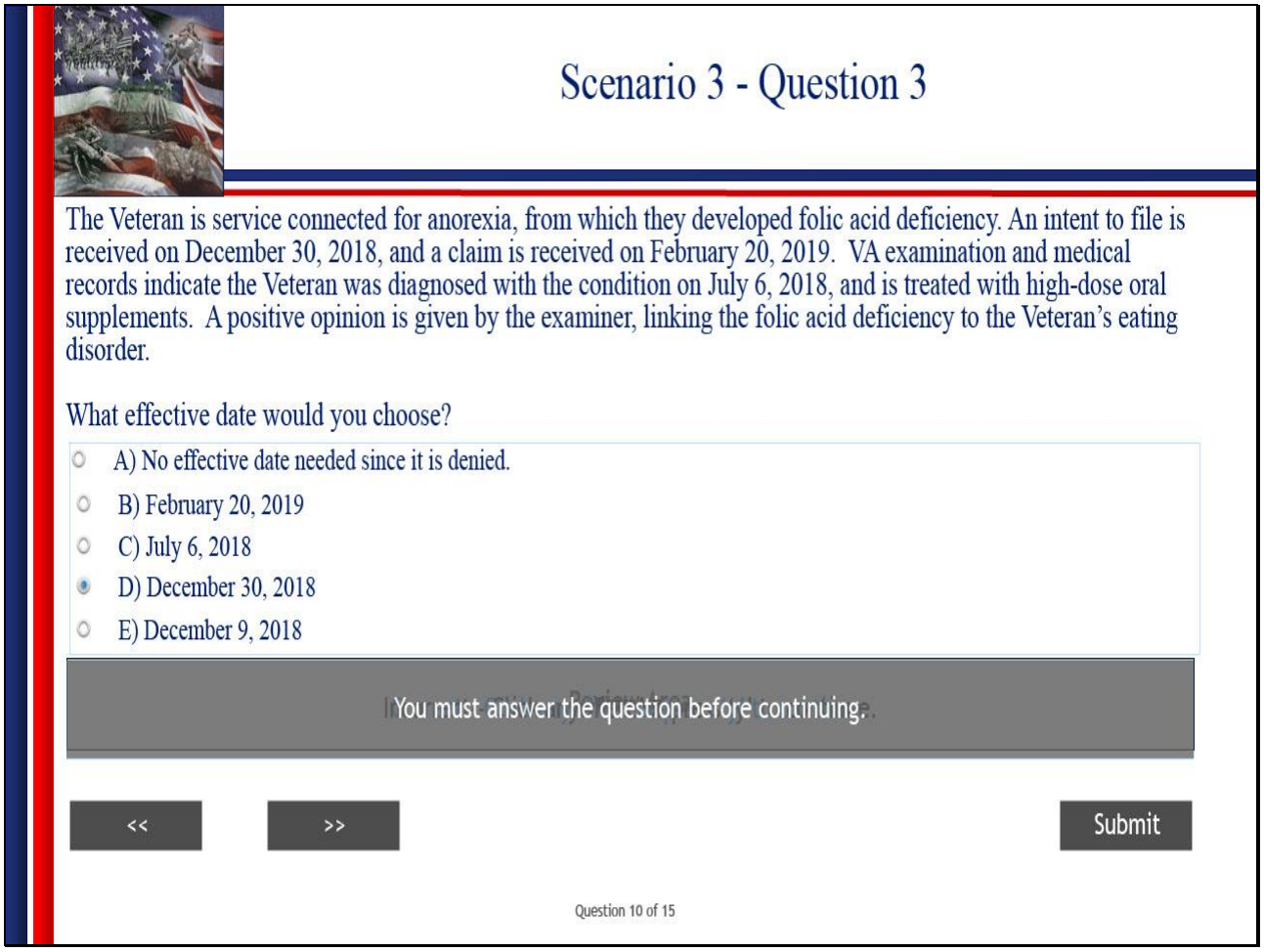


Slide notes

Scenario 3, question 2

<<<reading scenario and question>>>

Slide 51 - Slide 51

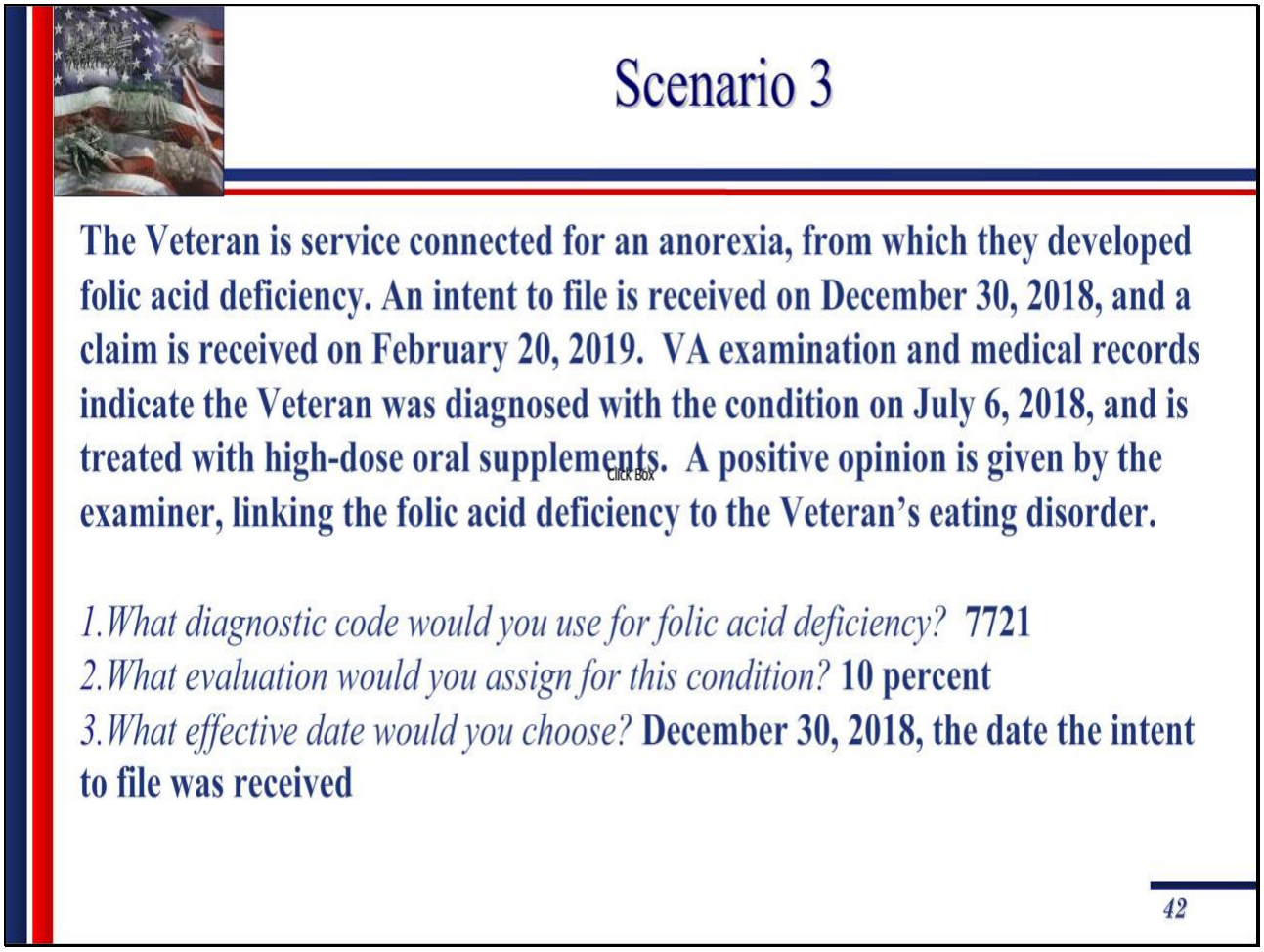


Slide notes

Scenario 3, question 3

<<<reading scenario and question>>>

Slide 52 - Scenario 3



Slide notes

Since there is a positive opinion linking the folic acid deficiency to the Veteran's eating disorder,

a grant for folic acid deficiency is in order under diagnostic code 7721.

An evaluation of 10 percent would be assigned based on treatment with

