Veterans Benefits Administration **Program Guide 21-2**
Department of Veterans Affairs
Washington, DC 20420

The Veterans Benefits Administration Program Guide 21-2 has been updated.

We added Regulatory Amendment Explanations 4-02-1 to 4-03-2 to bring current the Part 4 guide since 2002. We also updated the corresponding Index to Transmittal Sheets for Compensation and Pension Regulations for Part 4.

By Direction of the Under Secretary for Benefits

Renée Szybala, Director
Compensation and Pension Service

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Veterans Benefits Administration
Department of Veterans Affairs
Washington, DC 20420

PART II

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COMPENSATION AND PENSION REGULATIONS

38 CFR PART 4

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8020	[No Revision since 1945 Schedule]
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8022	[No Revision since 1945 Schedule]
8023	[No Revision since 1945 Schedule]
8024	[No Revision since 1945 Schedule]
8025	Ext 7; 6
8045	6; 17; 26
8046	6; 26
8100	Ext 9
8103	6; 7
8104	[No Revision since 1945 Schedule]
8105	[No Revision since 1945 Schedule]
8106	[No Revision since 1945 Schedule]
8107	[No Revision since 1945 Schedule]
8108	6
8205	[No Revision since 1945 Schedule]
8305	[No Revision since 1945 Schedule]
8405	[No Revision since 1945 Schedule]
8207	[No Revision since 1945 Schedule]
8307	[No Revision since 1945 Schedule]

8407 [No Revision since 1945 Schedule]

8209 [No Revision since 1945 Schedule]

8309 [No Revision since 1945 Schedule]

8409 [No Revision since 1945 Schedule]

8210 [No Revision since 1945 Schedule]

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8729 [No Revision since 1945 Schedule]

8530 [No Revision since 1945 Schedule]

8630 [No Revision since 1945 Schedule]

8730 [No Revision since 1945 Schedule]

8540 4-91-1

8910 Ext 7; 6

8911 6; 16

8912 6

8913 6

8914 6; 7; 17; 26

4.125 6; 12; 18; 24; 4-96-5

4.126 6; 12; 24; 4-96-5

4.127 6; 12; 18; 24; 4-96-5

4.128 6; 12; 4-96-5

4.129 6; 12; 4-96-5

4.130 6; 12; 18; 24; 4-96-5

4.131 6; 12; 24; 4-96-5

4.132 Ext 4; Ext 7; 6; 17; 24; 4-96-5

9201 6; 17; 24

9202 6; 17

9203 6; 17

9204 6; 17; 24

9205 6; 17; 24; 4-96-5

9206 6; 17; 24; 4-96-5

9207 6; 24; 4-96-5

9208 6; 17; 24; 4-96-5

9209 6; 17; 24; 4-96-5

9210 6; 12, 17; 24; 4-96-5

9211 4-96-5

9300 6; 17; 24; 4-96-5

9301 6; 17; 24; 4-96-5

9302 6; 17; 24; 4-96-5

9303 6; 17; 24; 4-96-5

9304 6; 17; 24; 4-96-5

9305 6; 17; 24; 4-96-5

9306 6; 17; 24; 4-96-5

9307 6; 17; 24; 4-96-5

9308 6; 17; 24; 4-96-5

9309 6; 17; 24; 4-96-5

9310 6; 17; 24; 4-96-5

9311	6; 17; 24; 4-96-5
9312	17; 24; 4-96-5
9315	17; 24; 4-96-5
9322	17; 24; 4-96-5
9324	17; 24; 4-96-5
9325	17; 24; 4-96-5
9326	4-96-5
9327	4-96-5
9400	6; 17; 24
9401	6; 17; 24; 4-96-5
9402	6; 17; 24; 4-96-5
9403	6; 17; 24; 4-96-5
9404	6; 17; 24
9405	6; 17; 24; 4-96-5
9408	17; 24; 4-96-5
9409	17; 24; 4-96-5
9410	17
9411	20; 24
9412	4-96-5
9413	4-96-5
9416	4-96-5
9417	4-96-5
9421	4-96-5
9422	4-96-5
9423	4-96-5
9424	4-96-5
9425	4-96-5
9431	4-96-5

9432 4-96-5

9433 4-96-5

9434 4-96-5

9435 4-96-5

9440 4-96-5

9500 6; 17; 24; 4-96-5

9501 6; 17; 24; 4-96-5

9502 6; 17; 24; 4-96-5

9505 17; 24; 4-96-5

9506 17; 24; 4-96-5

9507 17; 24; 4-96-5

9508 17; 24; 4-96-5

9509 17; 24; 4-96-5

9510 17; 24; 4-96-5

9511 17; 24; 4-96-5

9520 4-96-5

9521 4-96-5

4.133-48 [Reserved]

4.149 4-94-2; 3-99-2

4.150 16; 4-94-2

9900 Ext 7; 19; 4-94-2

9901 [No Revision since 1945 Schedule]

9903 [No Revision since 1945 Schedule]

9904 [No Revision since 1945 Schedule]

9905 19; 4-94-2

9906 [No Revision since 1945 Schedule]

9907 [No Revision since 1945 Schedule]

9908 [No Revision since 1945 Schedule]

9909 19; 21

9910 [No Revision since 1945 Schedule]

9911 [No Revision since 1945 Schedule]

9912 4-94-2

9913 4-94-2

9914 4-94-2

9915 4-94-2

9916 4-94-2

APPENDIX B

38 CFR Part 4 -- Rating Schedule

Regulatory Amendment Explanations

4-90-1 Through 4-03-2

REGULATORY AMENDMENT

4-90-1

Regulation Affected: 38 CFR 4.16(a)

EFFECTIVE DATE OF REGULATION: September 4, 1990.

Date Secretary Approved Regulation: July 10, 1990

Federal Register Citation: 55 FR 31579-80

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 4.16. In a report entitled "Veterans Benefits: Improving the Integrity of VA's Unemployability Compensation Program", the GAO recommended that VA define marginal employment so that the criteria used in making determinations of marginal employment in claims for unemployability are consistent between rating boards. 38 CFR 4.16(a) has been amended to provide that marginal employment is not considered substantially gainful employment. Generally, marginal employment is deemed to exist when a veteran's earned annual income does not exceed the amount established by the Bureau of the Census as the poverty threshold for one person. This should not preclude a finding of marginal employment in some cases when earned annual income exceeds the poverty threshold. Consideration will be given in all claims to the nature of the employment and the reasons for termination.

REGULATORY AMENDMENT

4-90-2

Regulation Affected: 38 CFR 4.117

EFFECTIVE DATE OF REGULATION: October 26, 1990

Date Secretary Approved Regulation: October 2, 1990

Federal Register Citation: 55 FR 43123-5 (October 26, 1990)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Section 4.117. On March 29, 1990, the Centers for Disease Control released a study entitled "The Association of Selected Cancers with Service in the U.S. Military in Vietnam". That study found that Vietnam veterans have a roughly 50 percent increased risk of developing non-Hodgkin's lymphoma (NHL) after service in Vietnam. The Secretary has determined that there is a relationship between Vietnam service and the subsequent development of NHL. 38 CFR Part 3 has been amended to add section 3.313 to provide the criteria to be used in considering claims for service connection for NHL by Vietnam veterans.

38 CFR 4.117 has been amended to add a diagnostic code and evaluation criteria for NHL.

REGULATORY AMENDMENT

4-91-1

Regulation Affected: 38 CFR 4.73, 4.104 and 4.124a

EFFECTIVE DATE OF REGULATION: October 15, 1991

Date Secretary Approved Regulation: September 16, 1991

Federal Register Citation: 56 FR 51651-3 (October 15, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Under 38 CFR 1.17(c), when VA determines that a significant statistical association exists between exposure to a herbicide containing dioxin and any disease, 38 CFR 3.311a shall be amended to provide guidelines for the establishment of service connection for the disease. These determinations are to be made after receiving the advice of the Veterans Advisory Committee on Environmental Hazards (VACEH) based on its evaluation of scientific or medical studies.

In a public meeting on May 16-17, 1990, the VACEH met in Washington, DC. At that meeting, the VACEH considered more than 80 scientific and medical documents relating to the connection, if any, between exposure to a herbicide containing dioxin and the subsequent development of soft-tissue sarcoma (STS). The VACEH found that the relative weights of valid positive and valid negative studies permitted the conclusion that it is at least as likely as not that there is a significant statistical association between exposure to a herbicide containing dioxin and STS. The Secretary has accepted that recommendation.

There is disagreement even among pathologists as to what tumors the term "soft-tissue sarcoma" encompasses. With the assistance of VHA and the VACEH, we compiled a list of those tumors which we consider to be soft-tissue sarcomas and included it in the regulation. For compensation purposes, such tumors must be malignant and arise from tissue of mesenchymal origin, including muscle, fat, blood or lymph vessels, or connective tissue (but not cartilage or bone). Tumors of infancy or childhood, and those having a strong, known causal association with a specific etiology have been excluded because it is unlikely that there is a reasonable probability of a significant statistical association between such tumors and exposure to a herbicide containing dioxin.

STS is currently rated by analogy because there are no specific diagnostic codes in the rating schedule. 38 CFR Part 4 has been amended to add specific diagnostic codes for STS as well as evaluation criteria. In addition, diagnostic code 5327 has been amended to exclude STS and to revise the point at which evaluations are based on residual disability from 1 year to 6 months following cessation of treatment. The revision has been made because medical advances have reduced the recovery time needed following surgery, chemotherapy, etc.

Section 4.73. Diagnostic code 5327 has been revised to exclude STS, and new diagnostic code 5329 has been added.

Section 4.104. New diagnostic code 7123 has been added.

Section 4.124a. New diagnostic code 8540 has been added.

REGULATORY AMENDMENT

4-91-2

Regulation Affected: 38 CFR 4.17

EFFECTIVE DATE OF REGULATION: December 16, 1991

Date Secretary Approved Regulation: October 10, 1991

Federal Register Citation: 56 FR 57985 (November 15, 1991)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Section 8002 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, amended 38 U.S.C. 1502(a) to eliminate the presumption of total disability at age 65 for pension purposes.

Section 4.17. 38 CFR 4.17 has been amended to delete the presumption of permanent and total disability at age 65. 38 CFR 4.17 has also been amended to require for all veterans, regardless of age, a single disability rated as 60 percent or a combined evaluation of 70 percent, with one disability ratable at 40 percent or higher (see § 4.16(a)). Claims of any veterans who fail to meet the required percentages but are otherwise entitled and unemployable will continue to be referred to the Adjudication Officer under § 3.321(b)(2).

REGULATORY AMENDMENT

4-92-1

Regulations Affected: 38 CFR 4.88a, diagnostic codes 6351, 6352, and 6353

EFFECTIVE DATE OF REGULATION: March 24, 1992

Date Secretary Approved Regulation: February 7, 1992

Federal Register Citation: 57 FR 10134-6 (March 24, 1992)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why these changes are being made. This comment is not regulatory.

Three diagnostic codes were previously used for rating HIV-related illnesses: diagnostic code 6351, Acquired immunodeficiency syndrome (AIDS); diagnostic code 6352, AIDS related complex (ARC); and diagnostic code 6353, HIV antibody positive. Diagnostic codes 6351 and 6352 were rated by reference to the underlying disease, and diagnostic code 6353 was assigned a 0 percent evaluation. The need for more specific rating criteria became clear when the multitude and complexity of symptoms associated with HIV infection were considered. Constitutional and neurological diseases can be rated under a variety of diagnostic codes, and since many analogies are possible, inconsistent evaluations often resulted. Opportunistic infections may resolve with minimal chronic impairment of the affected body system, but the average person's employment potential is markedly compromised. Although the HIV infection may not have progressed to the stage of AIDS or ARC, an individual may nevertheless be symptomatic and partially disabled.

Diagnostic codes 6352 and 6353 have been removed, and HIV-related illnesses are now rated under a single diagnostic code, 6351. This code contains evaluation criteria at the levels of 0, 10, 30, 60, and 100 percent which allow for rating by staging or symptomatology, whichever permits a higher evaluation. Separate evaluations under other diagnostic codes for manifestations of the disease are also permitted if a higher overall evaluation would thereby result.

Section 4.88a. Diagnostic codes 6351 (Acquired Immunodeficiency Syndrome), 6352 (Aids Related Complex), and 6353 (HIV Antibody positive) have been replaced by a single diagnostic code 6351 for HIV-related illnesses with evaluation criteria at the 0, 10, 30, 60, and 100 percentage levels.

REGULATORY AMENDMENT

4-93-1

Regulation affected: 38 CFR 4.31

EFFECTIVE DATE OF REGULATION: October 6, 1993

Date Secretary Approved Regulation: August 26, 1993

Federal Register Citation: 58 FR 52017-18 (October 6, 1993)

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

A majority of the disabilities addressed in the VA's Schedule for Rating Disabilities (38 CFR part 4) do not specify criteria for a zero percent level. Once it has been determined that a disability is service-connected, it has been VA's consistent practice to assign a zero percent evaluation whenever the condition does not meet the stated minimum requirements for compensable evaluation. In recent decisions, however, the U.S. Court of Veterans Appeals (COVA) pointed out that unless an individual diagnostic code requires residual disability for a compensable evaluation, a zero percent evaluation is not authorized under §§ 3.357(a) and 4.31. See Rabideu v. Derwinski, U.S. Vet. App. No. 90-1296 and Conley v. Derwinski, U.S. Vet. App. No. 91-527. From the Court's analysis it is apparent that VA regulations are seen as being inconsistent with VA's longstanding practice of assigning a zero percent evaluation for any disability which does not meet the minimum requirements for a compensable evaluation.

We have amended § 4.31 to eliminate this perceived discrepancy between VA practice and regulations. We have changed the heading of § 4.31 from "A no-percent rating" to "Zero percent evaluations" to more accurately represent the issue addressed in the regulation.

We have deleted § 3.357(a) because it is a duplicate of § 4.31 and because the issue is more appropriately addressed in the rating schedule.

Section 4.31: Section 4.31 has been revised to provide that, in every instance where the schedule does not provide a zero percent evaluation for a diagnostic code, a zero percent evaluation shall be assigned when the requirements for a compensable evaluation are not met.

REGULATORY AMENDMENT

4-94-1

Regulation affected: 38 CFR 4.115, 4.115a.

EFFECTIVE DATE OF REGULATION: February 17, 1994

Date Secretary Approved Regulation: March 5, 1993

Federal Register Citation: 59 FR 2523-2529, January 19, 1994

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

In December 1988, the General Accounting Office (GAO) recommended that VA prepare a plan for a comprehensive review of the rating schedule and, based on the results, revise the medical criteria accordingly. Based in part on this recommendation, the Compensation and Pension Service initiated a systematic review of the Schedule for Rating Disabilities (38 CFR Part 4) in order to remove outdated medical terminology and ambiguous rating criteria and to introduce recent medical advances.

We have made a number of editorial changes, primarily of syntax and punctuation, throughout these section, intended to clarify the rating criteria and represent no substantive amendment. We have deleted generic terms such as "severe", "moderate", and "mild" from various evaluation criteria and replaced them, whereever possible, with more objective, unambiguous descriptions of the levels of disability. We have also changed a number of terms to reflect current medical terminology and to clarify various anatomical aspects or treatment procedures.

We added two sentences to § 4.115 to clarify that hypertension or heart disease will be separately rated if absence of a kidney is the sole renal disability and that hypertension or heart disease will be separately rated if renal disease has progressed to the point where regular dialysis is required. This makes regulatory the long-established policy which is included in the Department of Veterans Benefits Manual of Adjudication Procedures, M21-1.

We have redesignated § 4.115a as § 4.115b and replaced the existing § 4.115a with an explanation of the three new dysfuntion formulas which follow.

In order to allow a broader range of possible evaluations for many disabilities and a more accurate level of compensation for each, we have provided three general dysfunction formulas for disabilities of the genitourinary system. Diagnostic codes throughout the section refer to these criteria for evaluation of the predominant dysfunction. The evaluations prescribed for each catagory of dysfunction are generally consistent with percentages and criteria currently specified under the following diagnostic codes: 7502, nephritis, corresponding to renal dysfunction; 7512, cystitis with criteria relating to frequency of urination, corresponding to voiding dysfunction; 7518, stricture of urethra with criteria relating to dialtion treatments, corresponding to urinary tract infection, and also relating to obstructed voiding as a catagory of voiding dysfunction; and, 7519, fistula of urethra with criteria relating to frequency of drainage, corresponding to continual urinary leakage as a catagory of voiding dysfunction.

Under renal dysfunction and diagnostic code 7530, chronic renal disease requiring regular hemodialysis, the word dialysis has been used instead of hemodialysis in order to include consideration of continuous ambulatory peritoneal dialysis, as well as hemodialysis, in the assignment of a total evaluation. Specific measurements of creatinine and blood urea nitrogen (BUN) are provided for the 100 and 80 percent evaluations under renal dysfunction. The term "nonprotein nitrogen" shown under diagnostic code 7502, chronic nephritis, is obsolete and has been removed as a measure of kidney dysfunction. We have

described hypertension requirements in terms of diagnostic code 7101, essential hypertension, under the 60, 30 and 0 percent levels of evaluation for renal dysfunction in order to promote a clear understanding of the rule and for internal consistency within the rating schedule.

We have deleted the one year period of convalescence under diagnostic code 7528, malignancies of the genitourinary system in favor of an indefinite period of convalescence with mandatory examination at the end of six months; any reduction in evaluation based on the findings of the examination will be implimented in accordance with § 3.105(e). This will provide the claimant contemporaneous notification and base any reduction on current medical findings rather than a regulatory assumption that there has been an improvement.

Similarly, we have deleted the two year convalescence period under diagnostic code 7531, kidney transplant. Kidney transplants have become far more common since 1975, when a total evaluation for two years was first specified in the rating schedule, and improved surgical techniques and experience with immuno-suppressive management make it possible to assess residual impairment one year after surgery instead of two. As with malignancies, there will be an indefinite period of convalescence with a mandatory VA examination, in this case one year after hospital discharge following surgery, and any reduction will be based on the findings of this examination, subject to the provisions of 38 CFR 3.105(e). We have retained the 30 percent minimum evaluation. Subsequent to convalescence, the residuals are to be evaluated as renal dysfunction, in order to provide consistent evaluations and objective criteria.

We have eliminated four of the diagnostic categories. Pyelitis, diagnostic code 7503, is not currently used in medical practice and is generally understood to be included under pyelonephritis, which remains as diagnostic code 7504. Intersitial cystitis, diagnostic code 7513 is included under chronic cystitis, diagnostic code 7512, since these are essentially the same disability. Chronic cystitis is amended to include cystitis of all etiologies, infectious and non-infectious. Tuberculosis of the bladder, diagnostic code 7514, is a very uncommon disease and it does not warrant a separate code in this section of the schedule. Ratings for nonpulmonary tuberculosis are prescribed by §§ 4.88b and 4.89. Resection or removal of the prostate gland is included under diagnostic code 7527, prostate gland injuries. Residuals of total prostatectomy are to be evaluated according to the severity of the individual disability instead of assigning a minimum evaluation of 20 percent. A separate diagnostic code is therefore redundant.

Eleven new codes have been added to this section of the rating schedule. Renal tubular dysfunctions, diagnostic code 7532, is given a minimum 20 percent evaluation if symptomatic, with instructions to otherwise rate as renal dysfunction. The following nine conditions are to be rated as renal dysfunction: Cystic disease of the kidneys, code 7533; atherosclerotic renal disease, 7534; toxic neuropathy, 7535; glomerulonephritis, 7536; interstitial nephritis, 7537; papillary necrosis, 7538; renal amyloid disease, 7539; disseminated intravascular coagulation with renal cortical necrosis, 7540; and renal involvement in diabetes mellitus, sickle cell anemia, systemic lupus erythematosus, vasculitis, or other systemic disease processes, 7541. These additional codes have been added in order to reduce reliance on the uncertain practice of rating many kidney disorders by analogy. We have added diagnostic code 7542, neurogenic bladder, with instructions to rate the condition under the criteria for voiding dysfunction. This is a common condition in cases of severe spinal cord injury.

Diagnostic code 7500, removal of one kidney, is changed to instruct the rater to evaluate the condition as renal dysfunction if there is nephritis, infection or pathology of the other kidney. This represents consideration of entire renal dysfunction and is the most consistent means of rating kidney disorders.

Diagnostic code 7508, nephrolithiasis, has been changed to provide a 30 percent evaluation for recurrent stone formation if drug or diet therapy or invasive or non-invasive procedures, more than two times per year are required. If stone formation is not recurrent to this extent, the condition will be evaluated according to the criteria for hydronephrosis, diagnostic code 7509. Ureterolithiasis, code 7510,

and stricture of the ureter, code 7511, have been given the same criteria for evaluation. This provides objective criteria and consistency within this section of the schedule.

We have changed the criteria for the "severe" level of hydronephrosis, diagnostic code 7509, to to instruct the rater to use objective evaluation criteria under the general formula for renal dysfunction.

The percentage evaluation for loss of one testicle under diagnostic code 7524 has been reduced from 10 percent to zero percent and the term "other than undecended or congenitally undeveloped" has been deleted from the new zero percent level. No significant employment handicap is anticipated from loss of a single testical, any retrogressive changes in secondary sex characteristics even following removal of both testes after sexual maturity would occur slowly, if at all, and a solitary testis is adequate to sustain normal endocrine function without hormone replacement.

The title of epididymo-orchitis, tuberculous, active or inactive, diagnostic code 7525, has been changed to epididymo-orchitis, chronic only, with instructions to rate as urinary tract infection. The instructions to rate tubercular infections under §§ 4.88b or 4.89 has been retained. These new instructions allow for evaluation of any type of epididymal infection under this code.

The instructions for evaluation of prostate gland injuries, infections, hypertrophy, or postoperative residuals, diagnostic code 7527, have been changed to evaluate the conditions as voiding dysfunction or urinary tract infection, consistent with other codes in this section and to provide the widest, most objective range of criteria.

