Health Documentation & VA Rating Scales

A primer on how VA grades your conditions, and why your records decide the number.

How VA Rating Scales Work

Every service-connected condition is rated under a specific Diagnostic Code (DC), and each code has its own scale, usually running from 0% up to 100% in 10-point steps. The percentage you land on is decided by matching your documented symptoms to the criteria written into that code, not by how severe your condition feels to you day to day.

When you have more than one rated condition, VA does not simply add the percentages together. Ratings are combined using VA math, which applies each additional percentage to what's left of your "whole person," so two 30% ratings do not equal 60%. This is also where the bilateral factor, special monthly compensation (SMC), and TDIU can come into play once your combined picture reaches certain points.

Why Documentation Drives the Number

VA can only rate what is written down. Two veterans with the exact same condition can receive very different ratings depending on how well that condition is documented. Three things consistently move a rating up or down within its scale:

- **Frequency:** how often symptoms occur (daily, weekly, episodic).
- **Severity:** measurable findings, not general descriptions (degrees of motion, test scores, imaging results).
- **Duration:** how long symptoms last, and whether they are permanent or improving.

Example: how wording changes the outcome

Weak: "Shoulder hurts sometimes when I move it."
Strong: "Forward flexion limited to 70 degrees, with pain beginning at 45 degrees, occurring daily and worsening with overhead activity."

What Good Documentation Looks Like

- **Specific, measurable findings:** degrees of motion, AHI scores, PHQ-9/GAD-7 results, lab values, imaging findings.
- **Consistency across visits:** the same symptoms, described the same way, show up over time, not just once.
- **Alignment:** your personal statement matches what your treatment records and exam findings actually show.

Documents That Matter Most

- **Diagnostic imaging and test results:** X-rays, MRIs, sleep studies, bloodwork.
- **Specialist treatment notes:** not just primary care, the provider treating the specific condition.
- **Your C&P exam report:** this is often the single most influential document in your file.
- **Buddy statements and personal statements:** fill gaps where medical records are thin.
- **Symptom and flare logs:** turn "it's bad sometimes" into documented frequency and severity.

Want your documentation reviewed?

Schedule a free consult: https://calendly.com/bungardwj/1-1-coaching-call