high-dose oral supplements.

This evaluation would be effective December 30, 2018, the date the intent to file was received.

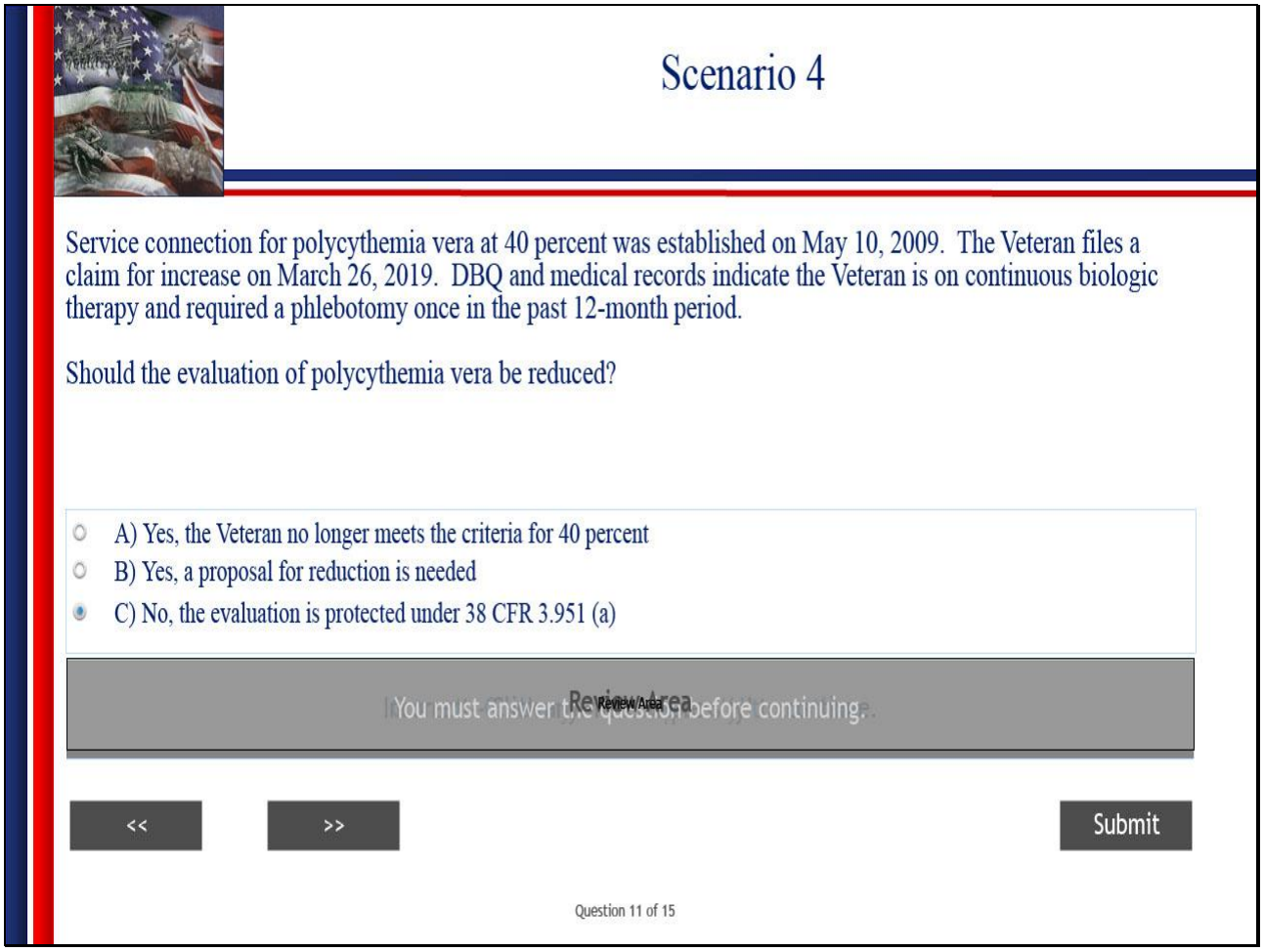
Although the Veteran met the criteria for the 10 percent evaluation for

folic acid deficiency at the time of the rating schedule change, December 9, 2018,

the intent to file and claim were both received after this date.

A grant would not be warranted prior to the rating schedule change, as the rating schedule change is not liberalizing legislation.