The title of diagnostic code 7528, new growths, malignant, any specified part of genitourinary system, has been changed to malignant neoplasms of the genitourinary system because the term neoplasm better connotes the pathological abnormality. Following convalescence, as explained above, the condition will be evaluated as voiding dysfunction or renal dysfunction, whichever is predominant, in order to provide consistent evaluations and objective criteria.

Section 4.115: Revised to clarify that hypertension or heart disease will be separately rated if absence of a kidney is the sole renal disability, if it has progressed to the point where regular dialysis is required.

Section 4.115a: Redesignated as section 4.115b, and replaced with the explanation of the three new dysfunction formulas for evaluating a number of genitourinary disabilities.

Section 4.115b: Added as the heading for the section containing the rating codes and diagnoses for genitourinary disabilities.

Diagnostic codes Revised	Diagnostic codes Added	Diagnostic codes Removed
7500	7532	7503
7502	7533	7513
7508	7534	7514
7509	7535	7526
7510	7536	
7511	7537	
7524	7538	
7525	7539	
7527	7540	
7528	7541	
7530	7542	
7531		

REGULATORY AMENDMENT

4-94-2

Regulation affected: 38 CFR 4.150.

EFFECTIVE DATE OF REGULATION: February 17, 1994

Date Secretary Approved Regulation: August 19, 1993

Federal Register Citation: 59 FR 2529-2530, January 18, 1994

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

In December 1988, the General Accounting Office (GAO) recommended that VA prepare a plan for a comprehensive review of the rating schedule and, based on the results, revise the medical criteria accordingly. Based in part on this recommendation, the Compensation and Pension Service initiated a systematic review of the Schedule for Rating Disabilities (38 CFR Part 4) in order to remove outdated medical terminology and ambiguous rating criteria and to introduce recent medical advances.

The schedule of ratings for Dental and Oral Conditions lists five disabilities without diagnostic codes: Carious teeth, treatable; missing teeth, replaceable; dento-alveolar abscess; pyorrhea alveolaris; and Vincent's stomatitis. These conditions are not considered disabling and the issue of service-connection is addressed by raters only for the purpose of determining entitlement to out patient dental treatment under the provisions of 38 CFR 3.382 and 17.123. We have deleted them from § 4.150 and added a new section designated as § 4.149 which states, in more contemporary terms, that these conditions are not compensable conditions, but that they may be considered service-connected solely for the purpose of establishing entitlement to dental examination or outpatient dental treatment.

We have included osteoradionecrosis under diagnostic code 9900, osteomyelitis of the maxilla or mandible, because this condition occurs often enough in the veteran population to warrant inclusion and because its disabling effects are similar to osteomyelitis.

We have denoted categories of both inter-incisal and lateral excursion of the temporomandibular joint, diagnostic code 9905 because this diagnostic code does not specify this type of limitation. We have provided evaluation levels of 10, 20, 30, and 40 percent for precise ranges of inter-incisal motion limitation and a 10 percent evaluation for limited lateral excursion from 0 to 4 millimeters. We have provided a NOTE following the code specifying that ratings for limited inter-incisal movement will not be combined with ratings for limited lateral excursion under this code in accordance with the prohibition against pyramiding (38 CFR 4.14).

We have deleted diagnostic code 9510, maxilla, loss of whole or part of substance of, nonunion of , or malunion of because disabilities of the maxilla are not comparable to those of the mandible, as the instructions to rate the disability imply. We have added three new codes, 9914, 9915 and 9916, each with its own percentage ranges and evaluation criteria in order to provide complete and equitable evaluations for these disabilities.

We have revised the note following diagnostic code 9913, teeth, loss of, due to loss of substance of maxilla or mandible to use the less ambiguous term "periodontal disease" instead of "natural resorption" and to explain why loss of the alveolar process without loss of bone is not compensable.

We have revised the evaluation criteria of diagnostic code 9913 because the current descriptions are confusing and unclear. No substantive change is intended by this revision.

We have substituted the word "prosthesis" for the term "prosthetic appliance under codes 9911 and 9912 for the sake of consistency, since "prosthesis" is used under code 9913 and other diagnostic codes throughout the schedule.

Section 4.149: This section is added to include the non-disabling conditions which are listed for the purpose of determining entitlement to dental examination and dental outpatient treatment and to instruct the rater that these are not compensable conditions.

Section 4.150: This section is amended to:

1) Include osteoradionecrosis under diagnostic code 9900, osteomyelitis of the maxilla or mandible,
2) Provide specific criteria for limitations of ranges of motion of the jaw, diagnostic code 9905, and to add a NOTE cautioning against pyramiding,
3) Add three diagnostic codes: 9914, maxilla, loss of more than half, 9915, maxilla, loss of half or less, and 9916, maxilla, malunion or nonunion, with percentage evaluations for each at levels appropriate to the levels of disability,
4) Amend the note following diagnostic code 9913, tooth loss due to damage of the mandible or maxilla, for clarity and to explain why loss of the alveolar process without bone loss is not compensable,
5) Clarify the descriptions of combinations of loss of teeth in diagnostic code 9913,
6) Substitute the word "prosthesis" for the term "prosthetic appliance" under diagnostic code 9912.

Diagnostic codes Revised	Diagnostic codes Added	Diagnostic codes Removed
9900	9914	NONE
9905	9915	
9912	9916	
9913		

REGULATORY AMENDMENT

4-94-3

Regulation Affected: 38 CFR 4.115b

EFFECTIVE DATE OF REGULATION: September 8, 1994

Date Secretary Approved Regulation: July 28, 1994

Federal Register Citation: 59 FR 46338-9 (September 8, 1994)

The purpose of the following comments on the changes included in these amendments of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

The final revision of the section of the Schedule for Rating Disabilities of the Genitourinary System was published in the Federal Register on January 18, 1994. Taking into account a comment we received after publication of the proposed revision of the genitourinary section of the rating schedule that we should add a n note under DC 7522 (Penis deformity, with loss of erectile power) indicating entitlement to SMC, we have reconsidered the issue of providing guidance to rating specialists in the rating schedule on the issue of special monthly compensation (SMC). We concluded that the combination of the two provisions added by this amendment is the best means of assuring that potential entitlement to SMC is considered.

The amendment adds a note at the beginning of 38 CFR 4.115b requiring rating specialists to refer to 38 CFR 3.350 any time they evaluate a claim involving loss or loss of use of a creative organ, and also adds a footnote at diagnostic codes 7522, 7523, and 7524 directing the rater to review for entitlement to special monthly compensation under § 3.350.

REGULATORY AMENDMENT

4-94-4

Regulation affected: 38 CFR 4.88a and 4.88b.

EFFECTIVE DATE OF REGULATION: November 29, 1994

Date Secretary Approved Regulation: August 1, 1994

Federal Register Citation: 59 FR 60901-2, November 29, 1994

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

We have amended 38 CFR 4.88a and 4.88b and added 4.88c by means of an interim rule with request for comments in order to add a diagnostic code and evaluation criteria for chronic fatigue syndrome to the portion of the rating schedule on systemic diseases. We have provided evaluation levels of 10, 20, 40, 60, and 100 percent. Chronic fatigue syndrome is of unknown etiology and is characterized by non-specific symptoms. Because it has been ill-defined and sometimes confused with other conditions, we have also added a section that provides diagnostic criteria for the syndrome.

We have made this an interim rule with request for comments so that it can be effective immediately, but comments will be received for 60 days, and the rule may be amended based on the comments.

Sections 4.88a and 4.88b are redesignated 4.88b and 4.88c respectively.

Section 4.88a is added to provide diagnostic criteria for chronic fatigue syndrome.

Section 4.88b. New diagnostic code 6354 has been added.

REGULATORY AMENDMENT

4-95-1

Regulation affected: 38 CFR 4.116 and 4.116a

EFFECTIVE DATE OF REGULATION: May 22, 1995.

Date Secretary approved regulation: December 22, 1994.

Federal Register Citation: 60 FR 19851-6, April 21, 1995

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended sections 4.116 and 4.116a of 38 CFR, Part 4, the sections of the rating schedule that deal with gynecological conditions and disorders of the breast. The intended effect of this action is to update the gynecological and breast disorders section of the rating schedule to ensure that it uses current medical terminology, unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

We changed the title of this part of the rating schedule from "gynecological conditions" to "gynecological conditions and disorders of the breast" to reflect more accurately the content. We made language changes consistent with current medical usage, such as changing "mammary glands" to "breasts," "new growths" to "neoplasms," and "extirpation," "resection," and "excision" to "removal."

We deleted the introductory section, 4.116, removing some material and putting the material that remained in the form of a note. We removed from the material the statement that excision of uterus, ovaries, etc., prior to the natural menopause is considered disabling because the implied distinction of the effects of the surgery itself before and after the menopause is not warranted.

We also removed from the material in § 4.116 the statement that surgical complications of pregnancy will not be held the result of service except when additional disability resulted from treatment, or they are otherwise attributable to unusual circumstances of service. These remarks were unclear, seemingly restricting service connection in most cases, and such chronic disabilities, if incurred during service, would be subject to service connection, as with other chronic disabilities. For further clarification, we added the statement that chronic residuals of medical or surgical complications of pregnancy may be disabilities for rating purposes.

We added footnotes at diagnostic codes (DC's) 7617 through 7620 and a note at the beginning of § 4.116 to alert the rater to consider special monthly compensation (SMC) because we believe that the combination of the footnotes and note is the best method of assuring that potential entitlement to SMC is considered.

We removed the criteria of "mild," "moderate," and "severe" that had been used to evaluate disease or injury of vulva, vagina, or cervix, and for disease, injury, or adhesions of uterus, Fallopian tube (including PID), or ovary (DC's 7610 through 7615). In their place, we provided a general rating formula using objective evaluation criteria based on the need for continuous treatment and whether symptoms are controlled by treatment. These changes will assure that comparable medical conditions are assigned comparable evaluations. We also revised the titles of DC's 7610 through 7615 to clarify the proper classification of gynecological conditions.

We changed the convalescent period following the removal of uterus and ovaries, or ovaries alone (DC's 7617 and 7619) from 6 months to 3 months, in accord with current medical practice, and taking into account improved surgical techniques, postoperative care, and the practice of early ambulation. We also changed the title of DC 7619 from "ovaries, removal of both" to "ovary, removal of" so that a three-month period of convalescence will apply to the removal of one or both ovaries. The evaluation for removal of one ovary with or without partial removal of the other (DC 7619) has been changed from 10 percent to 0 percent because the loss of one ovary does not compromise endocrine or reproductive function to such an extent that an impairment of earning capacity ordinarily results.

We provided specific criteria for rectovaginal fistula and urethrovaginal fistula (DC's 7624 and 7625, respectively) rather than referring the rater to diagnostic codes in other systems for evaluation criteria. We also removed subjective terminology such as "extensive leakage" and "fairly frequent" from the criteria for rectovaginal fistula (which we had proposed to be the same as the criteria for rectum and anus, impairment of sphincter control, DC 7332), replacing that language with more precise criteria, although with the same basis of evaluation.

We added definitions of the various types of breast surgery for clarity and also provided a compensable evaluation (30%) for less than a total mastectomy when there is significant alteration of size or form (DC 7626). This is a type of breast surgery that may be done for neoplasms and other conditions that is more conservative than a total mastectomy, but which may still be disabling.

We added a new diagnostic code and evaluation criteria for two common conditions that previously required rating by analogy: endometriosis (DC 7628) and benign neoplasms of the gynecological system or breast (DC 7629). In order to assure more consistent evaluations of endometriosis than rating by analogy, we provided evaluation criteria based on the presence of pelvic pain or heavy or irregular bleeding and whether they are controlled by treatment, and on whether there is symptomatic involvement of bladder or bowel. Benign neoplasms are to be evaluated on the basis of impairment of function

We made a minor revision in the language of the evaluation criteria for prolapse of uterus (DC 7621) to be more precise, changing "complete, through vulva" to "complete, through vagina and introitus."

We made changes in the convalescent period following treatment for malignant neoplasm (DC 7627) similar to changes we have made in other body systems, i.e., requiring a mandatory VA examination 6 months following completion of treatment and implementation of § 3.105(e) before any reduction can be made.

Section 4.116 is removed.
Section 4.116a is redesignated as § 4.116.

Diagnostic codes revised		Diagnostic codes added	Diagnostic codes removed
7610	7621	7628	NONE
7611	7622	7629	
7612	7623		
7613	7624		
7614	7625		
7615	7626		
7617	7627		
7618			
7619			
7620			

REGULATORY AMENDMENT

4-95-2

Regulation affected: 38 CFR 4.117

EFFECTIVE DATE OF REGULATION: October 23, 1995.

Date Secretary approved regulation: June 13, 1995.

Federal Register Citation: 60 FR 49225-28, September 22, 1995.

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended section 4.117 of 38 CFR, Part 4, the section of the rating schedule that deal with the hemic and lymphatic systems. The intended effect of this action is to update this section of the rating schedule to ensure that it uses current medical terminology, unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

We changed the title of DC 7700 from "pernicious anemia" to "hypochromic-microcytic and megaloblastic anemia" because we have expanded this code to include additional anemias that will be evaluated under the same criteria. The schedule formerly had evaluation levels for 30, 60, 70, and 100 percent. We changed the levels to 0, 10, 30, 70, and 100 percent since the difference between the 60 and 70 percent levels would be so slight as to be meaningless for rating purposes. We added a zero percent level to make it clear that those who are asymptomatic despite a hemoglobin level of 10gm/100ml or less warrant only a zero percent evaluation, and we added a ten percent level for those who are anemic and have mild symptoms such as weakness, easy fatigability, or headaches. We changed the criteria for these anemias to make them more objective, basing them on a certain range of hemoglobin levels plus specific signs and symptoms. Finally, we added a note directing that complications of pernicious anemia be rated separately because such complications occur often enough to warrant instructions in order to ensure consistent ratings.

We deleted DC 7701, secondary anemia, because this represents a symptom of another more specific disease and does not warrant its own diagnostic code.

For acute agranulocytosis, DC 7702, we changed the evaluation levels from 30, 60, 70, and 100 percent to 10, 30, 60, and 100 percent. We removed the 70 percent level because, as stated under DC 7700, the difference between the 60 and 70 percent levels would be so slight as to be meaningless for rating purposes. We added a 10 percent level when the condition requires continuous medication for control. Previously, acute agranulocytosis was rated under the criteria for acute pernicious anemia. However, the course and treatment of agranulocytosis are usually substantially different from those of pernicious anemia, and we have therefore provided new criteria based on the need for a bone marrow transplant or transfusions, the presence of recurrent infections, or the need for continuous medication for control, since these are more appropriate means of evaluating this condition than the criteria we have used for DC 7700. We added a note stating that a 100 percent evaluation will be assigned from the date of hospital admission for a bone marrow transplant, with a mandatory VA examination to be done six months later, and any change in evaluation to be subject to the provisions of § 3.105(e). This will ensure that no evaluation after bone marrow transplant is reduced without current medical evidence, offers veterans prior notice of any proposed action, and provides an opportunity for the veteran to present evidence showing that the action should not be taken.

Under DC 7703, leukemia, we edited the language regarding requirements for a 100 percent evaluation and changed the direction for rating otherwise, directing that it be under either DC 7700 or 7716 (a new code for aplastic anemia), depending on which results in a higher evaluation. This provides a broader range of evaluations, consistent with what may be seen in this condition. For consistency with the method of evaluating malignancies of other body systems, we added a note directing that the total evaluation be continued, with a mandatory VA examination six months following completion of therapy, and any change in evaluation be subject to the provisions of § 3.105(e).

We changed the title of DC 7704, primary polycythemia, to the more current name for this condition, polycythemia vera. This condition was formerly rated as pernicious anemia, but we have provided criteria more specific to this condition, with evaluation levels of 10, 40, and 100 percent, based on the need for phlebotomy or myelosuppressant therapy, and on whether it is stable. We added a note directing that complications be rated separately because they occur often enough that this instruction is needed to assure that veterans are rated consistently.

We changed the title of DC 7705 from purpura hemorrhagica to the more modern term, thrombocytopenia, primary, idiopathic or immune. We made the criteria more objective, basing them primarily on the blood platelet count, requirement for treatment, and whether there is bleeding. As with several other conditions in this section, we changed the evaluation levels from 30, 60, 70, and 100 percent to 0, 30, 70, and 100 percent because the 60 percent level is clinically indistinguishable from the 70 percent level for rating purposes, and we added a zero percent level to indicate that when the platelet count is stable and above 100,000, and there is no bleeding, the condition does not warrant more than a zero percent evaluation.

We changed the evaluation level for splenectomy, DC 7706, from 30 percent to 20 percent because, although antibiotics now available can diminish the consequences of splenectomy (such as increased susceptibility to infection), the spleen also has other functions, and splenectomy is therefore still considered moderately disabling. We added a note under DC 7706 to clarify that complications of splenectomy are to be separately evaluated.

Under DC 7707, spleen, injury of, healed, we changed the direction from "rate as peritoneal adhesions" to "rate for any residuals" to take into account the fact that residuals other than peritoneal adhesions may occur.

We changed the title of DC 7709 from lymphogranulomatosis (Hodgkin's disease) to Hodgkin's disease because this is the modern name for the condition. Rather than continuing evaluation levels of 30, 60, and 100 percent based on specific signs and symptoms, we based the 100 percent evaluation level on the presence of active disease or during a treatment phase and added a note directing the same procedure as for leukemia and other malignancies -- a mandatory VA examination six months following the cessation of treatment, and any change in evaluation to be subject to the provisions of § 3.105(e). In addition to the benefits mentioned above (under the discussion of DC 7702) regarding the use of § 3.105(e), this change will allow the assignment of any level of evaluation based on the findings at examination.

We changed the title of DC 7710 from adenitis, cervical, tuberculous, active or inactive, to adenitis, tuberculous, active or inactive. This consolidates three types of tuberculous adenitis that are now relatively uncommon: cervical, axillary (formerly DC 7711), and inguinal (formerly DC 7712), into a single code. We have deleted DC's 7711 and 7712. We also removed the direction to rate active disease at 100 percent and inactive as §§ 4.88b and 4.89 in favor of a direction to rate as §§ 4.88c or 4.89, which are the sections that direct how to evaluate nonpulmonary tuberculosis.

We have deleted DC 7713, adenitis, secondary, because it is commonly accepted as a symptom of a specific disease and would be included in the evaluation for that disease.

Under DC 7714, sickle cell anemia, we revised the language of the criteria for the sake of more objectivity by removing the subjective terms "mild," "moderately severe," "severe," and "pronounced"; and we made other editorial, non-substantive changes in the criteria and the note under the code.

There was an instruction under non-Hodgkin's lymphoma, DC 7715, to rate as Hodgkin's disease (DC 7709). For the sake of convenience of those using the schedule, we repeated the criteria used to evaluate Hodgkin's disease under DC 7715.

We added a new condition, aplastic anemia, DC 7716, with the same criteria and evaluation levels we have provided for acute agranulocytosis, DC 7702, because the treatment of these conditions is similar.

Diagnostic codes revised	Diagnostic codes added	Diagnostic codes removed
7700	7716	7701
7702		7711
7703		7712
7704		7713
7705		
7706		
7707		
7709		
7710		
7714		
7715		

REGULATORY AMENDMENT

4-96-1

Regulation affected: 38 CFR 4.71a.

EFFECTIVE DATE OF REGULATION: May 7, 1996

Date Secretary Approved Regulation: December 7, 1995

Federal Register Citation: 61FR 20438-9

The purpose of the following comment on the change included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

We have amended 38 CFR 4.71a by means of an interim rule with request for comments in order to add a diagnostic code and evaluation criteria for fibromyalgia to the portion of the rating schedule on musculoskeletal diseases. We have provided evaluation levels of 10, 20, and 40 percent. Fibromyalgia is a syndrome of unknown etiology that is characterized by chronic, widespread musculoskeletal pain associated with multiple tender or "trigger" points, and often with multiple somatic complaints, such as sleep disorders, anxiety, fatigue, headache, and irritable bowel symptoms. Other possible associated complaints include neurologic symptoms such as numbness and weakness without objective neurologic findings, depression, Raynaud's-like syndrome, and weakness.

Classification criteria for fibromyalgia for research and epidemiological purposes were established by the American College of Rheumatology in 1990. The first requirement is a history of widespread pain, which means pain in both the left and right sides of the body, pain both above and below the waist, and pain in both the axial (cervical spine, anterior chest, thoracic spine, or low back) and peripheral (extremity) skeleton. The second requirement is the presence of pain on digital palpation at a minimum of 11 of the following 18 tender point sites: occiput, low cervical, trapezius, supraspinatus, second rib, lateral epicondyle, gluteal, greater trochanter, knee (there is a left site and a right site at each location). In clinical practice, the diagnosis is often made on less stringent criteria, with fewer tender points required.

We are providing three levels of evaluation: 10, 20, and 40 percent, consistent, in our judgment, with the clinical range of impairment of this condition. While patients may have numerous symptoms that may be chronic, it is a benign disease that does not result in loss of musculoskeletal function. For the 40 percent level, the requirements are that the widespread pain and multiple tender points, with or without certain associated complaints, be constant, or nearly so, and refractory to therapy. For the 20 percent level, the requirements are that the pain and tender points, etc., be episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but present more than one-third of the time. For the 10 percent level, the requirement is that the pain and tender points, etc., require continuous medication for control.

We have made this an interim rule with request for comments so that it can be effective immediately, but comments will be received for 60 days, and the rule may be amended based on the comments.

Section 4.71a. New diagnostic code 5025 has been added.

REGULATORY AMENDMENT

4-96-2

Regulation affected: 38 CFR 4.119.

EFFECTIVE DATE OF REGULATION: June 6, 1996.

Date Secretary approved regulation: December 5, 1995.

Federal Register Citation: 61 FR 20440-47

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended section 4.119 of 38 CFR, Part 4, the section of the rating schedule that deals with endocrine system disabilities.