Slide 53 - Slide 53

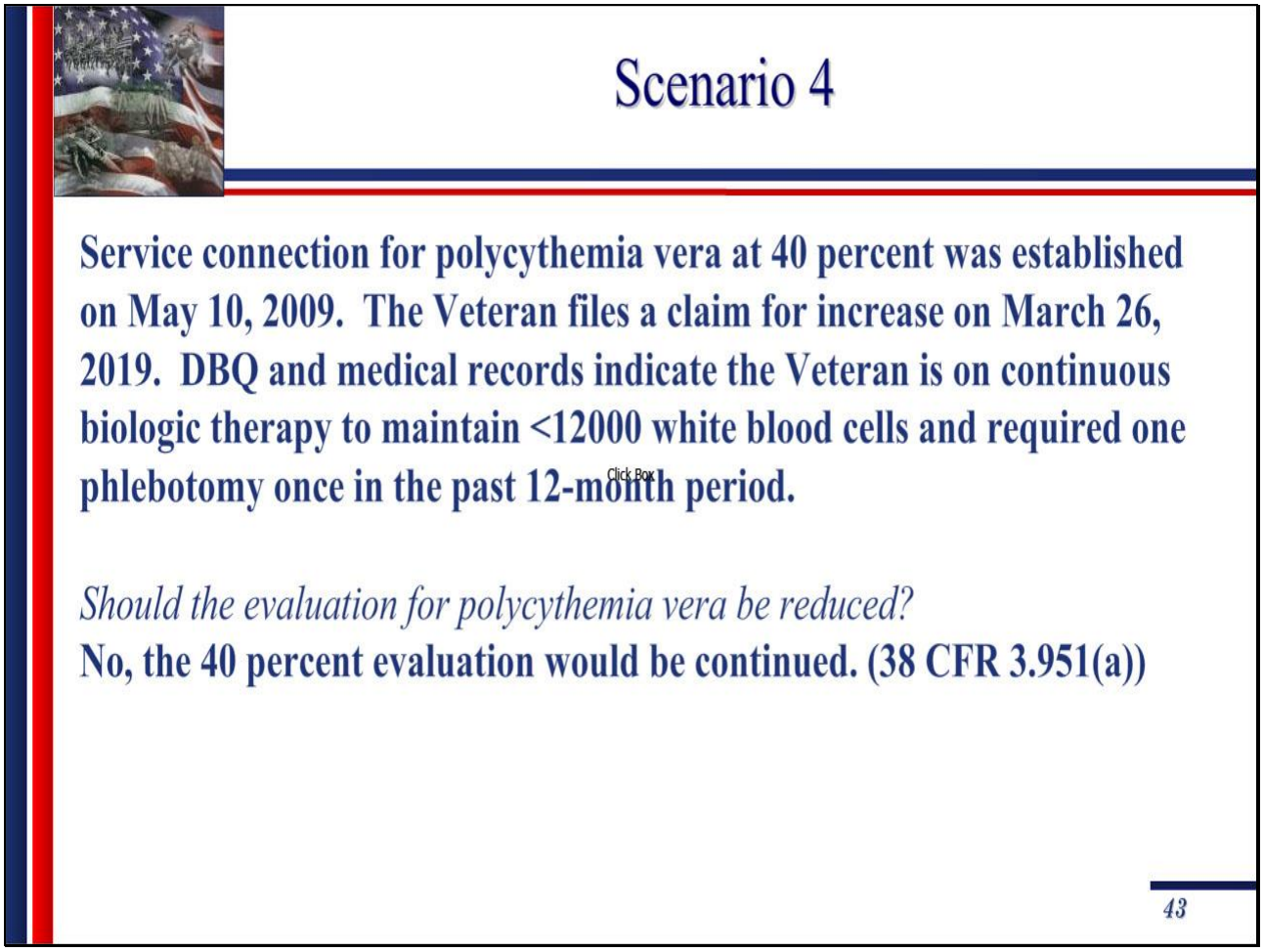


Slide notes

Scenario 4 has one question.

<<<reading scenario and question>>>

Slide 54 - Scenario 4



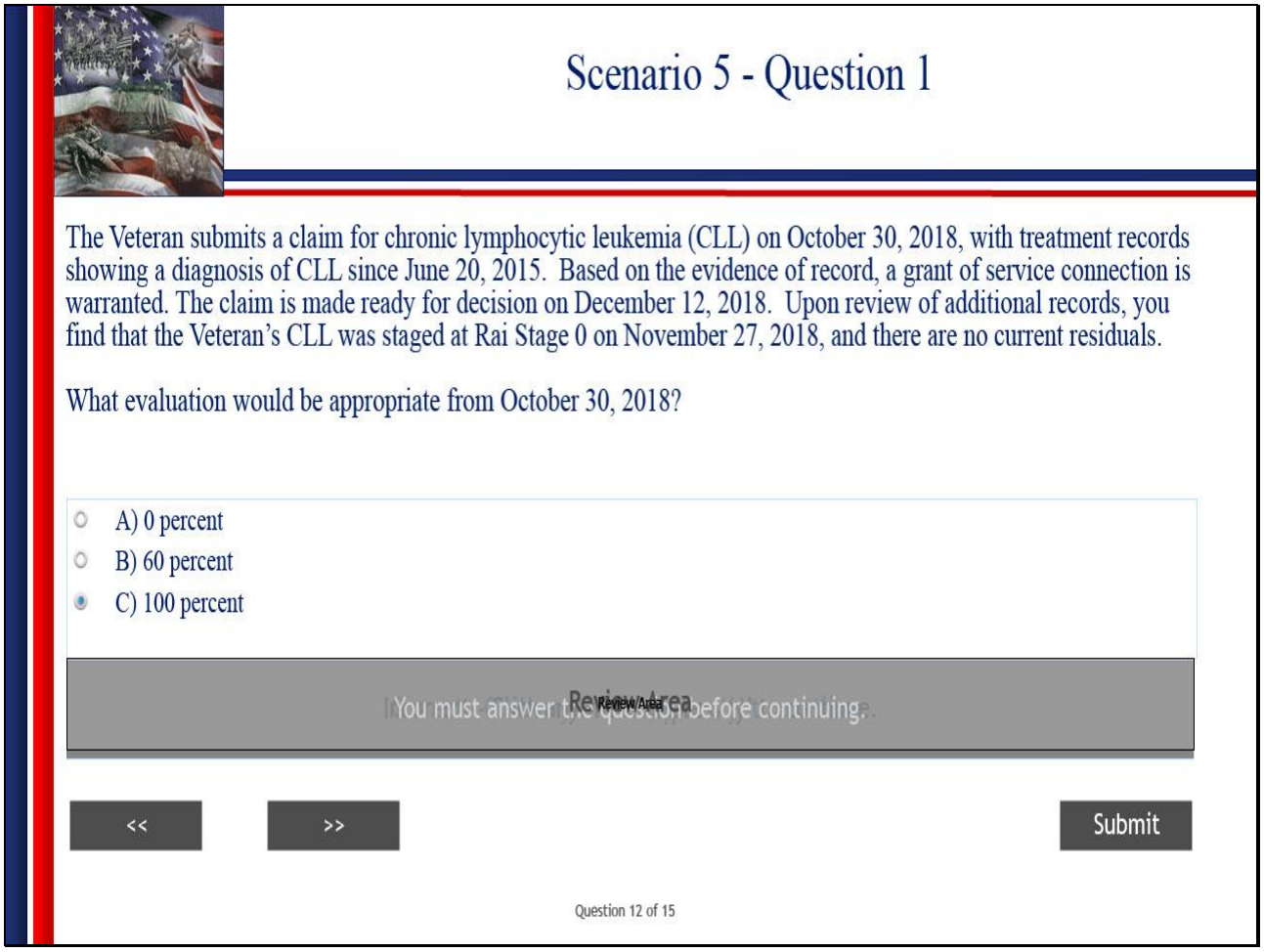
Slide notes

No, the 40 percent evaluation would not be reduced, the evaluation would be continued.

Although the Veteran meets a 30 percent evaluation under the new criteria based on the current findings,

a change in the rating schedule cannot be used as a basis for reduction, per 38 CFR 3.951(a).

Slide 55 - Slide 55

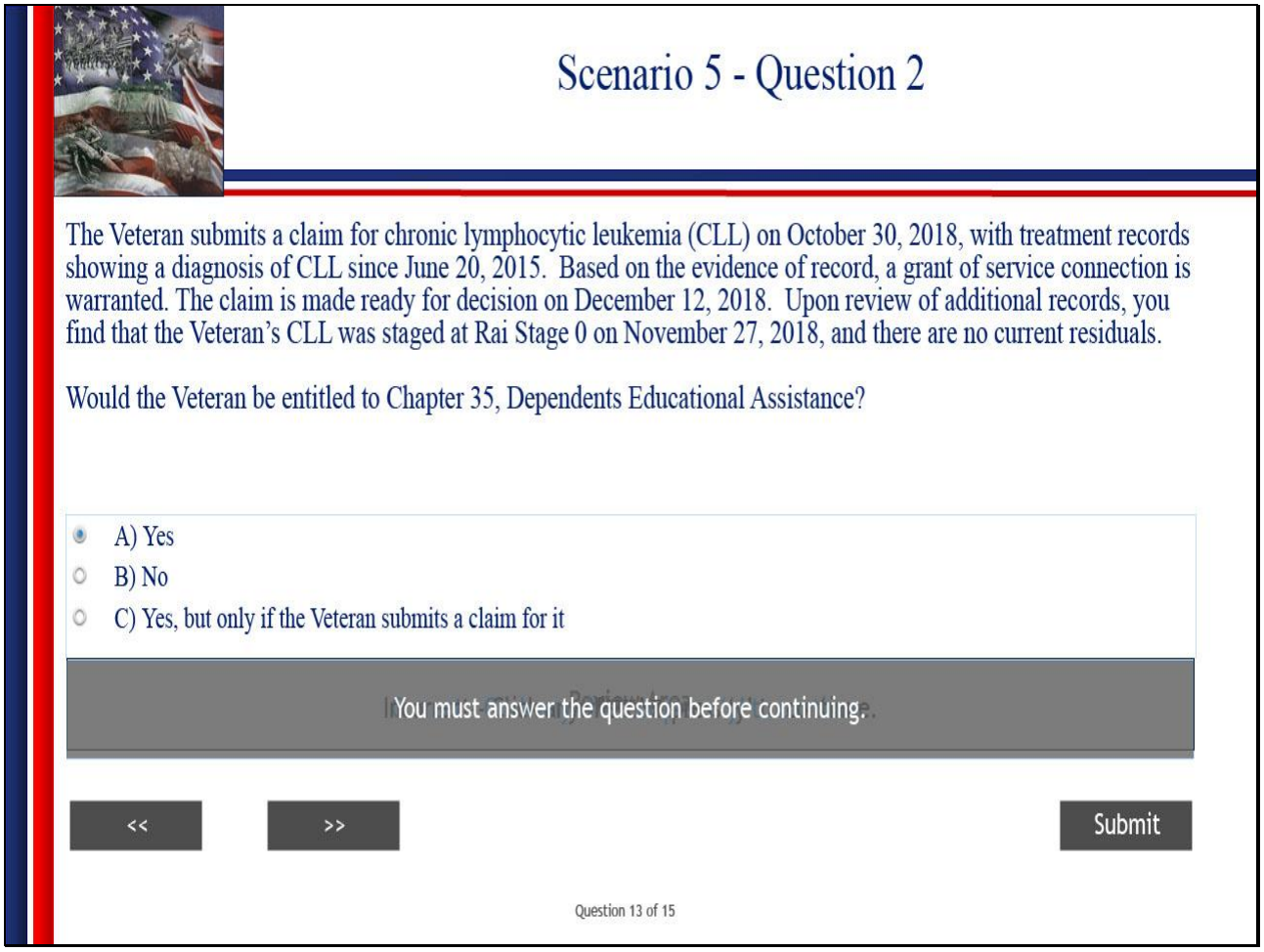


Slide notes

Scenario 5 has three questions. Each slide will have a different question.