We changed the evaluation criteria for hyperthyroidism (DC 7900) to make them more objective, for example, by removing subjective terms such as "pronounced," "severe," "moderately severe," "marked," and "moderate," because they serve no objective function, and by defining tachycardia as more than 100 beats per minute. The former schedule required "severe" tachycardia at the 100-percent level, but since the medical literature does not define severe tachycardia, we have removed "severe." We added eye involvement to the criteria for a 100-percent evaluation because long-standing hyperthyroidism can lead to significant impairment affecting the eyes. We deleted references to surgery because they are of no value in explaining the qualifying symptoms. We specified that the "nervous symptoms" formerly included in the 100-percent criteria are "sympathetic nervous system" symptoms since this is the part of the nervous system affected. We edited the notes under DC7900 for clarity.

We removed the zero-percent levels for DC's 7900 and 7903, which required that the condition be "in remission" because they merely restate the general rule found in §4.32. We deleted the criteria that referred to hormone levels for DC's 7900, 7903, and 7904 because although many endocrine conditions require laboratory confirmation of hormone levels for diagnosis, the hormone levels may not correlate with the severity of the clinical findings, and laboratory findings are therefore more useful for diagnosis than for evaluation.

Rather than directing in a note the assignment of a 10-percent evaluation for hyperthyroidism, hypothyroidism (DC 7903), and hypoparathyroidism (DC 7905) when continuous medication is required for control, we have added "continuous medication required for control" to the evaluation criteria themselves at the 10-percent level. For the sake of consistency, we have made "continuous medication required for control" a criterion for a 10-percent evaluation for hyperparathyroidism (DC 7904) as well.

For the convenience of rating specialists, we repeated the criteria for DC 7900 (hyperthyroidism) under DC 7901 (thyroid gland, toxic adenoma of) rather than directing to rate as DC 7900.

We removed "with pressure symptoms" from the criteria (because they are rarely encountered) in favor of a note directing that if there are symptoms due to pressure on adjacent organs, evaluation is to be made under the diagnostic code for disability of the affected organ, if doing so would result in a higher evaluation. We also removed "marked" as a modifier of disfigurement for a 20-percent evaluation because it is our judgment that any adenoma substantial enough to be disfiguring warrants a 20-percent evaluation.

As under DC 7900, we removed the subjective terms "pronounced," "severe," "moderately severe," and "moderate" from the criteria for DC 7903 (hypothyroidism). We also removed the requirement for slow return of reflexes for a 100-percent evaluation and added criteria of cold intolerance, muscular weakness, and cardiovascular involvement because these symptoms are typical of the disease

when it is totally disabling. Also at the 100-percent level, we changed "slow pulse" to the more objective "bradycardia (less than 60 beats per minute)" and removed "sluggish mentality" in favor of "mental disturbance (dementia, slowing of thought, depression)" because these are the common mental disturbances that may be seen in advanced hypothyroidism. We revised the former criteria for the 60-percent level in favor of the more objective criteria: "muscular weakness, mental disturbance, and weight gain". We made "fatigability, constipation, and mental sluggishness," instead of "sluggish mentality and other indications of myxedema," the criteria for the 30-percent level because they are commonly encountered symptoms and are more specific than the former criteria.

We removed "osteitis fibrosa cystica" from the title of DC 7904 (hyperparathyroidism) because that term represents certain bony findings that may be seen in hyperparathyroidism rather than being another term for hyperparathyroidism itself. As under other endocrine criteria, we removed subjective terms such as "pronounced," "severe," and "marked." We removed "high blood and urinary calcium" from the criteria for a 100-percent evaluation and "manifestations of hypercalcemia and urinary calcium" from the 60-percent level for the same reason we deleted criteria related to hormone levels under other endocrine conditions--these laboratory findings are more pertinent to diagnosis than to evaluation of functional impairment. We removed "marked weight loss" in favor of "gastrointestinal symptoms (nausea, vomiting, anorexia, constipation, weight loss, or peptic ulcer) because this is more representative of the variety of gastrointestinal symptoms that may be seen in hyperparathyroidism. We added "kidney stones" as an additional criterion at the 100-percent level because they are indicative of a totally disabling level. For consistency with the 100-percent level criteria, we changed "muscular weakness," one of the former criteria for the 60-percent level, to "weakness." We deleted the indefinite "with symptom combinations less than under 'pronounced' " from the 60-percent level criteria and, as at the 100-percent level, changed "marked weight loss" to "gastrointestinal symptoms. We revised the instructions under DC 7904 regarding post-operative or post-treatment evaluation, deleting the reference to "residual of benign tumor, considering especially bones and kidneys" to a more general direction to evaluate, following surgery or treatment as "digestive, skeletal, renal, or cardiovascular residuals."

We removed the reference to thyroidectomy in the criteria for a 100-percent level of hypoparathyroidism (DC 7905) because, although hypoparathyroidism may follow thyroidectomy if the parathyroid glands are also removed, there are other causes as well. There was a single 100-percent evaluation level based on painful muscular spasms or marked neuromuscular excitability. We revised the 100-percent criteria to "marked neuromuscular excitability," with examples, "plus either cataract or evidence of increased intracranial pressure," with examples. We added the alternative criteria because they are additional objective findings that may be seen at this level of disability. We clarified "marked neuromuscular excitability" by adding in parentheses "convulsions, muscular spasms (tetany), and laryngeal stridor" and eliminated the redundancy of including both "tetany" and "marked neuromuscular excitability" as separate symptoms. We added a 60-percent level based on either marked neuromuscular excitability or a combination of paresthesias (of arms, legs, or circumoral area) plus cataract or evidence of increased intracranial pressure, and a 10-percent level based on the need for continuous medication.

We changed the title of DC 7907 from "hyperpituitarism (pituitary basophilism, Cushing's syndrome)" to "Cushing's syndrome" since this is the medically accepted term for the condition. We removed the requirements at the 100-percent level for pathological fractures and enlargement of the sella turcica, which are rarely encountered, in favor of the more frequently seen findings of hypertension and weakness, and removed the subjective term "marked" modifying loss of muscle strength. We replaced the indefinite criteria of "severe; with symptom combination less than for the 100-percent rating with only partial control by treatment" at the 60-percent level with the more specific requirements of loss of muscle strength and enlargement of pituitary or adrenal gland. We added a 30-percent level for milder cases, especially those that are secondary to steroid treatment, with criteria of striae, obesity, moon face, glucose intolerance, and vascular fragility, which are indicators of milder disease than those criteria named at the 60- and 100-percent levels. We edited the note directing evaluation after recovery or control by expanding the list of possible residuals.

We changed the title of DC 7908 from "hyperpituitarism (acromegaly or gigantism)" to "acromegaly," since this is the most commonly used term for this disability. We removed the phrase

"hypofunctional stage of hyperfunction" from the criteria for the 100-percent level because this description does not assist in the evaluation of the condition. We edited and partially revised the list of symptoms for a 100-percent evaluation to "evidence of increased intra-cranial pressure (such as visual field defect), arthropathy, glucose intolerance, and either hypertension or cardiomegaly because these findings more accurately represent the 100-percent level of severity. We also replaced the former criteria for the 60-percent level with "arthropathy, glucose intolerance, and hypertension" because these are more frequently encountered symptoms. We removed the phrase "X-ray evidence of" modifying enlarged sella turcica at the 30-percent level as unnecessary.

We changed the title of DC 7909 from "hypopituitarism (diabetes insipidus)" to "diabetes insipidus" since this name alone is sufficient to identify this category of disease. We removed the subjective modifiers "pronounced," "severe," "moderately severe," and "moderate" because they did not aid in the evaluation of the condition. As elsewhere in the endocrine system, we removed the laboratory findings, in this case related to serum and urine osmolality from the criteria because they are not necessarily consistent with particular levels of functional impairment. In place of "excessive thirst," "polyuria," and :polydipsia," we added "polyuria with near-continuous thirst" as criteria for all levels. For clarity, we replaced "parenteral replacement therapy" with "episodes of dehydration requiring parenteral hydration" and specified a number of episodes of dehydration per year for the 40-, 60-, and 100-percent level for more objectivity.

Under Addison's disease, DC 7911, the former criteria included references to "episodes" and "crises," but they were not defined. We have added notes under DC 7911 defining them, and specified in the criteria the number of each that warrant each percentage evaluation. We removed the references to laboratory findings of hyponatremia, hyperpotassemia, azotemia, hypoglycemia, and cortisol deficiency for the same reasons as discussed under other endocrine conditions.

We revised the evaluation criteria for diabetes mellitus (DC 7913) to make them more objective and base them on how well the diabetes is controlled. The frequency of insulin injection and medical treatment are valid measures of the severity of diabetes, and we have stipulated a requirement for more than one daily injection of insulin for the 100-percent evaluation level. We also specified the number of hospitalizations per year required because of episodes of ketoacidosis or hypoglycemic reactions and the frequency of visits to a diabetic care provider that warrant a 60- or 100-percent evaluation. We eliminated the requirement for a "large" or "moderate" insulin dosage at the 40- and 20-percent levels respectively because the severity of diabetes is better determined by the degree of control in response to treatment than by the amount of medication required for control.

We deleted from the criteria for the 10- and 20-percent evaluation levels under DC 7913 the requirement "without impairment of health or vigor or limitation of activity" because they do not affirmatively denote required criteria for those evaluation levels. A requirement for regulation of activities was formerly one of the criteria for the 40- and 100-percent levels but not for the 60-percent level. For the sake of consistency, we have made "regulation of activities" one of the required criteria for the 40-. 60-, and 100-percent levels. We clarified the meaning of "severe" complications of diabetes and how to evaluate complications by means of a note and by including a reference to complications that would and would not be separately compensable under the 100- and 60-percent criteria respectively.

Under DC 7914, malignant neoplasms of the endocrine system, we made changes in the convalescent period following treatment that are similar to changes we have made in other body systems, i.e., requiring a mandatory VA examination 6 months following completion of treatment and implementation of § 3.105(e) before any reduction can be made.

We added four commonly occurring endocrine disorders: hyperpituitarism (prolactin secreting pituitary dysfunction) as DC 7916, hyperaldosteronism (benign or malignant) as DC 7917, and pheochromocytoma (benign or malignant) as DC 7918), all to be evaluated as malignant or benign neoplasm as appropriate, and C-cell hyperplasia of the thyroid as DC 7919, to be evaluated as malignant neoplasm.

We removed one condition from this section, hyperadrenia (adrenal genital syndrome), DC 7910, because it is a condition that occurs during infancy and childhood and is rarely encountered in individuals in service.

Diagnostic codes revised	Diagnostic codes added	Diagnostic codes removed
7900	7916	7910
7901	7917	
7902	7918	
7903	7919	
7904		
7905		
7907		
7908		
7909		
7911		
7912		
7913		
7914		
7915		

REGULATORY AMENDMENT
4-96-3

Regulation affected: 38 CFR 4.88 and 4.88b

EFFECTIVE DATE OF REGULATION: August 30, 1996

Date Secretary approved regulation: March 7, 1996

Federal Register Citation: 61 FR 39873 (July 31, 1996)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended sections 4.88 and 4.88b of 38 CFR, Part 4, the sections of the rating schedule that deal with infectious diseases, immune disorders, and nutritional deficiencies. The intended effect of this action is to update these sections to ensure that they use current medical terminology and unambiguous criteria, and that they reflect medical advances which have occurred since the last review.

We changed the title of this portion of the rating schedule from "Systemic diseases" to "Infectious diseases, immune disorders, and nutritional deficiencies" because the former title did not adequately depict the range of conditions that this section addresses.

We changed the convalescent period for Asiatic cholera (DC 6300) from six months to three months because treatment of this condition is now simple, and the condition is ordinarily self-limited to a few days duration. We also added a note under DC 6300 regarding the rating of residuals to assure that they will be evaluated.

We changed the title of DC 6301 from "kala-azar" to the more modern term for this condition, "visceral leishmaniasis." We also changed the convalescent period for this condition from one year to a requirement for a VA examination six months after the date of inactivity and any reduction in the total evaluation to be made under the provisions of § 3.105(e). This convalescence will allow a period for recuperation and also assure that the extent of residual impairment is documented by examination before any change in evaluation is considered. We added a note under DC 6301 regarding the rating of residuals such as liver damage or lymphadenopathy to assure that they will be evaluated.

Similarly, we changed the period of convalescence for leprosy (DC 6302) from one year to a requirement for a VA examination six months after the date of inactivity and any reduction in the total evaluation to be made under the provisions of § 3.105(e). This change was made for the same reason as for leishmaniasis. We edited the note regarding residuals, removing the instructions regarding contagious and noncontagious cases, because all active disease is regarded as 100 percent disabling; and, following the period of convalescence, the condition is to be evaluated on the basis of residuals such as skin lesions or peripheral neuropathy.

We changed the criteria for the evaluation of malaria (DC 6304) from those based on number of relapses and presence of symptoms such as anemia to a direction to rate active disease at 100 percent, since active infection is normally totally disabling, and there is no need to specify the signs and symptoms. We also provided a note explaining the diagnostic requirements for malaria in current medical practice and directing that residuals be rated under the appropriate system. This information replaces the two former notes that discussed diagnosis and evaluation.

We changed the title of DC 6305 from "filariasis" to "lymphatic filariasis" because the criteria formerly used for the evaluation of filariasis applied only to the lymphatic type. Other types of filariasis are included in DC 6320, Parasitic diseases otherwise not specified. We simplified the evaluation by changing the criteria from those based on recurrences and involvement of extremities and genitalia to a

direction to rate active disease at 100 percent and to rate residuals under the appropriate system, as we have done for a number of infectious diseases, and for the same reasons as discussed under malaria.

We modernized the title of DC 6306 by changing it from Oroya fever to Bartonellosis. We changed the period of convalescence from six months to three months, which is an adequate period of time for recuperation and stabilization of red blood cells in the average individual, according to our consultants. We also added a note regarding evaluation of residuals.

The only change we made under DC 6307, plague, is the addition of a note regarding residuals, and under DC 6308, relapsing fever, we added specific examples of residuals that might occur—liver or spleen damage or central nervous system involvement. We made only minor editorial changes in DC 6309, rheumatic fever. We also made editorial changes under DC 6310, syphilis, expanded the title to "syphilis, and other treponemal infections" to accommodate additional treponemal conditions that can be rated similarly, and listed specific diagnostic codes where complications might be rated. Under DC 6311, miliary tuberculosis, we referred the rater to §§ 4.88c or 4.89, the specific sections that apply to the evaluation of inactive nonpulmonary disease.

For the convenience of the rater, we repeated the criteria for the evaluation of pellagra, DC 6315, under DC 6313, avitaminosis, rather than referring the rater to DC 6315. We provided more objective criteria for beriberi, DC 6314, providing evaluation levels of 30- 60- and 100-percent. We removed the 10-percent level because it was to be assigned for "moderate residuals." By removing this level and adding a note regarding residuals, we provide more latitude in evaluating residuals at any level of disability and also indicate that active beriberi warrants at least a 30 percent evaluation.

We revised the criteria for the evaluation of pellagra, DC 6315, by removing subjective language and otherwise made only minor changes. We removed "Malta or undulant fever," alternative names that are no longer used, from the title of DC 6316, Brucellosis. We revised the criteria by establishing a 100-percent evaluation for active disease. We removed all other criteria and instead stated that residuals such as liver or spleen damage or meningitis are to be rated under the appropriate system.

We changed the period of convalescence for scrub typhus, DC 6317, from six months to three months because with modern therapy, recovery is prompt and uneventful, and convalescence is short. We also updated the note regarding the evaluation of residuals.

For melioidosis, DC 6318, we changed the requirement for 100 percent to active disease, as we have done for several other infectious diseases, rather than requiring specific signs or symptoms, and we modified the note regarding residuals.

We added two new diagnostic codes: 6319 for Lyme disease, which has been identified as a distinct disease and occurs often enough in the veteran population to warrant a separate code, and 6320, parasitic diseases otherwise not specified, to accommodate all parasitic diseases not otherwise listed without the need to rate by analogy. Active disease under both new codes warrants 100 percent, and residuals are to be rated under the appropriate system.

We changed the evaluation percentage levels and the criteria for lupus erythematosus, DC 6350, because the former three highest levels were indistinguishable clinically, and they are now included in the 100-percent evaluation level. Furthermore, two or three exacerbations per year of a week or more were felt to be more consistent with a 60-percent level of evaluation rather than the current 30 percent. We also added two additional potential residuals, adverse effects of medication, and neurological complications, to the note regarding residuals and also revised the note for clarity.

Section 4.88 is removed and reserved.

Diagnostic codes revised	Diagnostic codes added	Diagnostic codes removed
6300	6319	NONE
6301	6320	
6302		
6304		
6305		
6306		
6307		
6308		
6309		
6310		
6311		
6313		
6314		
6315		
6316		
6317		
6318		
6350		

REGULATORY AMENDMENT
4-96-4

Regulation affected: 38 CFR 4.96 and 4.97

EFFECTIVE DATE OF REGULATION: October 7, 1996

Date Secretary approved regulation: May 13, 1996

Federal Register Citation: 61FR 46720-31

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended sections 4.96 and 4.97 of 38 CFR, Part 4, the sections of the rating schedule that deal with the respiratory system. The intended effect of this action is to update this portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

We revised § 4.96 (a) only to reflect changed diagnostic codes in § 4.97. We added paragraph (c), concerning special monthly compensation (SMC), to § 4.96 as an additional reminder to the rating agency to refer to § 3.350 of this chapter to determine whether the veteran may be entitled to SMC. We also retitled § 4.96 to better reflect its content.

We have made one other change to remind the rating agency to consider SMC when there is organic aphonia. We placed footnotes at DC's 6518 (total laryngectomy) and 6519 (complete organic aphonia), conditions that may be associated with complete organic aphonia, directing to review for entitlement to SMC.

We removed chronic atrophic rhinitis (DC 6501) and in its place added three new diagnostic codes for specific types of rhinitis that may result in atrophic rhinitis: DC's 6522, allergic or vasomotor rhinitis, with evaluation levels of 10 and 30 percent; 6523, bacterial rhinitis, with evaluation levels of 10 and 50 percent; and 6524, granulomatous rhinitis, with evaluation levels of 20 and 100 percent. The percentage levels are highest for granulomatous diseases because they are most seriously disabling.

We modernized the title of DC 6502 by changing it from "septum, nasal, deflection of" to "septum, nasal, deviation of" and made the criteria more objective by requiring 50-percent obstruction of the nasal passage on both sides or complete obstruction on one side for a 10-percent evaluation rather than using the indefinite term "marked" for the required degree of interference with the breathing space.

We changed "exposing both nares" to "exposing both nasal passages" under DC 6504 (nose, loss of part of, or scars) for clarity, and added a note regarding alternative evaluation under DC 7800, scars, disfiguring, head, face, or neck.

We provided a general rating formula for sinusitis (DC's 6510 through 6514) based on more objective criteria, including signs, symptoms, and frequency of nonincapacitating episodes, and frequency and duration of antibiotic treatment of incapacitating episodes (defined in a note) that warrant a 10- or 30-percent evaluation, and specific findings following surgery that warrant a 50-percent evaluation.

In order to clarify and distinguish the criteria for the given percentages of DC 6516, chronic laryngitis, we have removed the indefinite terms "severe," "marked," and "moderate" and revised the requirements for a ten-percent evaluation to "hoarseness with inflammation of cords or mucous membrane" and for a thirty-percent evaluation to "hoarseness with thickening or nodules of cords, polyps, submucous infiltration, or pre-malignant changes on biopsy." We removed DC 6517, healed injuries of larynx, and combined residuals of laryngeal trauma and stenosis of the larynx under DC 6520, larynx, stenosis of,

including residuals of laryngeal trauma, with evaluation based on results of pulmonary function testing or on aphonia (under DC 6519). This provides more flexibility by providing alternative methods of evaluation. Under laryngectomy, DC 6518, in addition to adding a footnote regarding SMC, we added a direction on the evaluation of partial laryngectomy under DC's 6516, 6519, or 6520. We added more objective criteria for the evaluation of larynx, stenosis of, including residuals of laryngeal trauma (DC 6520) by basing them on pulmonary function tests (FEV-1) and the pattern of the Flow-Volume Loop instead of on subjective indicators such as whether there is dyspnea on "slight," "moderate," or "heavy" exertion.

We added a new diagnostic code, DC 6521, for injuries to the pharynx, with a single evaluation level of 50-percent based on the presence of stricture or obstruction of the pharynx or nasopharynx or on paralysis or absence of the soft palate.

We made the evaluation criteria for chronic bronchitis (DC 6600) more objective by basing them on the results of pulmonary function tests or, for the 100-percent level, the alternative criteria of cor pulmonale, right ventricular hypertrophy, pulmonary hypertension, episode(s) of acute respiratory failure, or a need for outpatient oxygen therapy. We established the similar criteria for conditions with similar functional impairments: pulmonary emphysema (DC 6603), chronic obstructive pulmonary disease (DC 6604), and the restrictive lung diseases--diaphragm paralysis or paresis (DC 6840), spinal cord injury with respiratory insufficiency (DC 6841), kyphoscoliosis, pectus excavatum, pectus carinatum (DC 6842), traumatic chest wall defect (DC 6843), post-surgical residual (DC 6844), and chronic pleural effusion or fibrosis (DC 6845).

We removed indefinite terms such as "pronounced," "severe," "considerable," "occasional," "moderate," etc., from the criteria under DC 6601, bronchiectasis and instead provided more objective, but flexible, criteria based either on the total duration per year of incapacitating episodes of infection, or on symptoms requiring a certain frequency and duration of antibiotic treatment. Using pulmonary impairment as for chronic bronchitis as an alternative was also added. We removed indefinite terms such as "pronounced," "severe," "frequent," and "several" from the criteria for bronchial asthma (DC 6602) and provided objective evaluation criteria based either on the results of selected pulmonary function tests (FEV-1 or FEV-1/FVC) or on treatment requirements.