<<<reading scenario and question>>>

Slide 56 - Slide 56

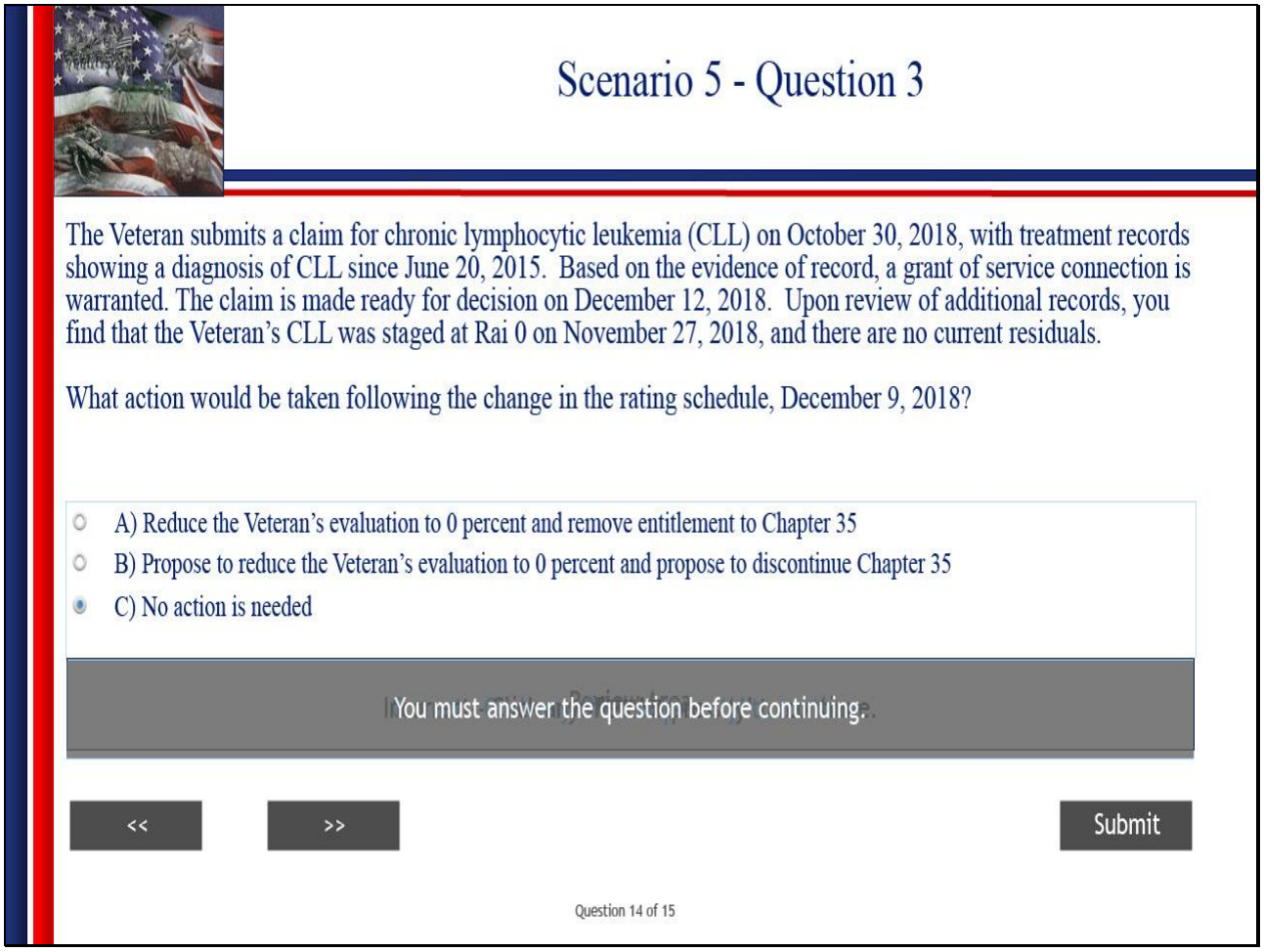


Slide notes

Scenario 5, question 2

<<<reading scenario and question>>>

Slide 57 - Slide 57



Slide notes

Scenario 5, question 3

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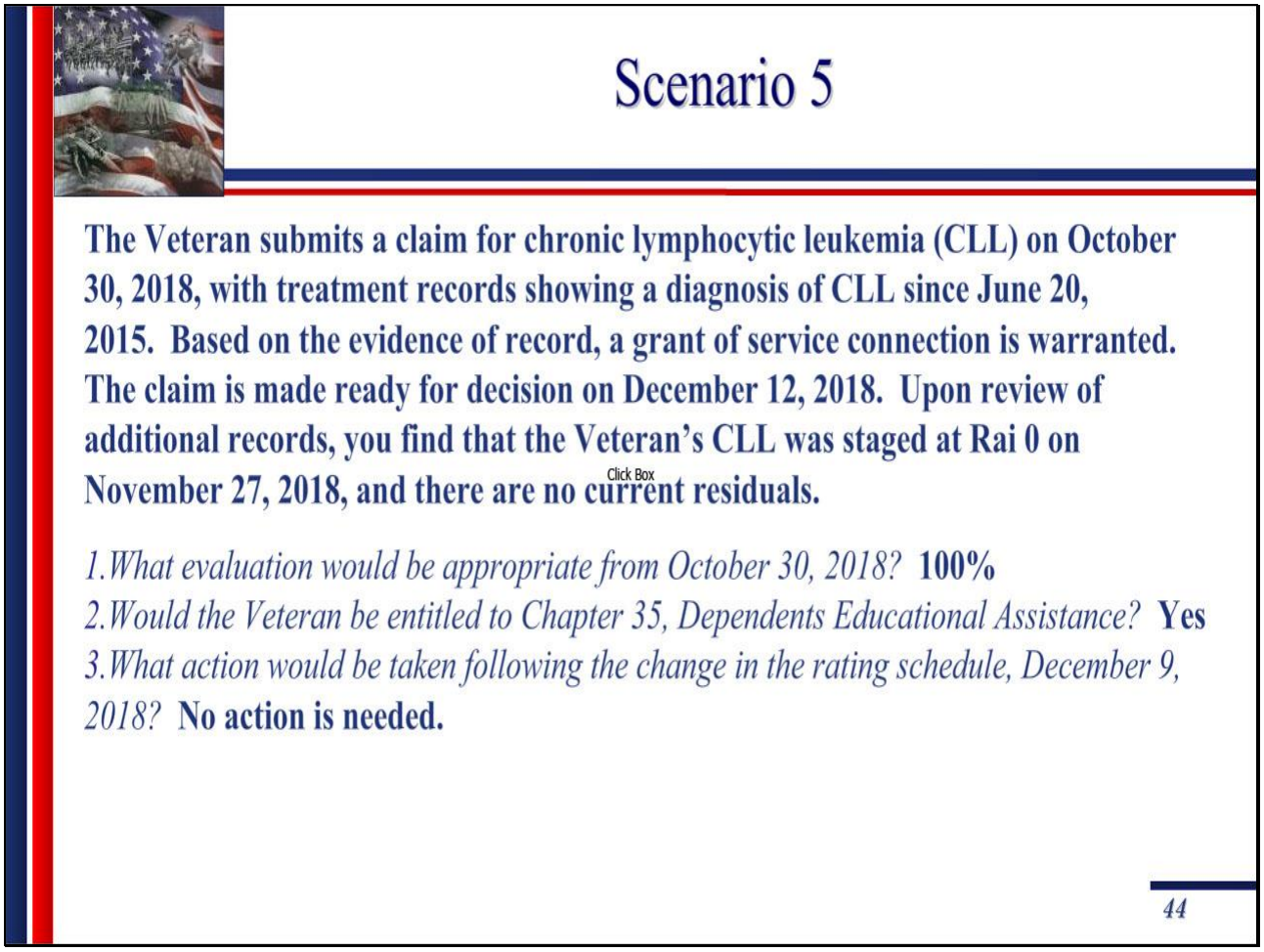
Slide 58 - Scenario 5



Slide notes

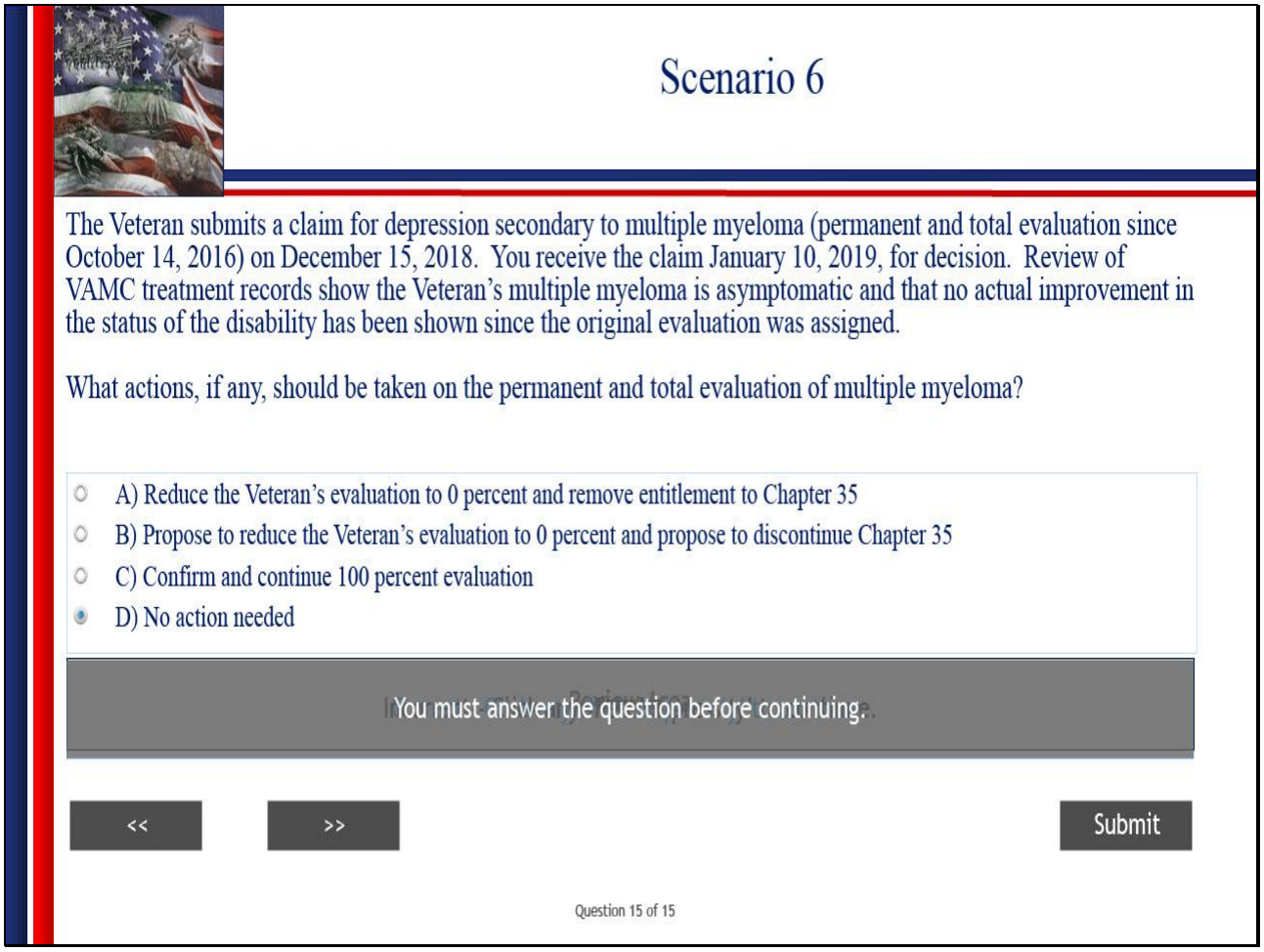
Since the claim was received prior to the criteria change for chronic lymphocytic leukemia and was pending after the change, both sets of criteria need to be considered.

Assess whether the evaluation assigned under the historical criteria is most advantageous and should be continued, especially since it is now protected under 38 CFR 3.951, or whether it will be more advantageous to evaluate the Veteran under the new criteria beginning on the date of the rating schedule change.

In this scenario, the evaluation would be based on the historical criteria and procedural guidance as it is the better benefit, and the Veteran would receive a static 100 percent evaluation for CLL.

Additionally, the Veteran would also be entitled to Chapter 35, Dependents Educational Assistance.