We made a technical change in Note (1) under the general rating formula for inactive pulmonary tuberculosis by referring to a footnote under 38 U.S.C. 1156 rather than to 38 U.S.C. 356, as in the former schedule, because 38 U.S.C. has been repealed by Public Law 90-493. Because of modern treatment methods of tuberculosis, we have revised the provision under DC 6731 (tuberculosis, pulmonary, chronic, inactive) for a total evaluation for one year after date of attainment of inactivity of tuberculosis to the requirement for a mandatory examination to be requested immediately following notification that active tuberculosis under DC 6730 has become inactive, and with any change in evaluation to be carried out under the provisions of § 3.105(e). We also removed subjective terms such as "pronounced," "severe," "extensive," and "slight" from the former criteria and replaced them with more objective, but flexible, criteria by directing to rate residuals as interstitial lung disease, restrictive lung disease, or, when obstructive lung disease is the major residual, as chronic bronchitis and to rate thoracoplasty as removal of ribs under DC 5297.

We reorganized the nontuberculous diseases that formerly included DC's 6800 through 6821 by grouping most of them into several categories--bacterial infections of the lung, interstitial lung disease, mycotic lung disease, and restrictive lung disease--and by providing a general rating formula for each of these categories of disease. Many conditions were given new diagnostic codes in order to group conditions in the same category together. Bacterial infections of the lung include actinomycosis, DC 6822 (formerly 6803); nocardiosis, DC 6823 (a new condition added because it is one of the common conditions in this category), and chronic lung abscess, DC 6824 (formerly DC 6809). This group is evaluated under a general rating formula with a total evaluation when there is active infection with systemic symptoms, and residuals are evaluated as interstitial or restrictive lung disease, or as chronic bronchitis when obstructive lung disease is the major residual. We deleted streptotrichosis of lung (DC 6804), because this is a term no longer in use.

We deleted DC's 6800 (anthracosis), 6801 (silicosis), and 6802 (pneumoconiosis, unspecified) and included all of these in the newly added DC 6832, titled "pneumoconiosis (silicosis, anthracosis, etc.)" in the category of interstitial lung disease. We also added under this category: diffuse interstitial fibrosis (DC 6825), desquamative interstitial pneumonitis (DC 6826), pulmonary alveolar proteinosis (DC 6827), eosinophilic granuloma of lung (DC 6828), drug-induced pulmonary pneumonitis and fibrosis (DC 6829), radiation-induced pulmonary pneumonitis and fibrosis (DC 6830), hypersensitivity pneumonitis (DC 6831), and asbestosis (DC 6832). All of these are evaluated under a general rating formula for interstitial lung disease that has 10-, 30-, 60-, and 100-percent evaluation levels based on FVC, DLCO, maximum exercise capacity measured in oxygen consumption, or, at the 100-percent level, alternative criteria of cor pulmonale, pulmonary hypertension, or a requirement for outpatient oxygen therapy.

For mycotic diseases, we removed sporotrichosis (DC 6806) because it usually affects only skin and lymph nodes rather than lung, and mycosis of lung, unspecified (DC 6808), and assigned new diagnostic codes for blastomycosis (changed from DC 6805 to 6836), aspergillosis (changed from DC 6807 to 6838), and coccidioidomycosis (changed from DC 6821 to 6835). We added histoplasmosis of lung (DC 6833), cryptococcosis (DC 6837), and mucormycosis (DC 6838). All of the mycotic diseases are evaluated under a general rating formula with percentage evaluation levels of zero-, 30- 50-, and 100-percent based on symptoms and treatment requirements. We placed the note (edited) about the incubation period of coccidioidomycosis that had been under DC 6821 under the general rating formula.

For restrictive lung diseases, we removed serofibrinous pleurisy (DC 6810), purulent pleurisy (DC 6811), bronchocutaneous or bronchopleural fistula (DC 6812), permanent collapse of the lung (DC 6813), spontaneous pneumothorax (DC 6814), pneumonectomy (DC 6815), lobectomy (DC 6816), and residuals of pleural cavity injuries (DC 6818). We added diaphragm paralysis or paresis (DC 6839); spinal cord injury with respiratory insufficiency (DC 6840); kyphoscoliosis, pectus excavatum, pectus carinatum (DC 6841); traumatic chest wall defect, pneumothorax, hernia, etc. (DC 6842); post-surgical residuals (lobectomy, pneumonectomy, etc.) (DC 6843); and chronic pleural effusion or fibrosis (DC 6844). DC 6813 was removed because collapse therapy for tuberculosis is no longer common. The conditions currently rated as pleurisy will be rated as chronic pleural effusion or fibrosis; fistula, pneumonectomy, and lobectomy will be rated under post-surgical residuals; pleural cavity injuries and pneumothorax will be rated as traumatic chest wall defect. The restrictive lung diseases will be evaluated under a general rating formula with 10-, 30-, 60-, and 100-percent levels based on the same criteria used to evaluate chronic bronchitis, emphysema, etc. Alternatively, the primary disorder may be rated.

We added three notes following the rating formula for restrictive lung diseases. One note stipulates a three-month period of convalescent evaluation from the date of hospital admission for a total spontaneous pneumothorax, a change from the assignment of a 100-percent evaluation for six months for spontaneous pneumothorax under DC 6814. A second note states that pleurisy with empyema will be evaluated at 100 percent until resolved. There was a range of evaluation levels from 10 to 100 percent in the former schedule. The third note discusses the evaluation of gunshot wounds of the pleural cavity, and this represents no substantive change from directions in the former schedule except for an added statement that muscle group XXI (the respiratory muscles) will not be combined with these injuries, a statement added to prevent pyramiding in evaluating these disabilities.

We retitled DC 6817 (lung, chronic passive congestion of) to "pulmonary vascular disease," a more inclusive title to accommodate all types of pulmonary vascular disease. Evaluation under this diagnostic code was formerly done by rating the underlying disease. However, we have provided objective criteria specific to pulmonary vascular disease with evaluation percentage levels of 100-, 60-, 30, and zero-percent.

We changed the method of evaluating respiratory system malignancies in favor of the same system we have used in other revised sections of the rating schedule, namely, a mandatory examination six following cessation of therapy, and implementation of any change in the total evaluation under the provisions of § 3.105(e).

We added a new diagnostic code, 6846, for sarcoidosis, with evaluation levels of zero, 30, 60, and 100 percent based on symptoms, cardiac involvement, treatment requirements, and X-ray findings. Alternatively, sarcoidosis can be evaluated as chronic bronchitis or, with extra-pulmonary involvement, under the specific body system involved. We also added a new diagnostic code, 6847, for sleep apnea, with evaluation levels of zero, 30, 50, and 100 percent based on symptoms, treatment requirements, and the presence of cor pulmonale or respiratory failure.

Diagnostic codes revised	Diagnostic codes removed	Diagnostic codes added
6502	6501	6521
6504	6517	6522
6510	6800	6523
6511	6801	6524
6512	6802	6604
6513	6803	6822
6514	6804	6823
6515	6805	6824
6516	6806	6825
6518	6807	6826
6519	6808	6827
6520	6809	6828
6600	6810	6829
6601	6811	6830
6602	6812	6831
6603	6813	6832
6730	6814	6833
6731	6815	6834
6732	6816	6835
6817	6818	6836
6819		6837
6820		6838
		6839
		6840
		6841
		6842
		6843
		6844
		6845
		6846
		6847

REGULATORY AMENDMENT

4-96-5

Regulation affected: 38 CFR 4.16 and 4.125 through 4.132

EFFECTIVE DATE OF REGULATION: November 7, 1996.

Date Secretary approved regulation: September 9, 1996.

Federal Register Citation: 61FR 52695-702.

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended sections 4.16 and 4.125 through 4.132 of 38 CFR, Part 4, the sections of the rating schedule that deal with mental disorders. The intended effect of this action is to update the mental disorders section of the rating schedule to ensure that it uses current medical terminology, such as mental retardation instead of mental deficiency, unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

Since DSM-IV is the common language of both VA and non-VA health care providers and researchers, we changed the basis of diagnosis and terminology of mental disorders in the rating schedule from DSM-III to DSM-IV in order to provide rating specialists with a standard by which examinations from all sources can be compared and assessed. This required some reorganization and renaming of the categories of mental disorders as well as changes in the terminology and organization of some of the mental disorders themselves.

In order to conform more closely to the categories in DSM-IV, we have provided eight, instead of four, categories of mental disorders: Schizophrenia and other psychotic disorders; Delirium, dementia, and amnestic and other cognitive disorders; Anxiety disorders; Dissociative disorders; Somatoform disorders; Mood disorders; Chronic adjustment disorder; and Eating disorders. We provided a general rating formula for all categories of mental disorders except eating disorders. The latter are manifested primarily by physical findings and therefore required a separate set of criteria.

We removed 29 diagnostic codes, added 20, revised 10, and did not change 8 codes. The added codes represent conditions not included in the former schedule that are encountered frequently enough in VA claims to warrant their inclusion.

We added a new category of "Schizophrenia and other psychotic disorders." Except for schizoaffective disorder, we did not change the diagnostic codes pertaining to schizophrenia (DC's 9201 through 9205). We deleted DC's 9206, bipolar disorder, manic, depressed, or mixed, and 9207, major depression with psychotic features, since we have provided a category for mood disorders that includes conditions such as these.

We updated the title of DC 9208 from "paranoid disorders (specify type)" to "delusional disorder" and placed it in the category of schizophrenia and other psychotic disorders, in accord with DSM-IV. We deleted DC 9209, major depression with melancholia, another condition that we moved to the category of mood disorders.

We revised the title of DC 9210 from "atypical psychosis" to "psychotic disorder, not otherwise specified (atypical psychosis)," and included it in the psychotic disorders category, in accord with DSM-IV. We also put schizoaffective disorder, formerly part of DC 9205, in this category as DC 9211. Although

schizoaffective disorder was linked to schizophrenia in the former schedule, DSM-IV named it as a separate psychotic disorder rather than as a type of schizophrenia.

We changed the name of the category of "Organic mental disorders" to "Delirium, dementia, and amnestic and other cognitive disorders," in accordance with the more current terminology in DSM-IV. The conditions in this category demonstrate a psychological or behavioral abnormality associated with transient or permanent dysfunction of the brain. We consolidated the 16 types of dementia in the former schedule into fewer categories because several of them, e.g., dementia associated with endocrine disorder (DC 9322) and dementia associated with systemic infection (DC 9324), are quite uncommon (only about one-tenth of one percent of VA beneficiaries being compensated for dementia have one of these types of dementia); and a number of others, such as dementia associated with central nervous system syphilis (DC 9301), dementia associated with intracranial infections other than syphilis (DC 9302), and dementia associated with epidemic encephalitis (DC 9315), lend themselves to logical groupings based on etiology (in this case, infection).

DSM-IV uses a more complex classification of dementias than is needed or useful for VA purposes. For example, it has separate categories for dementia due to Huntington's disease, Pick's disease, and Creutzfeldt-Jacob disease, each of which is uncommonly seen for VA rating purposes. We reorganized the dementias into six diagnostic codes, retaining some types because of their frequent occurrence and relevance to veterans, for example, dementia due to head trauma, (DC 9304, dementia associated with brain trauma in the current schedule) and some because they represent clusters of a particular etiology. We propose to retain diagnostic codes for the types of dementia most commonly seen in the general population, vascular dementia (which encompasses the former DC's 9305 and 9306, multi-infarct dementia with cerebral arteriosclerosis and multi-infarct dementia due to causes other than cerebral arteriosclerosis, respectively), and dementia of the Alzheimer's type (formerly DC 9312, primary degenerative dementia). This reorganization will not affect how dementias are evaluated, since all types will be evaluated under the same criteria, but will allow separation of the most common types by etiology.

We deleted DC's 9303 (dementia associated with alcoholism) and 9325 (dementia associated with drug or poison intoxication (other than alcohol)), in favor of including them under DC 9326, as discussed below. We revised DC 9304 (dementia associated with brain trauma) to dementia due to head trauma, because this is more modern terminology, and DC 9301 (dementia associated with central nervous system syphilis) to dementia associated with infection. We included in DC 9301 the conditions formerly under DC's 9301, 9302 (dementia associated with intracranial infections other than syphilis), 9315 (dementia associated with epidemic encephalitis), and 9324 (dementia associated with systemic infection), since the number of cases of dementia due to infection is small, and the specific type of infection has no bearing on the evaluation.

We deleted DC's 9307 (dementia associated with convulsive disorder), 9308 (dementia associated with disturbances of metabolism), 9309 (dementia associated with brain tumor), and 9322 (dementia associated with endocrine disorder), and included these conditions in DC 9326, Dementia due to other neurologic or general medical conditions (endocrine disorders, metabolic disorders, Pick's disease, brain tumors, etc.) or which are substance-induced (drugs, alcohol, poisons). This category encompasses in a single miscellaneous category a number of uncommon conditions that DSM-IV names separately.

We retitled "multi-infarct dementia with cerebral arteriosclerosis" (DC 9305) as "vascular dementia" and included in it the former DC 9306 (multi-infarct dementia due to causes other than cerebral arteriosclerosis) because both types are due to vascular disease, may be difficult to distinguish, and are addressed as a single entity in DSM-IV.

We revised the title of DC 9310 (formerly dementia due to unknown cause) to dementia of unknown etiology and included in it the former DC 9311 (dementia due to undiagnosed cause), now deleted, because, in practice, it may be impossible to differentiate these types. We retitled DC 9312 (formerly dementia, primary, degenerative) to dementia of the Alzheimer's type, in accord with DSM-IV.

We added DC 9327, organic mental disorder, other, to provide a code for conditions such as amnestic disorder, organic personality disorder, and other cognitive disorders that are not dementias.

We established a category for anxiety disorders, in accord with DSM-IV, that includes several conditions formerly in the category of psychoneurotic disorders: "generalized anxiety disorder" (DC 9400), "obsessive compulsive disorder" (DC 9404), "other and unspecified neurosis" (DC 9410), "post-traumatic stress disorder" (DC 9411), and "specific (simple) phobia; social phobia" (DC 9403) (modified from the former "phobic disorder," in accord with terminology in DSM-IV).

We moved some conditions formerly in the category of psychoneurotic disorders to new categories: DC 9401, dissociative amnesia; dissociative fugue; dissociative identity disorder (currently psychogenic amnesia; psychogenic fugue; multiple personality) and DC 9408, depersonalization disorder, to the category of dissociative disorders, as discussed below; DC 9402, conversion disorder; psychogenic pain disorder, and DC 9409, hypochondriasis, to somatoform disorders, as discussed below; and deleted DC 9405, dysthymic disorder; adjustment disorder with depressed mood; major depression without melancholia, also as discussed below. We added to anxiety disorders two conditions that occur frequently enough that diagnostic codes are needed and which are not now included in the rating schedule: "panic disorder and/or agoraphobia" (DC 9412) and "anxiety disorder, not otherwise specified" (DC 9413). While "other and unspecified neurosis" (DC 9410 in the current schedule) is not limited to anxiety disorders, we placed it in this category as a matter of convenience, rather than giving it a separate category.

We added a category for dissociative disorders, conditions, according to DSM-IV, where there is a disturbance in the usually integrated functions of identity, memory, consciousness, or perception of the environment. Included in this category are: "dissociative amnesia; dissociative fugue; dissociative identity disorder (multiple personality disorder)" (DC 9416, which we changed from DC 9401 to keep conditions in this category together) and "depersonalization disorder" (DC 9417, changed from DC 9408 for the same reason).

In accord with DSM-IV, we added a category for somatoform disorders, conditions characterized by the presence of physical symptoms that suggest a general medical condition and are not explained by a general medical condition, by the direct effects of a substance, or by another mental disorder. We moved "conversion disorder; psychogenic pain disorder" (DC 9402) and "hypochondriasis" (DC 9409), formerly under the category of psychoneuroses, to this category and assigned them new diagnostic codes so that the somatoform disorders are grouped together. We split "conversion disorder; psychogenic pain disorder" into "conversion disorder" (DC 9424), and "pain disorder (DC 9422), since the two conditions are distinct, and changed the code for "hypochondriasis" from DC 9409 to DC 9425. (Pain disorder is the current term for "psychogenic pain disorder.") We added two other conditions: "somatization disorder" (DC 9421), a commonly seen somatoform disorder not in the former schedule, and "undifferentiated somatoform disorder" (DC 9423), for somatoform disorders that do not fit elsewhere and for which there was no suitable code in the former schedule.

We established a category for mood disorders and placed in this category: bipolar disorder (DC 9432), dysthymic disorder (DC 9433), and major depressive disorder (DC 9434). Major depressive disorder was formerly under three diagnostic codes: 9207 (major depression with psychotic features), 9209 (major depression with melancholia), and 9405 (dysthymic disorder; adjustment disorder with depressed mood; major depression without melancholia). Since DSM-IV does not recognize three varieties of major depressive disorder, we have used a single diagnostic code, 9434, for major depressive disorder. We changed the diagnostic codes for dysthymic disorder (formerly dysthymia, DC 9405) and bipolar disorder (formerly DC 9206) to DC 9433 and DC 9432, respectively, in order to group the mood disorders together.

For the sake of completeness, we provided diagnostic codes for two additional mood disorders: cyclothymic disorder (DC 9431), which, although related to bipolar disorder, is classified as a separate entity by DSM-IV, and mood disorder, not otherwise specified (DC 9435), which allows the evaluation of

conditions with mood symptoms that do not meet the criteria for any specific mood disorder. As part of this reorganization, we removed DC 9405 ("dysthymic disorder; adjustment disorder with depressed mood; major depression without melancholia") since we have provided separate diagnostic codes for both "dysthymic disorder" (DC 9433) and "major depressive disorder" (DC 9434) under the category of mood disorders.

We added a new category and diagnostic code (9440) for chronic adjustment disorder, a condition seen fairly often in the veteran population.

We added a category for eating disorders, a group of mental disorders characterized by gross disturbances in eating behavior. This includes anorexia nervosa (DC 9520) and bulimia nervosa (DC 9521), and we have based their evaluation criteria partly on the extent of weight loss (per DSM-IV) and partly on the extent of incapacitating episodes and needed periods of hospitalization.

We deleted § 4.16 (c), because, in our judgment, it is possible that a veteran may be properly evaluated at a level less than 100 percent based on average impairment, but because of unique aspects of his or her individual situation, might still be unable to secure or follow a substantially gainful occupation. In order to allow rating specialists the flexibility to fairly evaluate such situations, we deleted § 4.16 (c) to allow § 4.16 (a) to apply to mental disorders in the same manner that it does to other disabilities.

We removed DC's 9500 through 9511, the codes for psychological factors affecting physical conditions, for the following reasons. DSM-IV renamed this group of disorders as "psychological factors affecting medical condition" (PFAMC) and placed them in a new category: "Other conditions that may be a focus of clinical attention." It said that PFAMC has two components: a medical condition and psychological factors. If the psychological factors do not constitute a recognized mental disorder, they would not be service-connectable in their own right. If one of the components is a service-connected medical condition or mental disorder, it would be evaluated under the appropriate code. If both components are service-connected, each would be separately evaluated. In either case, an additional separate evaluation for PFAMC would not then be warranted, and in fact would represent pyramiding (see 38 CFR 4.14).

The former mental disorders section provided separate rating formulas for psychotic disorders, organic mental disorders, and psychoneurotic disorders. There were some specific evaluation criteria at each level for psychoneurotic disorders, but the other formulas used only "mild," "definite," "considerable," or "severe" social and industrial adaptability as criteria for most levels. Because those are non-specific terms, and the formulas offered no objective guidance for the rater, they were subject to interpretation by individual raters and made comparison of one exam with another difficult.

We have therefore provided a general rating formula for mental disorders that contains more objective criteria based on signs and symptoms which characteristically produce a particular level of disability. These criteria are meant to assure more consistent evaluations and offer greater ease in comparing examinations. The symptoms indicated at each level are not intended to be comprehensive (and could not be, because of the multitude of symptoms in mental disorders), but to provide an objective framework for raters to use. The criteria focus on the level of impairment of occupational and social functioning as related to the specific symptoms which are present, whether the symptoms are persistent or transient, their frequency, and their severity. With these more specific and objective criteria, raters can make a determination of the level of severity based on all the evidence of record, including the detailed report of all signs and symptoms, relevant information regarding employment, report of daily activities, etc., rather than attempting an assessment based on whether the evidence corresponds to the non-specific language in the former schedule.

We reorganized and edited the material in §§ 4.125 through 4.131 and the notes in § 4.132 for clarity, less ambiguity, and to be more current, but the changes are not meant to be substantive. We also

removed material which is not regulatory, i.e., which neither prescribes VA policy nor limits the action a rating board may take.

We changed the title of § 4.125 from "General considerations" to "Diagnosis of mental disorders" and divided it into one paragraph requiring that the rating board return an examination report to the examiner if the diagnosis does not conform to DSM-IV or is not supported by the findings in the report, and a second paragraph directing the rating board to determine whether a change in diagnosis of a mental disorder represents progression of a prior diagnosis, correction of an error in a prior diagnosis, or development of a new and separate condition. This material is taken from §§ 4.126 (Substantiation of diagnosis) and 4.128 (Change of diagnosis).

We placed material on the evaluation of mental disorders from §§ 4.129 and 4.130, a statement and notes under DC 9511, notes (1) and (4) under DC 9325, and notes under the general rating formula for psychoneurotic disorders about evaluation of mental disorders in § 4.126 and changed its title from "Substantiation of diagnosis" to "Evaluation of disability from mental disorders." We divided it into four paragraphs, with paragraph (a) establishing the general basis for evaluating mental disorders as the frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the veteran's capacity for adjustment during remissions, with the requirement that evaluation be based on all evidence of record bearing on occupational and social impairment. This is derived from material currently found at § 4.130. We removed from § 4.130 the statement that the examiner's analysis of the symptomatology is an "essential" because it is the signs and symptoms that the examiner documents rather than his or her assessment of their level of severity that will determine the evaluation. We also deleted the statement that describes time lost from gainful work and decrease in work efficiency as "two of the most important determinants of disability." Since the proposed evaluation criteria are structured around the nature and extent of occupational and social impairment, including decreased reliability, productivity, and work efficiency, that statement is no longer necessary.

Paragraph (b), which is based on § 4.129 and note (1) following the general rating formula for psychoneurotic disorders, directs the rating board to consider the extent of social impairment, but not to assign an evaluation solely on the basis of social impairment. This does not represent a substantive change.