Slide 59 - Slide 59

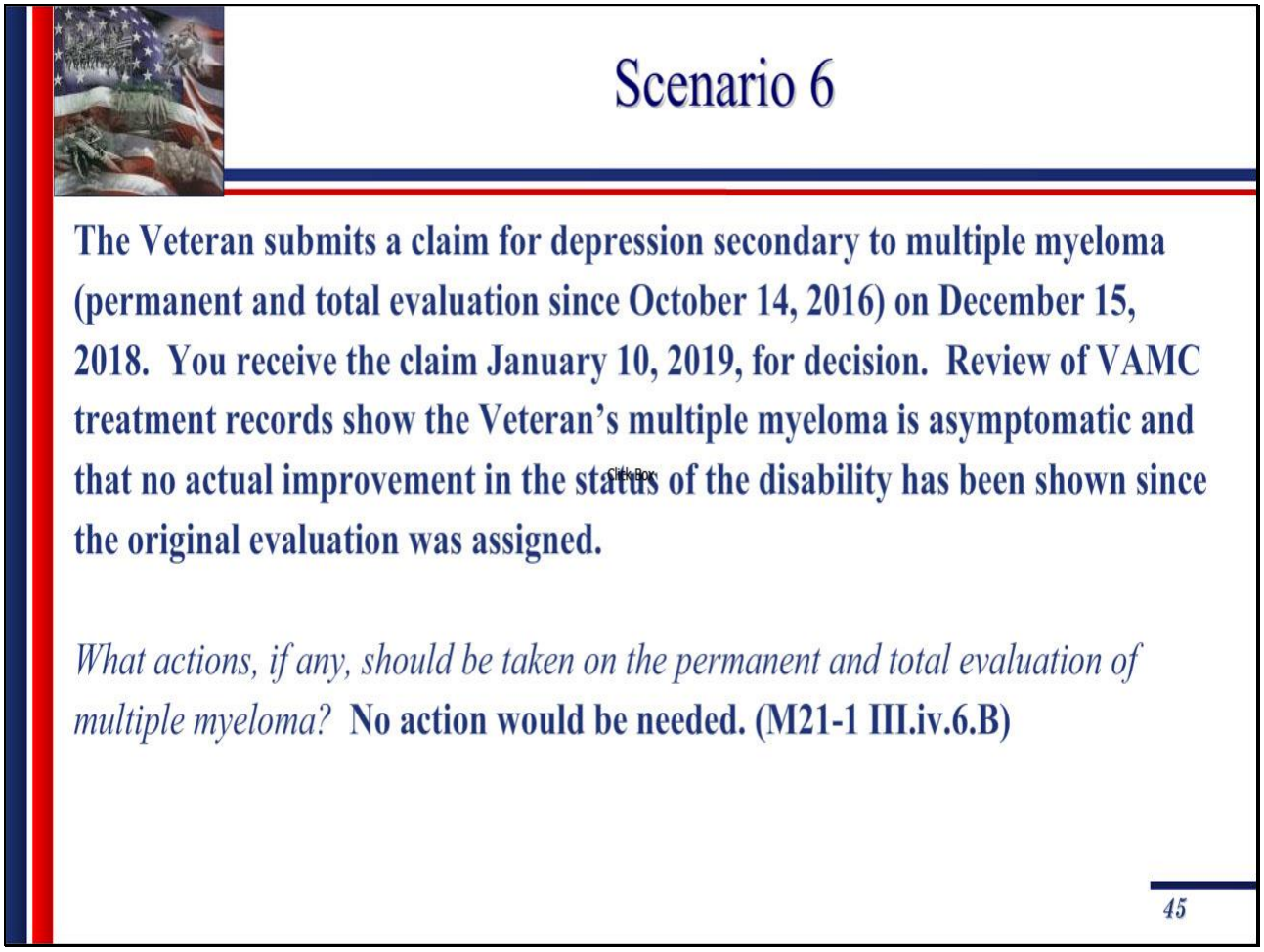


Slide notes

Scenario 6 has one question.

<<<reading scenario and question>>>

Slide 60 - Scenario 6



Slide notes

In this scenario, the Veteran does not have a claim pending for multiple myeloma, and it is only through review

of the evidence that the RVSR may be triggered to look at the evaluation for multiple myeloma.

Since this condition was evaluated prior to the change in the rating schedule,

it would have been evaluated analogous to Hodgkin's disease (7799-7709)

at 100 percent and entitlement to Chapter 35 would have also been granted.

The manual discusses inferred reductions based on a review of medical evidence

in connection with a claim for a different condition.

However, protection of historical evaluations under 38 CFR 3.951(a) supplants inferred reductions.

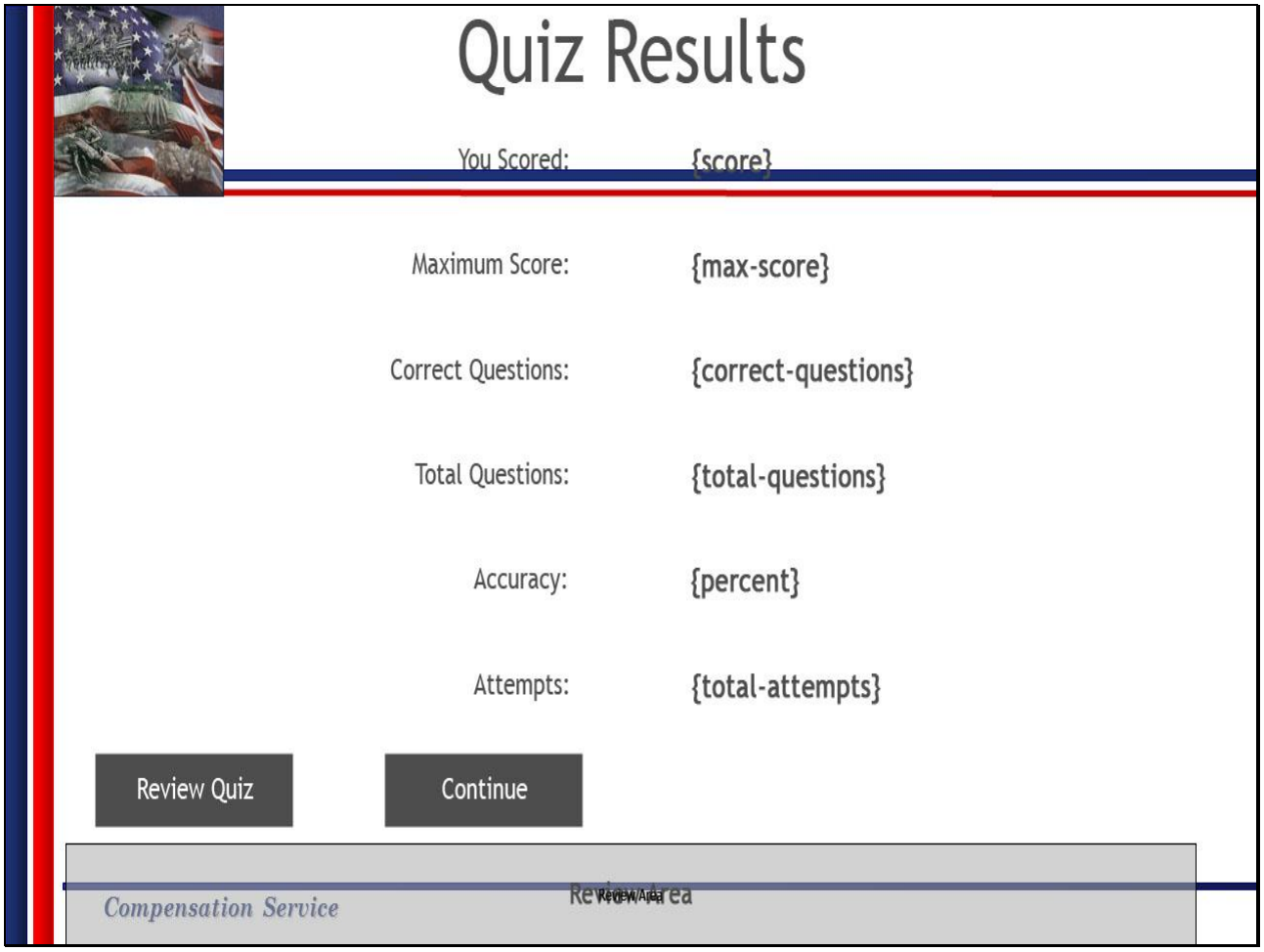
Therefore, in this scenario, no action would be needed