Paragraph (c) discusses the evaluation of delirium, dementia, and amnestic and other cognitive mental disorders and represents no substantive change from material currently contained in notes (1) and (2) under DC 9325.

Paragraph (d), which represents no substantive change from information in notes (4) and (2) at the end of the rating schedules for psychoneurotic disorders and psychological factors affecting physical condition, respectively, directs the rating board to evaluate a single disability that has been diagnosed both as a physical condition and as a mental disorder under the diagnostic code which represents the dominant (more disabling) aspect of the condition. We substituted "dominant (more disabling) aspect of the condition" for "major degree of disability" for clarity.

Section 4.127 represents a revision of the former § 4.127 and states that mental retardation and personality disorders will not be considered as diseases or injuries for compensation purposes, but a mental disorder that is superimposed upon the mental retardation or personality disorder may be a disability for VA compensation purposes.

We retitled § 4.128 "Convalescence ratings following extended hospitalization," and included material from a note under DC 9210 regarding a total evaluation following a period of hospitalization lasting six months or more and a mandatory examination six months after the veteran is discharged or released to nonbed care. We added a requirement that a change in evaluation based on that or any subsequent examination shall be subject to the provisions of 38 CFR 3.105(e) because stabilization and return to usual activities in the face of a severe mental disorder is often difficult to achieve. This change

will help to prevent a cycle of changes in evaluations followed by further examinations, further changes in evaluations, etc.

We modernized the title of § 4.129 to "Mental disorders due to traumatic stress," and it includes the requirement from the former § 4.131 to assign an evaluation of not less than 50 percent when a mental disorder that develops in service as a result of a highly stressful event is severe enough to cause the veteran's release from active service.

We retained the substance of the former § 4.131, "Mental disorders due to psychic trauma," in § 4 129 and deleted § 4.131.

There were four notes in § 4.132 following the rating formula for psychoneuroses. We deleted note (2) as redundant, since §§ 4.125 and 4.126 and the general rating formula set forth clear diagnostic and evaluation requirements. We incorporated the regulatory content of note (3) (regarding the return of an inadequate examination report to the examiner), and note (1) under DC 9511 (concerning the diagnosis of psychological disorders) into § 4.125 and deleted the part of note (3) that discussed the diagnosis of conversion disorder as unnecessary, since this is discussed in detail in DSM-IV.

We incorporated the regulatory content of note (2) under DC 9511, regarding a single condition diagnosed both as a mental and a physical disorder, into § 4.126 in order to keep in one place all of the regulatory material on evaluation of mental disorders.

We retitled § 4.130 "Schedule of ratings--mental disorders."

Section 4.16(c), § 4.131, and § 4.132 are removed.

Diagnostic codes revised	Diagnostic codes added	Diagnostic codes removed	
9205	9211	9206	9507
9208	9326	9207	9508
9210	9327	9209	9509
9300	9412	9302	9510
9301	9413	9303	9511
9304	9416	9306	
9305	9417	9307	
9310	9421	9308	
9312	9422	9309	
9403	9423	9311	
	9424	9315	
	9425	9322	
	9431	9324	
	9432	9325	
	9433	9401	
	9434	9402	
	9435	9405	
	9520	9408	
	9521	9409	
	9440	9500	
		9501	
		9502	
		9505	
		9506	

REGULATORY AMENDMENT
4-97-1

Regulation affected: 38 CFR 4.47 through 4.56, 4.69, 4.72, and 4.73.

EFFECTIVE DATE OF REGULATION: July 3, 1997.

Date Secretary approved regulation: March 5, 1997.

Federal Register Citation: 62 FR 30235-30240 (June 3, 1997).

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended §§ 4.47 through 4.56, 4.69, 4.72, and 4.73 of 38 CFR, Part 4, the sections of the rating schedule that address muscle injuries.

Section 4.47 was, in effect, a discussion of the results of missile wounds on muscles, pointing out that residual muscle fusion and scarring interfere with coordination and strength, and that fatigue and pain result from prolonged exertion of the injured muscles. Since this is common medical fact readily available in more complete form elsewhere, we deleted § 4.47 from the schedule. Similarly, § 4.48 was a discussion of scars resulting from wounds, emphasizing the importance of a complete examination to assess any disability arising from the scars. It was redundant because there was a regulatory requirement elsewhere that evaluations be based on a complete examination, and we deleted it.

Section 4.49 discussed residuals of wounds in deeper structures and the importance of reviewing the complete history of injury, which is also required by 38 CFR 4.1. Residuals of wounds and evaluation of evidence are discussed in Part VI of the VBA Manual and Chapter 2 of the Physician's Guide, and we deleted § 4.49 as unnecessary.

Section 4.50 recited the symptoms of missile wounds, emphasizing that it is the deeper scarring of muscles that is disabling. This information is not regulatory in nature, and we deleted it. The final three sentences of § 4.50, however, were regulatory; they specifically prohibited the evaluation of injured muscle groups which act upon ankylosed joints, with the two exceptions of the shoulder or knee joints. We incorporated all of the instructions concerning ankylosed joints into § 4.55 and deleted § 4.50 altogether.

Section 4.51 discussed muscle weakness due to injury, and the testing of muscles to evaluate occupational efficiency. Since symptoms of muscle injury are detailed in the section concerning factors for evaluating muscle disabilities (§ 4.56), we deleted § 4.51.

The section titled Muscle damage, § 4.52, discussed the anatomical structure of muscles and the effects of missile wounds, also discussing the symptoms of muscle injury. Since this subject is addressed in § 4.56, we deleted § 4.52.
Muscle patterns and the interaction of individual muscles in producing movement were discussed in § 4.53, with a list of the cardinal symptoms of muscle disability. These cardinal symptoms are an important factor in the evaluation of muscle injuries, and we moved them to § 4.56, the section dealing with evaluation of muscle injuries. Since the remaining material dealing with muscle patterns and the mechanics of movement in § 4.53 was medical in nature and not regulatory, we deleted it.

Section 4.54 listed the muscle groups and anatomical regions, repeated the cardinal symptoms of muscle disability, and listed the cardinal signs of muscle injuries. For the sake of clarity, we deleted § 4.54 and incorporated the portion dealing with muscle groups and anatomical regions into § 4.55, and the portion addressing cardinal signs and symptoms of muscle injury into § 4.56.

The scheme for rating muscle injuries placed individual muscles into 23 muscle groups, each with its own diagnostic code. Each muscle group was assigned to one of five anatomical regions: (1) the shoulder girdle and arm, (2) the forearm and hand, (3) the foot and leg, (4) the pelvic girdle and thigh, or (5) the torso and neck. The former schedule had interchangeable references to anatomical "regions" and "segments." For the sake of consistency, we used only anatomical regions.

In § 4.55, in addition to the revisions of paragraphs (a) through (f) described above, we removed paragraph (g), which stated that muscle injury ratings will not be combined with peripheral nerve paralysis for the same part, unless affecting entirely different functions because we have made § 4.55 deal exclusively with the principles of rating muscle injuries. We revised paragraph (d) to require that the combined evaluation of muscle groups acting upon a single unankylosed joint must be lower than the evaluation for unfavorable ankylosis of that joint.
Section 4.56 defined the four levels of muscle disability and the type of injury, history and complaint of the injury, and objective findings for each. We revised the descriptions of the various levels of muscle injury for clarity. The descriptions of objective findings within the categories of moderate and moderately severe injuries used the subjective adjectives "moderate" and "moderately severe." We deleted these words since they caused confusion within the categories by using the same words to describe the terms they were defining, and we deleted the word "marked" as ambiguous.

In part, § 4.72 described the significance of fractures and wounds. Since fractures are now classified in medical practice as either open or closed, we changed the term "compound" comminuted fracture, which is currently used in this section, to "open" comminuted fracture. Two regulatory instructions were stated in § 4.72, the first concerning evaluation of open comminuted fractures and the second concerning evaluation of through and through missile wounds. For ease of reference, we put these instructions under § 4.56 with the other factors relating to evaluation of muscle disabilities. We deleted the phrase "from the missile," since muscle wounds may also be due to other causes. With the rearranging of these regulatory instructions into § 4.56, we deleted § 4.72.

We listed the functions of the muscle group under each diagnostic code ahead of the specific muscles which comprise the group and perform those movements to simplify the rating process by identifying the muscle group by functional disability rather than by the names of the individual muscles involved.

The preferred medical terms describing handedness are "dominant" and "nondominant," and we substituted these designations for "major" and "minor," and changed the heading of § 4.69 to avoid confusion. We also amended § 4.69 to indicate that in an ambidextrous individual, the injured hand, or the most severely injured, will be considered the dominant hand for rating purposes.

The 50 percent level under diagnostic code 5317 (gluteus muscles) included a footnote directing that entitlement to special monthly compensation be considered when bilateral function of the buttocks is severely impaired. We retained the footnote and also added a note under § 4.73, preceding the coded evaluations of disabilities, instructing raters to refer to § 3.350 whenever they rate a muscle injury which has resulted in loss of use of any extremity or loss of use of both buttocks. We believe that this combination of note and footnote will be the most effective way to ensure complete review for special monthly compensation.

Since the word "neoplasm" connotes a pathological abnormality better than the term "new growth," we substituted that word under diagnostic codes 5327 and 5328, which pertain to malignant and benign muscle conditions, respectively.

Diagnostic codes 5327 (malignancies of muscles) and 5329 (soft tissue sarcomas) provided a 100 percent evaluation for six months following surgery or the cessation of antineoplastic therapy. We revised these codes to continue the total evaluation indefinitely after treatment is discontinued, and to examine the veteran six months thereafter. If the results of this or any subsequent examination warrant a reduction in evaluation, the reduction will be implemented under the provisions of 38 CFR 3.105(e). This method is the same as that used in other revised body systems.

We changed the heading of § 4.56 to "Evaluation of muscle disabilities" and of § 4.69 to "Dominant hand."

In DC 5325, "Muscle injury, facial muscles," we revised the evaluation instructions by directing that functional impairment due to injury to facial muscles be evaluated as seventh (facial) cranial nerve neuropathy (DC 8207), disfiguring scar (DC 7800), etc.

We added a the note at the beginning of § 4.73, referring to § 3.350, to clearly remind rating specialists that there is potential entitlement to special monthly compensation when evaluating any muscle injuries resulting in loss of use of any extremity or of both buttocks.

We also corrected the list of the plantar group of intrinsic muscles of the foot under Group X (DC 5310) by removing "opponens digiti V" (a hand muscle), moving "dorsal interossei" from the dorsal group (the plantar and dorsal interossei are both considered plantar muscles in standard anatomy textbooks), changing "flexor hallucis" to "flexor hallucis brevis," its more complete name, in order to distinguish it from "flexor hallucis longus," a muscle in another group, and changing "abductor hallucis" to "adductor hallucis." We changed "V" to the current designation "minimi" wherever "V" was used to indicate the fifth digit. We added "peroneus brevis" and "plantaris" to the list of posterior and lateral crural muscles and muscles of the calf in Group XI (DC 5311) because standard anatomy textbooks place them in this group. We changed "long extensors of toes" in Group XII (DC 5312) to "extensor digitorum longus" and "extensor hallucis longus," the specific names of these muscles.

We made several other nonsubstantive, editorial changes to the proposed rule based on our own review of the proposed regulation.

REGULATORY AMENDMENT
4-97-2

Regulation affected: 38 CFR 4.100, 4.101, 4.102, and 4.104.

EFFECTIVE DATE OF REGULATION: January 12, 1998

Date Secretary approved regulation: August 7, 1997

Federal Register Citation: 62 FR 65207-65224 (December 11, 1997)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended sections 4.100, 4.101, 4.102, and 4.104 of CFR, Part 4, the sections of the rating schedule that address the cardiovascular system. The intended effect of this action is to update this portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

We removed introductory sections 4.100, 4.101, and 4.102 for several reasons. Some of the material in them pertained to issues of service connection, which belong in the regulations beginning at 38 CFR 3.303, rather than in the rating schedule, which is intended as a guide to evaluation. Some material in the removed sections was general medical information about the types and course of heart disease, some of it now obsolete, and it did not bear on evaluation. Some material discussed issues related to the diagnosis of heart disease, but diagnosis is the responsibility of the examiner. The information about varicose veins in former § 4.102 became unnecessary in view of the revised evaluation criteria for varicose veins. The material about determining the separate effects of coexisting heart diseases was moved to a note in § 4.104.

We changed the title of DC 7000 from "rheumatic heart disease" to "valvular heart disease (including rheumatic heart disease)" to include all types of valvular heart disease, including traumatic. We changed the period of convalescence evaluation following active infection with valvular heart damage from six months to three months, in view of current medical information about the course of the condition. We provided a new set of more objective evaluation criteria for valvular heart disease and most other types of heart disease, based on such clinical or laboratory findings as the level of METs (metabolic equivalents) at which cardiac symptoms develop; the presence of chronic or recurrent congestive heart failure, the extent of ventricular dysfunction, as assessed by the ventricular ejection fraction; objective evidence of cardiac hypertrophy or dilatation; and whetheror a requirement for continuous medication. These remove the necessity of interpreting the meaning of "moderate exertion" or whether "more than light manual labor is not feasible."

One MET is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. The calculation of work activities in multiples of METs is a useful measurement for assessing disability. METs are measured by means of a treadmill exercise test, which is the most widely used test for diagnosing coronary artery disease and for assessing the ability of the coronary circulation to deliver oxygen according to the metabolic needs of the myocardium. Because administering a treadmill exercise test may not be feasible in some instances, we indicated in a note at the beginning of § 4.104 that when a treadmill test cannot be done for medical reasons, the examiner's estimation of the level of activity, expressed in METs and supported by examples of specific activities, such as slow stair climbing, or shoveling snow, that results in dyspnea, fatigue, angina, dizziness, or syncope, is acceptable as an alternative. The alternative objective evaluation criteria, such as cardiac hypertrophy or dilatation, decreased left ventricular ejection fraction, and congestive heart failure, may also be used in those cases.

A 100-percent evaluation is warranted if a workload of three METs or less produces dyspnea, fatigue, angina, dizziness, or syncope. A workload of three METs represents such activities as level walking, driving, and very light calisthenics. A 60-percent evaluation is warranted if a workload of greater than three METs but not greater than five METs results in cardiac symptoms. Activities that fall into this range include walking two and a half miles per hour, social dancing, light carpentry, etc. A 30-percent evaluation is warranted if a workload of greater than five METs but not greater than seven METs produces symptoms. Activities that fall into this range include slow stair climbing, gardening, shoveling light earth, skating, bicycling at a speed of nine to ten miles per hour, carpentry, and swimming. Some conditions also include a 10-percent evaluation, that is warranted if symptoms develop at a workload of greater than 7 METs but not greater than 10 METs. Activities that fall into this range include jogging, playing basketball, digging ditches, and sawing hardwood. When symptoms develop only during such activities, there may be some impairment of earning capacity, but it is likely to be slight. The alternative of the need for continuous medication warrants a 10-percent evaluation for some conditions.

We provided the same METs-based and other objective criteria for the evaluation of endocarditis (DC 7001), pericarditis (DC 7002), pericardial adhesions (DC 7003), syphilitic heart disease (DC 7004), arteriosclerotic heart disease (DC 7005), myocardial infarction (DC 7006), hypertensive heart disease (DC 7007), ventricular arrhythmias (DC 7011), atrioventricular block (DC 7015), heart valve replacement (DC 7016), coronary bypass surgery (DC 7017), and two newly added conditions—cardiac transplantation (DC 7019), and cardiomyopathy (DC 7020). They are also provided as alternative criteria for implantable cardiac pacemakers (DC 7018), another newly added condition. DC 7018 will otherwise be evaluated the same as supraventricular arrhythmias (DC 7010). We provided more objective criteria for the evaluation of supraventricular arrhythmias, based on the number of episodes per year of supraventricular arrhythmias or whether there is permanent atrial fibrillation. We removed the former evaluation criteria for hyperthyroid heart disease (DC 7008) and instead directed several possible ways of evaluation, depending on the specific findings, including under hyperthyroidism (DC 7900) or under supraventricular arrhythmias (DC 7010).

We removed permanent auricular fibrillation (DC 7012), paroxysmal tachycardia (DC 7013), and sinus tachycardia (DC 7014) in favor of using two codes for all arrhythmias—DC 7010 for supraventricular arrhythmias and DC 7011 for ventricular arrhythmias. These two codes distinguish between the ordinarily milder supraventricular arrhythmias, with evaluations of ten or 30 percent, and the more potentially disabling ventricular arrhythmias, with a range of evaluation from ten to 100 percent. We eliminated the need for a distinction between complete and incomplete heart block in the assessment of atrioventricular block (DC 7015) because the symptoms and severity of heart block of each type vary from individual to individual, and an assessment on the actual disabling symptoms that are present is more equitable than an evaluation based solely on the type of heart block. An evaluation of 100 percent under DC 7011 is also warranted if an Automatic Implantable Cardioverter-Defibrillator (AICD), a device used to treat supraventricular arrhythmias that has the potential for serious complications, is present.

We added several new conditions, based on the fact that they occur commonly enough in veterans to warrant inclusion in the schedule: implantable cardiac pacemakers (DC 7018), cardiac transplantation (DC 7019), and cardiomyopathy (DC 7020). Pacemakers were formerly included under auriculoventricular block (DC 7015), but we provided a separate code because pacemakers are used for conditions other than heart blocks. Cardiac transplantation was formerly rated analogous to renal transplantation, but was not listed in the schedule. We provided evaluation criteria for cardiac transplantation identical to those for most other heart diseases, based on a METs assessment or other objective findings, except that we stipulated a minimum evaluation of 30 percent, because of the ongoing need for immunosuppressive therapy in this condition. Cardiomyopathy has similar criteria but no minimum evaluation.

We removed "general arteriosclerosis" (DC 7100) because it was too broad a category for appropriate evaluation, and the effects of widespread arteriosclerosis can be better evaluated under the specific disabilities in various body systems as cerebrovascular disease, renal disease, etc.

We revised the convalescence evaluations for several conditions. The previous schedule provided convalescence evaluations for six months for the following conditions: rheumatic heart disease (DC 7000); arteriosclerotic heart disease, following coronary occlusion (DC 7005); myocardial infarction (DC 7006);

and soft tissue sarcoma (of vascular origin) (DC 7123). It provided convalescence evaluations for one year for the following conditions: auriculoventricular block, with implantation of a pacemaker (DC 7015); heart valve replacement (DC 7016); coronary artery bypass (DC 7017); and aortic aneurysm, following surgical correction (DC 7110). We changed the duration of convalescence evaluations for DC's 7000, 7005, and 7006 to three months; for DC 7018 (pacemaker implantation, formerly DC 7015) to two months; and for DC 7017 to three months. We proposed an indefinite period of convalescence evaluation with an examination at six months for DC's 7016, 7110, 7011 (now ventricular arrhythmias), 7111 (aneurysm of any large artery), and 7123 (soft-tissue sarcoma). We also provided an indefinite period of convalescence evaluation, but with an examination at one year, for cardiac transplantation (DC 7019). The new periods of convalescence evaluation reflect, according to medical sources we consulted, the average periods of recovery needed by the average person following certain procedures and illnesses. They can, of course, be extended, when medically warranted, under the authority of 38 CFR 4.29 and 4.30. The indefinite periods of convalescence require application of the notice and effective date provisions of 38 CFR 3.105(e) before a change in evaluation can be made.

In response to comments that it was needed to assure consistency, we added a note under hypertensive vascular disease (DC 7101) stating what the term hypertension means, and also added what the term "isolated systolic hypertension" means, for purposes of evaluation under § 4.104. We also specified the number of readings required (two or more times on at least three different days) to confirm the diagnosis of hypertension, because the former schedule gave an indefinite recommendation. We moved the provision for a ten-percent evaluation when hypertension is controlled by continuous medication and there is a history of diastolic blood pressure predominantly 100 or more from a note to the criteria for a ten-percent evaluation. We also added "systolic blood pressure predominantly 160 or more" to the criteria for a ten-percent evaluation to indicate the appropriate evaluation for isolated systolic hypertension of this extent.

We edited and made more objective the criteria for evaluating aortic aneurysm (DC 7110) by providing a 100-percent evaluation if the aneurysm is 5 cm. or greater in diameter or if it is symptomatic. Under DC 7111, aneurysm of any large artery is evaluated at 100 percent if it is symptomatic. Since the aorta is the largest artery in the body, it would be inconsistent and inequitable not to allow the same evaluation that the schedule provides for symptomatic aneurysms of other large arteries.

The previous schedule established a minimum evaluation of 20 percent following surgical correction of an aortic aneurysm (DC 7110). Because there is a wide range of possible complications and residual disability following surgical correction of an aortic aneurysm, depending on such factors as the location of the aneurysm, its type (dissecting or not), etc., with some warranting a higher, and some a lower, evaluation than 20 percent, we removed the minimum evaluation in favor of a direction to evaluate the actual residuals.

For the sake of consistency, we also provided objective criteria for aneurysm of any large artery (DC 7111), in place of the former subjective requirement that the lower extremities be "symptomatic" (for 60 percent) or the upper extremities be "symptomatic" (for 40 percent). As with aortic aneurysm, a 100-percent evaluation is required if symptomatic, or for an indefinite period from the date of hospital admission for correction. There is a range of evaluation levels for the postoperative state based on the objective criteria of severity of claudication, the ankle/brachial index, and the presence of trophic changes, ulcers, rest pain, and whether the extremity is cold. The same criteria apply to arteriosclerosis obliterans (DC 7114) and thrombo-angiitis obliterans (DC 7115). Those two conditions, plus intermittent claudication (DC 7166), which we removed because it is a symptom and not a disease, were all formerly evaluated under the same set of criteria, which were based on findings similar to, but more subjective than, the new criteria. We added three notes under DC 7111, the first explaining the ankle/brachial index, the second explaining the method of evaluation when more than one extremity is affected, and the third describing the method of postoperative convalescence evaluation.

The previous schedule provided a 10-percent evaluation for aneurysm of any small artery (DC 7112). We changed the evaluation for asymptomatic aneurysm of a small artery to zero percent, since asymptomatic small artery aneurysms are found in about five percent of the population and are not

considered disabling. Symptomatic aneurysms can be evaluated under the appropriate body system, depending on the actual findings, and we added a note directing how to evaluate them.

We changed the title of DC 7113 from "arteriovenous aneurysm, traumatic," to the currently accepted term for the condition, "arteriovenous fistula, traumatic," because the condition represents a direct communication between an artery and a vein rather than an aneurysm of a blood vessel. For the sake of more objectivity, we revised the criteria under DC 7113 to include such findings as enlarged heart, wide pulse pressure, tachycardia, edema, stasis dermatitis, ulceration, and cellulitis, in place of the former indefinite criteria, such as "with marked vascular symptoms." In addition, because the most serious cardiac consequence of arteriovenous aneurysm is high output congestive heart failure, we added a 100-percent evaluation level for that condition.

As described above, we provided evaluation criteria for arteriosclerosis obliterans (DC 7114) and thrombo-angiitis obliterans (DC 7115) that are identical to those of the postoperative criteria for aneurysm of any large artery (DC 7111). The notes regarding the ankle/brachial index and explaining the method of evaluation when more than one extremity is affected are the same as those following DC 7111. However, we also provided another note directing that the residuals of aortic and large arterial bypass surgery or arterial graft be evaluated as arteriosclerosis obliterans, since there had been no direction on how to rate those conditions. Under DC 7115, we provided only the notes about the ankle/brachial index and the evaluation when more than one extremity is affected.

The new method of evaluation when more than one extremity is affected by peripheral arterial disease requires a separate evaluation of each affected extremity, with use of the bilateral factor when applicable. These evaluations are to be combined, as other multiple disabilities of the extremities are. These instructions replace the former notes following DC 7117, which were complex, open to misinterpretation, and could result in an evaluation for involvement of multiple extremities no higher than that for involvement of a single extremity.

The former criteria for Raynaud’s syndrome (DC 7117) required subjective assessments of the meaning of "severe form," "multiple areas," "frequent vasomotor attacks," and "occasional attacks." In addition to adding a note defining "characteristic attacks" of Raynaud's disease, for VA purposes, we provided more objective criteria for evaluation using the specific frequency of characteristic attacks, the number of digital ulcers, and whether there is autoamputation of one or more digits, in order to ensure more consistent evaluations.

The former criteria for angioneurotic edema (DC 7118) were also subjective, e.g., "severe, frequent attacks with severe manifestations." We established more objective criteria based on the typical duration of attacks, their frequency, and on whether there is laryngeal involvement. In our judgment, angioneurotic edema affecting the larynx warrants separate consideration because laryngeal edema commonly causes respiratory distress due to airway obstruction and requires emergency treatment. Laryngeal edema is serious enough that if it occurs once or twice a year, it warrants a 20-percent evaluation; if it occurs more than twice a year, it warrants a 40-percent evaluation. We also added a 10-percent evaluation level for attacks without laryngeal involvement that occur two to four times a year. These criteria will foster more consistent evaluations.

The former criteria for erythromelalgia (DC 7119) were subjective—"severe," "moderate," or "mild." We provided a note that defines "characteristic attacks" of erythromelalgia, for purposes of § 4.104, and provided evaluation criteria based on the frequency and duration of attacks and their response to treatment.

As with the peripheral arterial diseases, we revised the method of evaluating multiple extremity involvement by venous diseases. Under the previous schedule, a variety of methods were used to evaluate vascular diseases affecting the extremities, particularly when more than one extremity was affected. For example, the criteria for thrombophlebitis (DC 7121) applied to a single extremity, and if other extremities were affected, they were separately evaluated. For varicose veins (DC 7120), the criteria for a 10-percent evaluation applied to either unilateral or bilateral involvement, but at other evaluation levels, different

percentages were assigned for unilateral and bilateral involvement. There was no direction for evaluation if one extremity was more severely affected than the other. We therefore revised the method of evaluating varicose veins (DC 71720) to have the criteria apply to a single extremity, as for DC 7121, as well as arteriosclerosis obliterans (DC 7114), thrombo-angiitis obliterans (DC 7115), and postoperative aneurysm of any large artery (DC 7111).

We revised the evaluation criteria for varicose veins (DC 7120) and post-phlebitic syndrome of any etiology (DC 7121) in order to adopt the more consistent method of separately evaluating each extremity and to assure that venous conditions with similar findings receive consistent evaluations,. Varicose veins are ordinarily asymptomatic or mildly symptomatic, but may produce prolonged venous insufficiency and progress to thrombophlebitis and postphlebitic syndrome. Signs of venous insufficiency, such as edema, stasis pigmentation, ulceration, eczema, and induration, and symptoms such as aching and fatigue, are the major disabling effects of varicose veins. The size, location, extent, etc., of varicose veins, do not correlate with symptoms, and we removed those criteria as factors in evaluation. The presence or absence of impairment of the deep circulation is more an indicator of the feasibility of surgical repair than of functional impairment, and we therefore also removed references to the deep circulation and replaced them with criteria based on symptoms (such as aching and fatigue after prolonged standing or walking) or objective physical findings (such as edema, stasis pigmentation, eczema, or ulceration). These changes will allow accurate and consistent evaluations when more than one extremity is affected by varicose veins, but to different degrees.

The effects of chronic venous insufficiency are the same, whether from varicosities, thrombophlebitis, or some other cause. The postphlebitic syndrome may itself lead to the development of varicosities because of chronic venous insufficiency, and the possible manifestations and disabling effects of varicose veins and postphlebitic syndrome are very similar. We therefore used the same criteria to evaluate both conditions, with evaluation levels of 0, 10, 20, 40, 60, and 100 percent for involvement of a single extremity. We added under DC 7120: "With the following findings attributed to the effects of varicose veins," and under DC 7121: "With the following findings attributed to venous disease" in order to assure that the examiner has determined that the abnormal findings are attributed to venous disease. We changed the title of DC 7121 from "phlebitis or thrombophlebitis" to "post-phlebitic syndrome of any etiology" because both superficial and deep acute thrombophlebitis are transient conditions, but it is the chronic form of thrombophlebitis with venous insufficiency, known as "postphlebitic leg," "postphlebitic sequelae of chronic venous insufficiency," "postphlebitic syndrome," or "stasis syndrome," that is the disabling residual of thrombophlebitis.

We revised the title of DC 7122 from "frozen feet, residuals of" to "cold injury residuals" to indicate that this code may be used to evaluate any cold injury. Because cold injury produces similar tissue changes wherever it occurs, a single diagnostic code and set of evaluation criteria are adequate. However, we revised the criteria to more accurately reflect the range of effects that cold injury may produce, such as arthralgia, tissue loss, nail abnormalities, and color changes. We also deleted the bilateral evaluations in favor of evaluating each affected part separately and combining them for the overall evaluation for cold injury, similar to changes we made in the method of evaluating peripheral arterial and venous diseases of the extremities, and for the same reasons. In the case of paired extremities, the evaluations will be combined, if appropriate, in accordance with §§ 4.25 and 4.26 (as described in Note (2), following DC 7122). Note (1) has been amended to include more information about the evaluation of complications that may occur following cold injury, such as peripheral neuropathy, or squamous cell carcinoma of the skin at the site of a scar.

The former schedule provided six-months of convalescence evaluation for soft tissue sarcoma of vascular origin (DC 7123). The change to an indefinite period of a 100-percent evaluation is described earlier.

Diagnostic codes revised	Diagnostic codes removed	Diagnostic codes added
7000	7012	7018

7001	7013	7019
7002	7014	7020
7003	7100	
7004	7116	
7005		
7006		
7007		
7008		
7010		
7011		
7015		
7016		
7017		
7101		
7110		
7111		
7112		
7113		
7114		
7115		
7117		
7118		
7119		
7120		
7121		
7122		
7123		

For the reasons set out in the preamble, 38 CFR part 4, subpart B, is amended as set forth below:

PART 4--SCHEDULE FOR RATING DISABILITIES

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

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

Subpart B--Disability Ratings

§§ 4.100 through 4.102 [Removed and Reserved]

2. Sections 4.100, 4.101, 4.102 are removed and reserved.

3. Section 4.104 is revised to read as follows:

§ 4.104 Schedule of ratings—cardiovascular system.

DISEASES OF THE HEART

NOTE (1): Evaluate cor pulmonale, which is a form of secondary heart disease, as part of the pulmonary condition that causes it.

NOTE (2): One MET (metabolic equivalent) is the energy cost of standing quietly at
rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. When the level of METs at which dyspnea, fatigue, angina, dizziness, or syncope develops is required for evaluation, and a laboratory determination of METs by exercise testing cannot be done for medical reasons, an estimation by a medical examiner of the level of activity (expressed in METs and supported by specific

examples, such as slow stair climbing or shoveling snow) that results in dyspnea, fatigue, angina, dizziness, or syncope may be used.

Rating

7000 Valvular heart disease (including rheumatic heart disease):

During active infection with valvular heart damage and for three months following cessation of therapy for the active infection.....100

Thereafter, with valvular heart disease (documented by findings on physical examination and either echocardiogram, Doppler echocardiogram, or cardiac catheterization) resulting in:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100

More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent 60

Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30

Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7001 Endocarditis:

For three months following cessation of therapy for active infection with cardiac involvement.....100

Thereafter, with endocarditis (documented by findings on physical examination and either echocardiogram, Doppler echocardiogram, or cardiac catheterization) resulting in:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100

More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina,

dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60

Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30

Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7002 Pericarditis:

For three months following cessation of therapy for active infection with cardiac involvement.....100

Thereafter, with documented pericarditis resulting in:

Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100

More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60

Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30

Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7003 Pericardial adhesions:

Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100

More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60

Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30

Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7004 Syphilitic heart disease:

Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope,

or; left ventricular dysfunction with an ejection fraction of
than 30 percent.....100
More than one episode of acute congestive heart failure in the
past year, or; workload of greater than 3 METs but not greater
than 5 METs results in dyspnea, fatigue, angina, dizziness, or
syncope, or; left ventricular dysfunction with an ejection
fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs
results in dyspnea, fatigue, angina, dizziness, or syncope, or;
evidence of cardiac hypertrophy or dilatation on electrocardiogram,
echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs
results in dyspnea, fatigue, angina, dizziness, or syncope,
or; continuous medication required.....10

NOTE: Evaluate syphilitic aortic aneurysms under DC 7110 (aortic aneurysm).

7005 Arteriosclerotic heart disease (Coronary artery disease):

With documented coronary artery disease resulting in:
Chronic congestive heart failure, or; workload of 3 METs or less
results in dyspnea, fatigue, angina, dizziness, or syncope, or;
left ventricular dysfunction with an ejection fraction of less
than 30 percent.....100
More than one episode of acute congestive heart failure in the
past year, or; workload of greater than 3 METs but not greater
than 5 METs results in dyspnea, fatigue, angina, dizziness, or
syncope, or; left ventricular dysfunction with an ejection
fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs
results in dyspnea, fatigue, angina, dizziness, or syncope, or;
evidence of cardiac hypertrophy or dilatation on
electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs
results in dyspnea, fatigue, angina, dizziness, or syncope,
or; continuous medication required.....10

NOTE: If nonservice-connected arteriosclerotic heart disease is superimposed on service-connected valvular or other non-arteriosclerotic heart disease, request a medical opinion as to which condition is causing the current signs and symptoms.

7006 Myocardial infarction.

During and for three months following myocardial infarction,
documented by laboratory tests.....100

Thereafter:
With history of documented myocardial infarction, resulting in:
Chronic congestive heart failure, or; workload of 3 METs or
less results in dyspnea, fatigue, angina, dizziness, or syncope,
or; left ventricular dysfunction with an ejection fraction of
less than 30 percent.....100

More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7007 Hypertensive heart disease:

Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7008 Hyperthyroid heart disease:

Include as part of the overall evaluation for hyperthyroidism under DC 7900. However, when atrial fibrillation is present, hyperthyroidism may evaluated either under DC 7900 or under DC 7010 (supraventricular arrhythmia), whichever results in a higher evaluation.

7010 Supraventricular arrhythmias:

Paroxysmal atrial fibrillation or other supraventricular tachycardia, with more than four episodes per year documented by ECG or Holter monitor.....30
Permanent atrial fibrillation (lone atrial fibrillation), or; one to four episodes per year of paroxysmal atrial fibrillation or other supraventricular tachycardia documented by ECG or Holter monitor.....10

7011 Ventricular arrhythmias (sustained):

For indefinite period from date of hospital admission for initial evaluation and medical therapy for a sustained ventricular arrhythmia, or; for indefinite period from date of hospital admission for ventricular aneurysmectomy, or; with an automatic implantable Cardioverter-Defibrillator (AICD) in place.....100

Chronic congestive heart failure, or; workload of 3 METs or less results

in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent 100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent 60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

NOTE: A rating of 100 percent shall be assigned from the date of hospital admission for initial evaluation and medical therapy for a sustained ventricular arrhythmia or for ventricular aneurysmectomy. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

7015 Atrioventricular block:

Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent 100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 ercent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication or a pacemaker required.....10

NOTE: Unusual cases of arrhythmia such as atrioventricular block associated with a supraventricular arrhythmia or pathological bradycardia should be submitted to the Director, Compensation and Pension Service. Simple delayed P-R conduction time, in the absence of other evidence of cardiac disease, is not a disability.

7016 Heart valve replacement (prosthesis):

For indefinite period following date of hospital admission for valve replacement.....100

Thereafter:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent 100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs

results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

NOTE: A rating of 100 percent shall be assigned as of the date of hospital admission for valve replacement. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

7017 Coronary bypass surgery:

For three months following hospital admission for surgery.....100

Thereafter:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent 100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent 60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

7018 Implantable cardiac pacemakers.

For two months following hospital admission for implantation or reimplantation.....100

Thereafter:
Evaluate as supraventricular arrhythmias (DC 7010), ventricular arrhythmias (DC 7011), or atrioventricular block (DC 7015).
Minimum.....10

NOTE: Evaluate implantable Cardioverter-Defibrillators (AICD's) under DC 7011.

7019 Cardiac transplantation:

For an indefinite period from date of hospital admission for cardiac transplantation.....100

Thereafter:
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.....100

More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Minimum.....30

NOTE: A rating of 100 percent shall be assigned as of the date of hospital admission for cardiac transplantation. One year following discharge,the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

7020 Cardiomyopathy:

Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent 100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent.....60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray.....30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required.....10

DISEASES OF THE ARTERIES AND VEINS

7101 Hypertensive vascular disease (hypertension and isolated systolic hypertension).

Diastolic pressure predominantly 130 or more.....60
Diastolic pressure predominantly 120 or more.....40
Diastolic pressure predominantly 110 or more, or; systolic pressure predominantly 200 or more... 20
Diastolic pressure predominantly 100 or more, or; systolic pressure predominantly 160 or more, or; minimum evaluation for an individual with a history of diastolic pressure predominantly 100 or more who requires continuous medication for control.....10

NOTE (1): Hypertension or isolated systolic hypertension must be confirmed by readings taken two or more times on at least three different days. For purposes of this section, the term hypertension means that the diastolic blood pressure is predominantly 90mm. or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm. or greater with a diastolic blood pressure of less than 90mm.

NOTE (2): Evaluate hypertension due to aortic insufficiency or hyperthyroidism, which is usually the isolated systolic type, as part of the condition causing it rather than by a separate evaluation.

7110 Aortic aneurysm:

If five centimeters or larger in diameter, or; if symptomatic, or; for indefinite

period from date of hospital admission for surgical correction (including any type of graft insertion)....100
Precluding exertion....60
Evaluate residuals of surgical correction according to organ systems affected.

NOTE: A rating of 100 percent shall be assigned as of the date of admission for surgical correction. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

7111 Aneurysm, any large artery:

If symptomatic, or; for indefinite period from date of hospital admission for surgical correction....100

Following surgery:
Ischemic limb pain at rest, and; either deep ischemic ulcers or ankle/brachial index of 0.4 or less....100
Claudication on walking less than 25 yards on a level grade at 2 miles per hour, and; persistent coldness of the extremity, one or more deep ischemic ulcers, or ankle/brachial index of 0.5 or less....60
Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour, and; trophic changes (thin skin, absence of hair, dystrophic nails) or ankle/brachial index of 0.7 or less....40
Claudication on walking more than 100 yards, and; diminished peripheral pulses or ankle/brachial index of 0.9 or less....20

NOTE (1): The ankle/brachial index is the ratio of the systolic blood pressure at the ankle (determined by Doppler study) divided by the simultaneous brachial artery systolic blood pressure. The normal index is 1.0 or greater.

NOTE (2): These evaluations are for involvement of a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor, if applicable.

NOTE (3): A rating of 100 percent shall be assigned as of the date hospital admission for surgical correction. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

7112 Aneurysm, any small artery:

Asymptomatic....0

NOTE: If symptomatic, evaluate according to body system affected. Following surgery, evaluate residuals under the body system affected.

7113 Arteriovenous fistula, traumatic:

With high output heart failure....100
Without heart failure but with enlarged heart, wide pulse pressure, and tachycardia....60
Without cardiac involvement but with edema, stasis dermatitis, and either ulceration or cellulitis:
Lower extremity....50
Upper extremity....40

With edema or stasis dermatitis:
Lower extremity.....30
Upper extremity.....20

7114 Arteriosclerosis obliterans:

Ischemic limb pain at rest, and; either deep ischemic ulcers or ankle/brachial index of 0.4 or less.....100
Claudication on walking less than 25 yards on a level grade at 2 miles per hour, and; either persistent coldness of the extremity or ankle/brachial index of 0.5 or less.....60
Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour, and; trophic changes (thin skin, absence of hair, dystrophic nails) or ankle/brachial index of 0.7 or less.....40
Claudication on walking more than 100 yards, and; diminished peripheral pulses or ankle/brachial index of 0.9 or less.....20

NOTE (1): The ankle/brachial index is the ratio of the systolic blood pressure at the ankle (determined by Doppler study) divided by the simultaneous brachial artery systolic blood pressure. The normal index is 1.0 or greater.

NOTE (2): Evaluate residuals of aortic and large arterial bypass surgery or arterial graft as arteriosclerosis obliterans.

NOTE (3): These evaluations are for involvement of a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.

7115 Thrombo-angiitis obliterans (Buerger's Disease):

Ischemic limb pain at rest, and; either deep ischemic ulcers or ankle/brachial index of 0.4 or less.....100
Claudication on walking less than 25 yards on a level grade at 2 miles per hour, and; either persistent coldness of the extremity or ankle/brachial index of 0.5 or less.....60
Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour, and; trophic changes (thin skin, absence of hair, dystrophic nails) or ankle/brachial index of 0.7 or less.....40
Claudication on walking more than 100 yards, and; diminished peripheral pulses or ankle/brachial index of 0.9 or less.....20

NOTE (1): The ankle/brachial index is the ratio of the systolic blood pressure at the ankle (determined by Doppler study) divided by the simultaneous brachial artery systolic blood pressure. The normal index is 1.0 or greater.

NOTE (2): These evaluations are for involvement of a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.

7117 Raynaud's syndrome:

With two or more digital ulcers plus autoamputation of one or more digits and history of characteristic attacks.....100
With two or more digital ulcers and history of characteristic attacks.....60
Characteristic attacks occurring at least daily.....40
Characteristic attacks occurring four to six times a week.....20

Characteristic attacks occurring one to three times a week.....10

NOTE: For purposes of this section, characteristic attacks consist of sequential color changes of the digits of one or more extremities lasting minutes to hours, sometimes with pain and paresthesias, and precipitated by exposure to cold or by emotional upsets. These evaluations are for the disease as a whole, regardless of the number of extremities involved or whether the nose and ears are involved.

7118 Angioneurotic edema:

Attacks without laryngeal involvement lasting one to seven days or longer and occurring more than eight times a year, or; attacks with laryngeal involvement of any duration occurring more than twice a year.....40
Attacks without laryngeal involvement lasting one to seven days and occurring five to eight times a year, or; attacks with laryngeal involvement of any duration occurring once or twice a year.....20
Attacks without laryngeal involvement lasting one to seven days and occurring two to four times a year.....10

7119 Erythromelalgia:

Characteristic attacks that occur more than once a day, last an average of more than two hours each, respond poorly to treatment, and that restrict most routine daily activities.....100
Characteristic attacks that occur more than once a day, last an average of more than two hours each, and respond poorly to treatment, but that do not restrict most routine daily activities.....60
Characteristic attacks that occur daily or more often but that respond to treatment.....30
Characteristic attacks that occur less than daily but at least three times a week and that respond to treatment.....10

NOTE: For purposes of this section, a characteristic attack of erythromelalgia consists of burning pain in the hands, feet, or both, usually bilateral and symmetrical, with increased skin temperature and redness, occurring at warm ambient temperatures. These evaluations are for the disease as a whole, regardless of the number of extremities involved.

7120 Varicose veins:

With the following findings attributed to the effects of varicose veins:
Massive board-like edema with constant pain at rest.....100
Persistent edema or subcutaneous induration, stasis pigmentation or eczema, and persistent ulceration 60
Persistent edema and stasis pigmentation or eczema, with or without intermittent ulceration.....40
Persistent edema, incompletely relieved by elevation of extremity, with or without beginning stasis pigmentation or eczema.....20
Intermittent edema of extremity or aching and fatigue in leg after prolonged standing or walking, with symptoms relieved by elevation of extremity or compression hosiery.....10
Asymptomatic palpable or visible varicose veins.....0

NOTE: These evaluations are for involvement of a single extremity. If more than one extremity is involved, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.

7121 Post-phlebitic syndrome of any etiology:

With the following findings attributed to venous disease:
Massive board-like edema with constant pain at rest.....100
Persistent edema or subcutaneous induration, stasis pigmentation or eczema, and persistent ulceration.....60
Persistent edema and stasis pigmentation or eczema, with or without intermittent ulceration.....40
Persistent edema, incompletely relieved by elevation of extremity, with or without beginning stasis pigmentation or eczema.....20
Intermittent edema of extremity or aching and fatigue in leg after prolonged standing or walking, with symptoms relieved by elevation of extremity or compression hosiery.....10
Asymptomatic palpable or visible varicose veins.....0

NOTE: These evaluations are for involvement of a single extremity. If more than one extremity is involved, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.