since the evaluation should remain permanent and total, as it is protected.

For more information on compensation entitlement issues, refer to the manual at

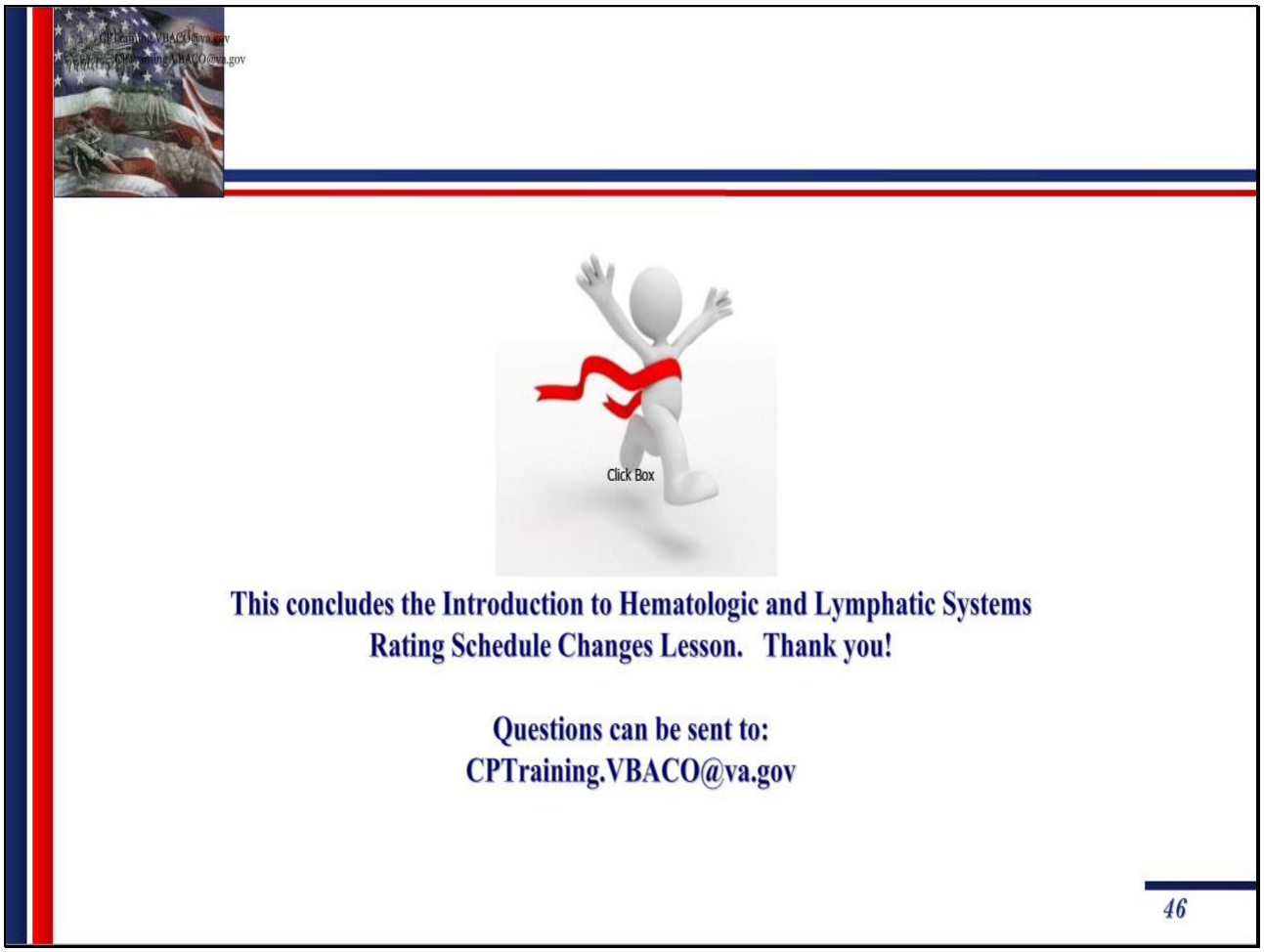
M21-1, Part III, Subpart iv, Chapter 6, Section B.

Slide 61 - Slide 61



Slide notes

Slide 62 - This concludes the Introduction to Hematologic and Lymphatic Systems Rating Schedule Changes Lesson. Thank you!



Slide notes

And we are finished!

Remember, the effective date for the rating schedule change for the new hematologic

and lymphatic rating schedule is December 9, 2018.

Liberalizing legislation does not apply to the rating schedule change, therefore

your general effective date rules will be applied when evaluating hematologic and lymphatic conditions.

It is a good idea to become familiar with how to access the historical rating schedule,

so that you can effectively evaluate hematologic and lymphatic conditions.

As a reminder, it can be found in Rating Job Aids or in the Knowledge Management Portal

This concludes the Introduction to Hematologic and Lymphatic Rating Schedule Changes Lesson.

Questions regarding this training can be sent to CPTraining.VBACO@va.gov

Until next time!