7122 Cold injury residuals:

With pain, numbness, cold sensitivity, or arthralgia plus two or more of the following: tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, X-ray abnormalities (osteoporosis, subarticular punched out lesions, or osteoarthritis) of affected parts.....30
With pain, numbness, cold sensitivity, or arthralgia plus tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, or X-ray abnormalities (osteoporosis, subarticular punched out lesions, or osteoarthritis) of affected parts.....20
With pain, numbness, cold sensitivity, or arthralgia.....10

NOTE (1): Amputations of fingers or toes, and complications such as squamous cell carcinoma at the site of a cold injury scar or peripheral neuropathy should be separately evaluated under other diagnostic codes.

NOTE (2): Evaluate each affected part (hand, foot, ear, nose) separately and combine the ratings, if appropriate, in accordance with §§ 4.25 and 4.26.

7123 Soft tissue sarcoma (of vascular origin).....100

NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.

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

REGULATORY AMENDMENT
4-98-1

Regulation affected: 38 CFR 4.104.

EFFECTIVE DATE OF REGULATION: August 13, 1998

Date Secretary approved regulation: June 30, 1998

Federal Register Citation: 63 FR 37778-79 (July 14, 1998)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

In the Federal Register of March 28, 1997 (62 FR 14832) we published a proposal to revise the provisions of VA's rating schedule (38 CFR part 4) governing evaluations for frozen feet (38 CFR 4.104, diagnostic code 7122). As part of a final rule published in the Federal Register on December 11, 1997, revising the cardiovascular portion of the rating schedule, we adopted the revision proposed on March 28, 1997, with only minor changes. This final rule responds to comments received in response to the proposed rule and makes additional nonsubstantive technical changes. It also expands the discussion of possible residual effects in note (1).

In the evaluation criteria, we changed "pain" to "arthralgia or other pain" to emphasize the relatively new concept that arthralgia may result from cold injury, and we added a direction in note (1) to separately evaluate other disabilities that are determined to be residuals of cold injury, such as Raynaud's phenomenon and muscle atrophy, unless they are used to support an evaluation under diagnostic code 7122, in response to a comment.

For the reasons set out in the preamble, 38 CFR part 4, subpart B, is amended as set forth below:

Part 4--SCHEDULE FOR RATING DISABILITIES

Subpart B—Disability Ratings

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

AUTHORITY: 38 U.S.C. 1155 unless otherwise noted.

2. Section 4.104 is amended by revising diagnostic code 7122 to read as follows:

§ 4.104 Schedule of ratings—cardiovascular system.

* * * * *

7122 Cold injury residuals.

With the following in affected parts: Arthralgia or other pain, numbness, or cold sensitivity plus two or more of the following: tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, X-ray abnormalities (osteoporosis, subarticular punched out lesions, or osteoarthritis)……..…….30
Arthralgia or other pain, numbness, or cold sensitivity plus tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, or X-ray abnormalities (osteoporosis, subarticular punched out lesions, or osteoarthritis)…… 20
Arthralgia or other pain, numbness, or cold sensitivity ……10

NOTE (1): Separately evaluate amputations of fingers or toes, and complications such as squamous cell carcinoma at the site of a cold injury scar or peripheral neuropathy, under other diagnostic codes. Separately evaluate other disabilities that have been diagnosed as the residual effects of cold injury, such as Raynaud's phenomenon, muscle atrophy, etc., unless they are used to support an evaluation under diagnostic code 7122.

NOTE (2): Evaluate each affected part (e.g., hand, foot, ear, nose) separately and combine the ratings in accordance with §§ 4.25 and 4.26.

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

REGULATORY AMENDMENT
4-99-1

Regulation affected: 38 CFR 4.85, 4.86, 4.87, 4.87a, and 4.87b.

EFFECTIVE DATE OF REGULATION: June 10, 1999.

Date Secretary approved regulation: January 8, 1999.

Federal Register Citation: 64 FR 25202 (May 11, 1999).

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of its ongoing revision of the Schedule for Rating Disabilities, the Department of Veterans Affairs (VA) has amended sections 4.85 through 4.87b of 38 CFR, Part 4, the sections of the rating schedule that address the ear and other sense organs. The intended effect of this action is to update this portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

We revised introductory section 4.85 to indicate that an examination for hearing impairment must be conducted by a state-licensed audiologist, to state what puretone frequencies are averaged to obtain the puretone threshold average and to state that it is the Maryland CNC speech discrimination test that must be used, to direct that if only one ear is service-connected, the NSC ear will be assigned a hearing impairment level of I, and to refer the rater to 38 CFR 3.383 for consideration of SMC in any claim for impaired hearing. Section 4.86 was revised to provide directions on evaluating veterans with either of two exceptional patterns of hearing impairment. This change is based on a VHA study indicating that without these special provisions, these small groups of veterans would be underrated. We removed § 4.86a and revised 4.87 by providing more objective criteria for peripheral vestibular disorders, DC 6204, (formerly chronic labyrinthitis) and Meniere's syndrome, DC 6205. We removed DC 6206, mastoiditis, and included mastoiditis with chronic suppurative otitis media and cholesteatoma in DC 6200, since these are closely related and often co-existent. We removed DC 6203, otitis interna, as an obsolete term. The condition is included in DC 6204. More detailed explanations for some of these changes are included in the "Supplementary Information" section of both the final revision, which is enclosed, and the proposed revision, which was published in the Federal Register on April 12, 1994 (59 FR 17295).

Diagnostic codes revised	Diagnostic codes removed	Diagnostic codes added
6200	6203	
6201	6206	None
6204	6101	
6205	6102	
6207	6103	
6208	6104	
6209	6105	
6210	6106	
6260	6107	
6275	6108	
6276	6109	
	6110	

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900-AF22

Schedule for Rating Disabilities; Diseases of the Ear and Other Sense Organs

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends that portion of the Department of Veterans Affairs (VA) Schedule for Rating Disabilities that addresses the ear and other sense organs. The intended effect of this action is to update this portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances that have occurred since the last review.

DATES: Effective Dates: This amendment is effective June 10, 1999.

FOR FURTHER INFORMATION CONTACT: Vickie Milton, M.D., Consultant, Regulations Staff (211B), Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Ave., NW, Washington DC 20420, (202) 273-7230.

SUPPLEMENTARY INFORMATION: As part of its review of the Schedule for Rating Disabilities, VA published a proposal to amend that portion of the Schedule pertaining to the ear and other sense organs in the Federal Register of April 12, 1994 (59 FR 17295-17301). Interested persons were invited to submit written comments on or before June 13, 1994. We received comments from the Veterans of Foreign Wars, Disabled American Veterans, and three individuals.

The evaluation of hearing impairment in the previous rating schedule was based on two criteria: the results of a puretone audiometry test and the results of a controlled speech discrimination test. Based on the results of these tests, one of two tables was used to determine a Roman numeral designation for hearing impairment: Table VI, where the number is determined by combining the percent of speech discrimination with the average puretone decibel (dB) loss, and Table VIa, which is based solely on average puretone dB loss, and was used only if language difficulties or inconsistent speech audiometric scores made use of Table VI inappropriate. The Roman numeral designations determined for each ear using Table VI or VIa were then combined using Table VII, in order to determine the percentage evaluation for hearing impairment. We proposed no change in this method of evaluation and included information about it in Sec. 4.85, ``Evaluation of hearing impairment'' and Sec. 4.86, ``Auditory acuity, hearing aids, and evidence other than puretone audiometry and controlled speech.'' In response to several comments we received about the method of evaluation, and requesting more specific details, we have reorganized Secs. 4.85 and 4.86 for the sake of clarity, as explained in detail below.

One commenter stated that nowhere is VA's authority to use the specific hearing tests it uses spelled out in the regulations. We agree that the tests required were not specified in the rating schedule and have therefore stated in Sec. 4.85(a) that the Maryland CNC speech discrimination test and the puretone audiometry test are to be used for evaluating hearing impairment. The use of the Maryland CNC speech discrimination test and the puretone threshold average determined by an audiometry test was established by a regulation on the evaluation of hearing loss published in the Federal Register on November 18, 1987 (52 FR 44117). That regulation changed the method of evaluating hearing loss based on a VA study on hearing loss testing methods and assistive hearing devices that had been requested by Congress in 1984. The results of the study were published in a VA report titled ``Report on Hearing Loss Study'' that was issued on January 6, 1986. Although the regulation revised the rating schedule to incorporate rating tables based on the new method of evaluation, it did not add to the schedule specific details about the new testing methods.

One commenter stated that if only VA examinations or authorized audiological clinic examinations are to be used, this should be stated in the proposed regulation. Based on this comment, we have stated in Sec. 4.85(a) that an examination for hearing impairment for VA purposes must be conducted by a state-licensed audiologist. This will help to assure that examinations of veterans will be accurate and consistent because state licensing agencies require that audiologists meet specific educational and training requirements and pass a national competency examination.

Two commenters noted that the meaning of average puretone decibel loss is not explained in the rating schedule. We agree that this information should be included in the rating schedule and have added an explanation in Sec. 4.85(d). For VA purposes, the average puretone decibel loss means a four-frequency puretone threshold average obtained by adding the puretone thresholds at four specified frequencies'1000, 2000, 3000, and 4000 Hertz and dividing by four. This method and the reasons for its selection were explained in the 1987 regulation referred to above. Current terminology is ``puretone threshold average'' rather than ``average puretone decibel loss,'' and we have used this language in Sec. 4.85 and have revised the labels in Tables VI and VIa. For clarity, we have also titled Table VIa, untitled in the proposed rule, ``Numeric Designation of Hearing Impairment Based Only on Puretone Threshold Average'' and retitled Table VI, titled ``Numeric Designation of Hearing Impairment'' in the proposed rule, ``Numeric Designation of Hearing Impairment Based on Puretone Threshold Average and Speech Discrimination.'' In the proposed rule we inadvertently placed the numeric tables in Sec. 4.86, we have moved them to Sec. 4.85(h) as the more appropriate location. We removed the examples from Sec. 4.85 because the directions for using the tables are clear enough without them.

We also proposed to add two new provisions for evaluating veterans with certain patterns of hearing impairment that cannot always be accurately assessed under Sec. 4.85, because the speech discrimination test may not reflect the severity of communicative functioning these veterans experience. These veterans were identified in review studies carried out by the Veterans Health Administration's (VHA's) Audiology and Speech Pathology Service in 1991. One of the new provisions, proposed as Sec. 4.85(d), stated that if puretone thresholds in any four of the five frequencies of 500, 1000, 2000, 3000, and 4000 Hertz are 55 dB's or more, an evaluation could be based either on Table VI or Table VIa, whichever results in a higher evaluation. (This provision has been redesignated Sec. 4.86(a), as discussed below.)

One commenter, although offering no rationale for the comment, suggested that the level of hearing loss for this provision should be 50 dB instead of 55.

To conduct a speech discrimination test in someone with hearing impairment, the sounds must be amplified sufficiently for the individual to hear the words. The greater the dB threshold level, the higher the level of amplification that is needed. Up to a 50 dB threshold level, amplification sufficient to conduct a speech discrimination test is feasible. However, with a 55 dB threshold level--the level at which speech becomes essentially inaudible--the high level of amplification needed to attempt to conduct a speech discrimination test would be painful to most people, and speech discrimination tests may therefore not be possible or reliable. The new provision will allow evaluation of hearing impairment in such individuals on the basis of puretone threshold average only, if that results in a higher evaluation than one based on a combination of speech discrimination and puretone threshold average.

The same commenter suggested applying proposed Sec. 4.85(d) if three of the five specified frequencies have a threshold of 55 dB or more because the frequencies of 2000 and above are the most important frequencies for speech discrimination, and precipitous hearing impairment in the high frequencies is extremely handicapping in the work environment.

The frequencies selected and the dB threshold were chosen because VHA, through their clinical studies, found that speech discrimination studies are quite variable in veterans with a 55 dB threshold in four or more frequencies and may not accurately reflect the true extent of disability. Also based on the results of their studies, they did not extend the recommendation for an alternative method of evaluation to those with that extent of hearing impairment at only three frequencies. In view of VHA's recommendations, based on tests conducted on 1565 individuals, we make no change based on this comment.

The second provision we proposed to add (as Sec. 4.85(e)) was to direct the rating agency to choose the Roman numeral designation derived from either table VI or VIa, whichever is higher, when puretone thresholds are 30 dB or less at frequencies of 1000 Hertz and below, and are 70 dB or more at 2000 Hertz. It also directed the rating agency to elevate that Roman numeral designation one level. This provision was meant to compensate for a pattern of hearing impairment that is an extreme handicap in the presence of any environmental noise. VHA found that when this pattern of impairment is present, a speech discrimination test conducted in a quiet room with amplification of the sounds does not always reflect the extent of impairment experienced in the ordinary environment. This provision allows evaluation of hearing impairment in these individuals on puretone average only, if that results in a higher evaluation. (This provision has been redesignated Sec. 4.86(b), as discussed below.)

One commenter said it appears in proposed Sec. 4.85(d) and (e) that 500 Hertz is one of the frequencies to be used in the puretone average, although when Sec. 4.85 was revised in 1987, the supplementary information stated that puretone frequencies at 1000, 2000, 3000, and 4000 Hertz were to be used to determine the puretone threshold average. The commenter also said that the use of four frequencies in some circumstances and of five or more in others requires an explanation of why such a methodology does not give rise to disparate treatment.

In the proposed rule, the four frequency puretone threshold average was the basis of the evaluation for hearing impairment in all cases, and the 500 Hertz frequency was to be used only to help select the veterans to whom the special provisions would be applied. However, in order to remove any suggestion of disparate treatment, and after consultation with VHA, we removed the 500 Hertz stipulations from the two proposed special provisions. VHA assured us that this change would not affect the need for the special provisions and would not affect the disability ratings of any group of veterans.

One commenter suggested that the language for evaluation parallel the language of 38 CFR 3.385.

The purpose of Sec. 3.385, ``Disability due to impaired hearing,'' is to explain the basis for determining whether impaired hearing is a disability, which is different from the purpose of Sec. 4.85, which is to explain how to evaluate hearing impairment, once it has been determined to be a disability, for purposes of disability compensation. Since these regulations serve different purposes, and different frequencies are involved, the use of parallel language is neither necessary nor feasible.

When the puretone threshold average is 105 dB or more, tables VI and VIa require a numeric designation of XI, the highest level of evaluation. This is unchanged from the previous schedule. One commenter stated that a loss of greater than 92 dB, rather than 105 dB, would result in total impairment in everyone, according to the American Academy of Otolaryngology and Otolaryngology Guide for the Evaluation of Hearing Impairment.

Methods of measuring hearing impairment and assessing disability based on the results vary from one organization to another, making direct comparisons infeasible. Not all organizations use the same range of frequencies, for example, to determine a puretone threshold average. While VA uses 1000, 2000,

3000, and 4000 Hertz for evaluation, based on the results of the VA study referred to above, the American Medical Association (AMA), in its ``Guides to the Evaluation of Permanent Impairment'' 4th ed., 1993, uses 500, 1000, 2000, and 3000 Hertz. The National Institute for Occupational Safety and Health proposed using puretone thresholds at 1000, 2000, 3000, and 4000 Hertz, as has the American Speech and Hearing Association Task Force, and their rationale is that these frequencies are most sensitive to discrimination ability in quiet and in noise. Not all organizations use a speech discrimination test in evaluating hearing impairment; the AMA, for example, does not. The guide referred to by the commenter is no longer in existence, but the AMA Guides states that the criteria it uses are adapted from the 1979 Academy of Otolaryngology-Head and Neck Surgery Guide. The AMA Guides considers impairment of hearing to be total if the average of the four puretone frequencies they use is over 91.7 dB. However, total impairment of hearing under their system does not mean that a 100-percent disability evaluation is assigned. Under the AMA disability evaluation system, each disability is considered in terms of its effect on the whole person. The evaluation they would assign for a bilateral puretone threshold of 91.7 dB (in workers' compensation claims, for example) is 35 percent, not 100 percent. With a unilateral puretone threshold of 91.7 dB (with the other ear normal), the AMA system would evaluate monaural hearing impairment at 100 percent, and binaural hearing impairment at approximately 17 percent, but the actual evaluation they would assign is six percent. Thus, direct comparisons of different systems of evaluating disability due to hearing loss are not possible, and we make no change based on this comment.

One commenter pointed out that Sec. 4.86 in the previous schedule stated that evaluations are intended to make proper allowance for improvement by hearing aids and that examination to determine the improvement is not necessary. The commenter further stated that because Table VI appears to be unchanged in the proposed regulations, it would appear that Table VI continues to be built on the assumption of improvement with hearing aids and that performing audiology tests with hearing aids or adjusting the rating values based on an assumption of improvement with hearing aids violates the policy of determining impairment of body function without the use of any prosthetic device.

We are unaware of any general policy which prohibits consideration of the effect of a prosthetic device in determining the degree of impairment. In fact, there is a standard method for measuring best corrected vision, and the rating schedule requires that examinations for visual impairment include corrected, as well as uncorrected, visual acuity. However, there is no standard procedure for measuring best corrected hearing, and the amended instruction (Sec. 4.85(a)) states that examinations for hearing impairment will be conducted without the use of hearing aids. Section 4.85(a) is clear enough that, in order to avoid confusion, we have removed the language in proposed Sec. 4.86(b) stating that the evaluations are designed to measure the best residual uncorrected hearing and that examinations comparing hearing with and without hearing aids are unnecessary. VHA consultants indicated that it is well accepted in the audiological literature that the better the speech discrimination score, the better the overall result with hearing aids, but they also stated that the language in the former rating schedule about anticipated improvement by a hearing aid did not in any way affect the method of evaluation or disability ratings themselves, and that removal of that language would also have no effect on the method of evaluation or on disability ratings.

The previous Sec. 4.87 and proposed Sec. 4.86(a) defined ``impairment of auditory acuity,'' for VA purposes. However, that term is not used elsewhere in the rating schedule, although the terms ``hearing impairment,'' ``hearing loss,'' and ``deafness'' are used. We have therefore removed Sec. 4.86(a) as unnecessary and have, for the sake of clarity, used ``hearing impairment'' in all other parts of the rating schedule to designate a loss of hearing except where the statutory terms ``deafness'' or ``hearing loss'' are required (by 38 U.S.C. 1114(k)).

Former section 4.86a, ``Evidence other than puretone audiometry and controlled speech,'' explained that where claims contain evidence which predates the use of puretone audiometry and controlled speech, determination of service connection will be evaluated under the regulations in effect on December 17, 1987. We proposed to retain this instruction in Sec. 4.86(c). One commenter suggested that this is not a rating regulation and that it properly belongs in Part 3 of 38 CFR.

We agree that regulations regarding service connection are not appropriate in the rating schedule, which is used for the evaluation of disabilities, and we have removed Sec. 4.86(c). This completes the removal of the contents of proposed Sec. 4.86. We have, however, retained Sec. 4.86, retitled it ``Exceptional patterns of hearing impairment,'' and added paragraphs (a) and (b) for the two provisions that were proposed as Sec. 4.85(d) and (e). This change better highlights the unusual aspects of evaluating these uncommon patterns of hearing impairment.

The previous schedule did not provide specific instructions on evaluating bilateral hearing impairment when hearing impairment is service-connected in only one ear. One commenter suggested that we add a note indicating that a non-service-connected ear is to be treated as having normal hearing.

We concur and have added Sec. 4.85(f) to specify that a non-service-connected ear will be assigned a Roman numeral designation of I, subject to the provisions of Sec. 3.383, ``Special consideration for paired organs and extremities.'' This is consistent with the manner in which we evaluate other paired organs, where only one of the pair is service-connected (38 CFR 4.73 (muscle injuries) and 38 CFR 4.124a (diseases of the cranial and peripheral nerves)).

One commenter stated that the regulation should include a specific effective date and should state whether the regulatory change constitutes a liberalizing law or issue.

The effective date of the regulation will be 30 days after publication of this final rule in the Federal Register. The revisions of the sections addressing ear and other sense organs are part of the overall revision of the rating schedule based on medical advances, etc., rather than representing liberalizing interpretations of regulations. We have explained above the reasons for the provisions of Sec. 4.86. The preamble erred in discussing these provisions as liberalizations. Rather, they are an attempt to assure more equitable evaluations in a small number of veterans with unusual patterns of hearing impairment.

Special monthly compensation (SMC) is a benefit authorized by 38 U.S.C. 1114 that is payable in addition to the compensation payable for specific disabilities, or combinations of disabilities, based upon the extent of impairment under the Schedule for Rating Disabilities. We proposed removing the footnote regarding SMC in Table VII in favor of a single note at the end of Sec. 4.85 directing the rating agency to refer to Sec. 3.350 (``Special monthly compensation ratings'') to determine whether a claimant is entitled to SMC. One commenter suggested that we retain this footnote.

In response to the comment, and for the sake of consistency with references to SMC that we have made in other revised sections of the rating schedule, we have added this information as Sec. 4.85(g) and also restored a footnote to Table VII, Percentage Evaluations for Hearing Impairment, indicating that the rating agency is to review for entitlement to special monthly compensation under Sec. 3.350. (We proposed to put the information now in Sec. 4.85(g) in a footnote following Sec. 4.86, but moved it to Sec. 4.85 instead to remove ambiguity about whether it referred only to the provisions of Sec. 4.86 or to all hearing evaluations.) A single footnote to Table VII is adequate because we have deleted all but one diagnostic code (DC), 6100, for hearing impairment, since it is unnecessary for any practical purpose to have multiple diagnostic codes to indicate various evaluation levels of the same disability. SMC may be warranted not only when hearing impairment is evaluated at 100 percent, but also for various levels of deafness (or hearing impairment) when they occur in combination with blindness, and the single footnote will assure that SMC is always considered when there is hearing impairment. We believe that the combination of the footnote and Sec. 4.85(g) is the most effective method for ensuring complete review for special monthly compensation.

38 U.S.C. 1114(k) authorizes payment of SMC if there is absence of air and bone conduction in both ears. The implementing regulation, 38 CFR 3.350(a)(5), states that deafness of both ears, having absence of air and bone conduction, will be held to exist when bilateral hearing loss is equal to or greater than the minimum bilateral hearing loss required for a maximum rating (100 percent) under the schedule. One commenter suggested that we add a footnote to the 80- and 90-percent levels indicating entitlement to special monthly compensation, because these evaluations constitute deafness, for all practical purposes.

We do not concur. Complete loss of air and bone conduction would result in no response on audiometry, even at 105 dB, according to VHA consultants, and would therefore warrant a 100-percent evaluation. If there is a response on audiometry, which would necessarily be the case to establish an 80- or 90-percent evaluation for hearing impairment, there is not complete absence of air and bone conduction, and the hearing impairment in those cases would not meet the requirements of 38 U.S.C. 1114(k). Such a footnote would therefore be contrary to statutory requirements.

The previous schedule listed mastoiditis under its own diagnostic code (6206), with evaluation based on suppuration and impairment of hearing. We proposed to combine it with suppurative otitis media under DC 6200. The previous schedule provided neither diagnostic code nor evaluation criteria for cholesteatoma; raters have generally evaluated it analogous to otitis media. We also proposed to include cholesteatoma under DC 6200, because the three conditions are closely related, and their manifestations may be essentially the same. One commenter suggested that we assign separate diagnostic codes for cholesteatoma and mastoiditis because the proposed rule is ambiguous as to whether one of these conditions must accompany otitis media to assign a 10-percent evaluation and because mastoiditis and cholesteatoma can exist without forming pus (suppuration).

Chronic otitis media, mastoiditis, and cholesteatoma may exist with or without suppuration. However, two or more of these conditions, all of which are interrelated, commonly coexist, and their manifestations may be very similar. For example, chronic mastoiditis may develop simultaneously with otitis media or may occur as a later complication. Therefore, a single diagnostic code and set of evaluation criteria for all three conditions is appropriate, and we have revised the title of DC 6200 to clarify that it can apply to any of these conditions. We have also added aural polyps to the criteria for a 10-percent evaluation because they are a possible consequence of chronic otitis media. We have also expanded the note directing that hearing impairment be evaluated separately to include a list of other possible complications--labyrinthitis, tinnitus, facial nerve paralysis, and bone loss of skull--that would also warrant separate evaluations. These criteria better encompass the usual range of impairments that may develop in this group of conditions. Placing these related conditions under a single diagnostic code will help assure that the same impairment is not evaluated twice when more than one of these conditions is present in an individual.

The previous schedule addressed otitis interna under DC 6203 and evaluated it based on the extent of hearing loss. We proposed to eliminate this diagnostic code because otitis interna is an archaic name for a general ear infection condition which is more accurately classified as a peripheral vestibular disorder, DC 6204. One commenter suggested that we provide instructions under peripheral vestibular disorders explaining how to evaluate otitis interna. We do not concur. Otitis interna is an obsolete term, and conditions which it formerly encompassed are best evaluated under the criteria for peripheral vestibular disorders.

The previous rating schedule provided three evaluation levels for Meniere's syndrome, DC 6205, based on the severity and frequency of attacks. Among other things, we proposed to provide objective measures for the frequency of the attacks. One commenter stated that the prodromal signs, the duration of the episode, and the recovery period for an attack may last as long as ten days, and therefore suggested that the frequency of attacks proposed for the 100-percent evaluation (more than once weekly) and 60-percent evaluation (once a week or less) was too stringent. The commenter also said that ``attacks occurring once a week or less'' should be better defined.

Attacks of vertigo in Meniere's syndrome appear suddenly and last from a few to 24 hours (Boies Fundamentals of Otolaryngology, Sixth Edition, W.B. Saunders Company, 1989, p.139, and The Merck Manual of Diagnosis and Therapy, Merck Research Laboratories, 1992, p. 2336). Since the attacks of vertigo (often accompanied by nausea, vomiting, hearing impairment, and tinnitus) generally subside within 24 hours, requiring attacks more than once weekly for a 100-percent level, and one to four times a month for a 60-percent level, are reasonable requirements, in our judgment, that are equivalent to, but more objective than, the requirements of ``frequent and typical,'' and ``less frequent'' in the previous schedule. In response to the comment, however, we better defined the criteria by changing the requirements for a 60-percent evaluation from ``deafness with attacks of vertigo and cerebellar gait occurring once a week or less'' to ``hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a

month, with or without tinnitus," and by changing the requirements for a 30-percent evaluation from ``deafness with occasional vertigo" to ``hearing impairment with vertigo less than once a month, with or without tinnitus." Tinnitus is commonly, but not universally, present in Meniere's syndrome. We included the phrase ``with or without tinnitus" in these criteria to emphasize that the overall evaluation of Meniere's syndrome is the same whether or not tinnitus is present. This will avoid the assignment of a separate evaluation for tinnitus when evaluating the syndrome under DC 6205, and at the same time, indicate that the absence of tinnitus in certain cases has no effect on the evaluation to be assigned under DC 6205.

We proposed to retain ``deafness" as one of the criteria at the 100-percent evaluation level of Meniere's syndrome (DC 6205). One commenter suggested that there be a footnote appended to the 100-percent level, signaling that entitlement to Special Monthly Compensation is payable.

We do not concur. A particular level of impaired hearing is not a requirement for the 100-percent level for Meniere's syndrome. The term ``deafness" was meant to indicate any level of hearing impairment, and we have changed ``deafness" to ``hearing impairment" in the criteria for Meniere's syndrome to make that clear. The requirements for a 100-percent evaluation of Meniere's syndrome are met if there is any levelof hearing impairment, and vertigo and cerebellar gait occur more than once weekly. 38 CFR 3.350(a)(5), on the other hand, requires an absence of air and bone conduction and hearing loss equal to or greater than the minimum bilateral hearing loss required for a 100-percent rating, for entitlement to SMC on the basis of hearing impairment. For this reason, a footnote referring to entitlement to SMC is not appropriate here, and Sec. 4.85(g) and the footnote to Table VII will assure consideration of SMC in any case of hearing impairment.

Another commenter suggested that we add a note under Meniere's syndrome instructing the rating agency that hearing impairment will be rated separately and combined. We did not adopt this suggestion because the evaluation criteria and percentages are based on all of the manifestations of Meniere's syndrome, with attacks often consisting of hearing impairment, vertigo, tinnitus, and staggering gait. Any of the symptoms may be intermittent. It would be contrary to 38 CFR 4.14 (Avoidance of pyramiding), which prohibits the evaluation of the same manifestation under different diagnoses, to evaluate hearing impairment separately, and also use it to support an evaluation under DC 6205. However, we have added a note stating that Meniere's syndrome may be evaluated either under DC 6205 or by separately evaluating vertigo (as a peripheral vestibular disorder), hearing impairment, and tinnitus, whichever method results in a higher overall evaluation. The note also prohibits combining an evaluation for hearing impairment, tinnitus, or vertigo with an evaluation under DC 6205.

The previous schedule provided a minimum 10-percent evaluation for malignant neoplasms of the ear, DC 6208. We proposed to delete the minimum evaluation. One commenter suggested that we reinstate the minimum 10-percent evaluation because it was meant to compensate for skull loss.

In our judgment, loss of function is the most accurate and equitable basis for evaluating the residuals of this condition. If a malignant neoplasm results in skull loss, the skull loss would be separately evaluated under the skeletal system (DC 5296).

The previous rating schedule provided a 10-percent evaluation for tinnitus, DC 6260, with the criteria being: ``persistent as a symptom of head injury, concussion or acoustic trauma." We proposed to remove the requirement that tinnitus be a symptom of head injury, concussion or acoustic trauma and that it be persistent and instead provide a 10-percent evaluation for recurrent tinnitus. One commenter suggested that we add a note following tinnitus instructing that the evaluation for tinnitus be combined with ratings for hearing impairment, suppurative otitis media, and peripheral vestibular disorder.

We agree and have added a note under DC 6260 stating that a separate evaluation for tinnitus under DC 6260 may be combined with an evaluation under DC's 6100, 6200, 6204, or other diagnostic code except when tinnitus supports an evaluation under one of those diagnostic codes.

We added the word ``nonsuppurative" to the proposed title of DC 6201, ``chronic nonsuppurative otitis media with effusion (serous otitis media)," to better distinguish it from DC 6200,

``chronic suppurative otitis media, mastoiditis, or cholesteatoma." We also made additional nonsubstantive changes throughout this final rule for the sake of clarity and succinctness.

he Secretary hereby certifies that this regulatory amendment will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. The reason for this certification is that this amendment would not directly affect any small entities. Only VA beneficiaries could be directly affected. Therefore, pursuant to 5 U.S.C. 605 (b), this amendment is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

This regulatory action has been reviewed by the Office of Management and Budget under Executive Order 12866.

The Catalog of Federal Domestic Assistance numbers are 64.104 and 64.109.

List of Subjects in 38 CFR Part 4

Disability benefits, Individuals with disabilities, Pensions, Veterans.

For the reasons set out in the preamble, 38 CFR part 4 is amended as set forth below:

PART 4--SCHEDULE FOR RATING DISABILITIES

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

Authority: 38 U.S.C. 1155.

Subpart B--Disability Ratings

2. Section 4.85 is revised to read as follows:

Sec. 4.85 Evaluation of hearing impairment.

(a) An examination for hearing impairment for VA purposes must be conducted by a state-licensed audiologist and must include a controlled speech discrimination test (Maryland CNC) and a puretone audiometry test. Examinations will be conducted without the use of hearing aids.

(b) Table VI, ``Numeric Designation of Hearing Impairment Based on Puretone Threshold Average and Speech Discrimination," is used to determine a Roman numeral designation (I through XI) for hearing impairment based on a combination of the percent of speech discrimination (horizontal rows) and the puretone threshold average (vertical columns). The Roman numeral designation is located at the point where the percentage of speech discrimination and puretone threshold average intersect.

(c) Table VIa, ``Numeric Designation of Hearing Impairment Based Only on Puretone Threshold Average," is used to determine a Roman numeral designation (I through XI) for hearing impairment based only on the puretone threshold average. Table VIa will be used when the examiner certifies that use of the speech discrimination test is not appropriate because of language difficulties, inconsistent speech discrimination scores, etc., or when indicated under the provisions of Sec. 4.86.

(d) ``Puretone threshold average," as used in Tables VI and VIa, is the sum of the puretone thresholds at 1000, 2000, 3000 and 4000 Hertz, divided by four. This average is used in all cases (including those in Sec. 4.86) to determine the Roman numeral designation for hearing impairment from Table VI or VIa.

(e) Table VII, ``Percentage Evaluations for Hearing Impairment," is used to determine the percentage evaluation by combining the Roman numeral designations for hearing impairment of each ear. The

horizontal rows represent the ear having the better hearing and the vertical columns the ear having the poorer hearing. The percentage evaluation is located at the point where the row and column intersect.

(f) If impaired hearing is service-connected in only one ear, in order to determine the percentage evaluation from Table VII, the non-service-connected ear will be assigned a Roman Numeral designation for hearing impairment of I, subject to the provisions of Sec. 3.383 of this chapter.

(g) When evaluating any claim for impaired hearing, refer to Sec. 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation due either to deafness, or to deafness in combination with other specified disabilities.

(h) Numeric tables VI, VIA*, and VII.

3. Section 4.86 is revised to read as follows:

Sec. 4.86 Exceptional patterns of hearing impairment.

(a) When the puretone threshold at each of the four specified frequencies (1000, 2000, 3000, and 4000 Hertz) is 55 decibels or more, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. Each ear will be evaluated separately.

(b) When the puretone threshold is 30 decibels or less at 1000 Hertz, and 70 decibels or more at 2000 Hertz, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. That numeral will then be elevated to the next higher Roman numeral. Each ear will be evaluated separately.

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

Sec. 4.86a [Removed]

4. Section 4.86a is removed.

5. Section 4.87 is revised to read as follows:

Sec. 4.87 Schedule of ratings--ear.

Rating
DISEASES OF THE EAR
6200 Chronic suppurative otitis media, mastoiditis, or cholesteatoma (or any combination):
During suppuration, or with aural polyps.....10

Note: Evaluate hearing impairment, and complications such as labyrinthitis, tinnitus, facial nerve paralysis, or bone loss of skull, separately.

6201 Chronic nonsuppurative otitis media with effusion (serous otitis media):
Rate hearing impairment

6202 Otosclerosis:
Rate hearing impairment

6204 Peripheral vestibular disorders:
Dizziness and occasional staggering.....30
Occasional dizziness.....10

Note: Objective findings supporting the diagnosis of vestibular disequilibrium are required before a compensable evaluation can be assigned under this code. Hearing impairment or suppuration shall be separately rated and combined.

6205 Meniere's syndrome (endolymphatic hydrops):
Hearing impairment with attacks of vertigo and cerebellar gait occurring more than once weekly, with or without tinnitus.....100
Hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus.....60
Hearing impairment with vertigo less than once a month, with or without tinnitus.....30

Note: Evaluate Meniere's syndrome either under these criteriaor by separately evaluating vertigo (as a peripheral vestibular disorder), hearing impairment, and tinnitus, whichever method results in a higher overall evaluation. But do not combine an evaluation for hearing impairment, tinnitus, or vertigo with an evaluation under diagnostic code 6205.

6207 Loss of auricle:
Complete loss of both..... 50
Complete loss of one..... 30
Deformity of one, with loss of one-third or more of the substance.....10

6208 Malignant neoplasm of the ear (other than skin only)..... 100

Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation treatment, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based on that or any subsequent examination shall be subject to the provisions of Sec.3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.

6209 Benign neoplasms of the ear (other than skin only):
Rate on impairment of function.

6210 Chronic otitis externa:
Swelling, dry and scaly or serous discharge, and itching requiring frequent and prolonged treatment.....10

6210 Tympanic membrane, perforation of 0

6260 Tinnitus, recurrent.....10

Note: A separate evaluation for tinnitus may be combined with an evaluation under diagnostic codes 6100, 6200, 6204, or other diagnostic code, except when tinnitus supports an evaluation under one of those diagnostic codes.

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

6. Section 4.87a is revised to read as follows:

Sec. 4.87a Schedule of ratings--other sense organs.

	Rating
6275 Sense of smell, complete loss	10
6276 Sense of taste, complete loss	10

Note: Evaluation will be assigned under diagnostic codes 6275 or 6276 only if there is an anatomical or pathological basis for the condition.

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

Sec. 4.87b [Removed]

7. Section 4.87b is removed.

TABLE VI
NUMERIC DESIGNATION OF HEARING IMPAIRMENT BASED ON PURETONE THRESHOLD AVERAGE AND SPEECH DISCRIMINATION

	Puretone Threshold Average								
% of discrim-ination	0-41	42-49	50-57	58-65	66-73	74-81	82-89	90-97	98+
92-100	I	I	I	II	II	II	III	III	IV
84-90	II	II	II	III	III	III	IV	IV	IV
76-82	III	III	IV	IV	IV	V	V	V	V
68-74	IV	IV	V	V	VI	VI	VII	VII	VII
60-66	V	V	VI	VI	VII	VII	VIII	VIII	VIII
52-58	VI	VI	VII	VII	VIII	VIII	VIII	VIII	IX
44-50	VII	VII	VIII	VIII	VIII	IX	IX	IX	X
36-42	VIII	VIII	VIII	IX	IX	IX	X	X	X
0-34	IX	X	XI	XI	XI	XI	XI	XI	XI

TABLE VIA*
NUMERIC DESIGNATION OF HEARING IMPAIRMENT BASED ONLY ON PURETONE THRESHOLD AVERAGE

Puretone Threshold Average										
0-41	42-48	49-55	56-62	63-69	70-76	77-83	84-90	91-97	98-104	105+
I	II	III	IV	V	VI	VII	VIII	IX	X	XI

* This table is for use only as specified in §§ 4.85 and 4.86.

TABLE VII
PERCENTAGE EVALUATION FOR HEARING IMPAIRMENT
(DIAGNOSTIC CODE 6100)

Poorer Ear											
XI	100*										
X	90	80									
IX	80	70	60								
VIII	70	60	50	50							
VII	60	60	50	40	40						
VI	50	50	40	40	30	30					
V	40	40	40	30	30	20	20				
IV	30	30	30	20	20	20	10	10			
III	20	20	20	20	20	10	10	10	0		
II	10	10	10	10	10	10	10	0	0	0	
I	10	10	0	0	0	0	0	0	0	0	0
	XI	X	IX	VIII	VII	VI	V	IV	III	II	I

* Review for entitlement to special monthly compensation under §3.350 of this chapter.

REGULATORY AMENDMENT
3-99-2

Regulations Affected: 38 C.F.R. §3.381 and §3.382; 38 C.F.R. §4.149

EFFECTIVE DATE OF THE REGULATION: June 8, 1999

Date Secretary Approved Regulation: April 21, 1999

Federal Register Citation: 64 FR 30392-93 (June 8, 1999)

The purpose of the following comments on the changes included in this amendment of VA regulations is to inform all concerned why the changes are being made. These comments are not regulatory.

38 CFR Part 4, the Schedule for Rating Disabilities, provides evaluations for dental conditions considered disabling in nature. There are, however, other dental conditions which are not considered disabling and consequently do not fall under the purview of the rating schedule. The issue of service connection for these conditions arises only for the purpose of determining eligibility to outpatient dental treatment. These conditions include carious teeth, replaceable missing teeth, dental or alveolar abscesses, periodontal disease, and Vincent's stomatitis (also referred to as Vincent's disease, Vincent's infection, or acute necrotizing gingivitis). These conditions were listed in the former 38 CFR §4.149, in the Schedule for Rating Disabilities. Because these conditions are not evaluated for compensation, but only to determine eligibility for treatment, it is more appropriate to list them in 38 CFR Part 3, which contains general rules for determining service connection. Therefore, §4.149 has been deleted.

Prior to the current revision, §3.381 provided that service connection will be granted for certain dental conditions shown after a "reasonable period of service"; however, this subjective term was not defined. The new rule replaces this subjective term with the objective requirement of 180 days or more of active service in decisions pertaining to service connection for dental conditions that develop over a period of time. Such conditions include dental caries, periodontal disease, and disease of pathology of third molars or teeth in which an existing filling requires replacement. Because these conditions take time to develop, (often a year or two in permanent teeth), it is more likely than not that caries or pathology that become apparent within the first 180 days of service pre-existed that service.

The new rule also eliminates overlapping provisions in 38 CFR §§ 3.381 and 3.382 which did not clearly state requirements for service connection or which appeared to be possibly conflicting. Section 3.381(d) now includes specific rules for determining whether dental conditions that are noted at entry into service and treated during active duty are service connected for treatment purposes. These provisions provide concrete guidelines for decisions related to tooth extractions and restorations, as well as for missing teeth.

Former §3.381(c) which addressed the principle of secondary service connection for dental diseases and injuries was deleted because it was superfluous given the provisions governing secondary service connection already contained in §3.310. Likewise, paragraphs (a) and (b) of §3.382 were deleted because its statements related to the types of evidence needed to establish service connection were redundant of provisions contained elsewhere in the regulations which adequately describe evidence requirements for establishing service connection. (*See* 38 CFR §3.303, §3.304)

Former §3.381(d) specifically stated that the presumption of soundness does not apply to non-compensable dental conditions. While no longer explicitly stated in the revised regulation, the presumption of soundness is clearly inapplicable based on 38 U.S.C. §1110 and §1111. Section 1111 requires VA to consider every veteran
to have been in sound condition at the time of entry except as to defects noted at that time. It specifically references §1110 of Title 38 which applies only to payment of compensation for disability. Section 1111 is therefore not applicable to determining eligibility to outpatient dental treatment under 38 U.S.C. §1712. In

addition, §1153 of Title 38 U.S.C. applies only to disabilities. Because non-compensable dental conditions are not considered to be disabilities, §1153 is also not applicable to 38 U.S.C. §1712 determinations.

The revised rule retains the general principle contained in former §3.381(b) which stated that treatment during service is not considered *per se* aggravation of a dental condition noted as present at the time of entry because such treatment is considered ameliorative. However, the phrase "*per se"* has been deleted and is replaced with a statement that treatment in service is not evidence that a condition noted at entry has been aggravated unless additional pathology developed after 180 days or more of service. This is consistent with the change reflected in §3.381(d) requiring 180 days of active duty service as a prerequisite to considering specified dental conditions as service connected for purposes of treatment.

Paragraph 3.381(e) lists conditions that will not be service connected for treatment purposes, replacing former §3.382(c). Current medical terminology has been used to describe these conditions with "calculus" replacing "salivary deposits," and "periodontal disease" replacing "gingivitis," "Vincent's disease," and "pyorrhea." Impacted or malposed teeth are considered developmental defects as is the presence of third molars (wisdom teeth). These conditions are not service connected unless separate pathology develops after 180 days of active service. The use of the 180-day time period has been explained above. Periodontal disease is related to dental hygiene and can be affected by other factors such as diet, abnormal stress, other disease processes, and reaction to certain drugs or chemicals. With proper treatment, most periodontal disease resolves with no residuals. Therefore, service connection for acute periodontal disease is not subject to service condition in the former rule and remains not subject to service connection in the present rule. However, chronic periodontal disease (formerly described as "Pyorrhea"), which may result in tooth extraction, will warrant service connection for the lost teeth.

For the reasons set forth in the preamble, 38 CFR Part 3 is amended as follows:

1. The Authority citation for part 3 continues to read as follows:

AUTHORITY: 38 U.S. C. 501 (a), unless otherwise noted.

2. Section 3.381 is amended by revising the heading and text to read as follows:

§ 3.381 Service connection of dental conditions for treatment purposes.

(a) Treatable carious teeth, replaceable missing teeth, dental or alveolar abscesses, and periodontal disease will be considered service-connected solely for the purpose of establishing eligibility for outpatient dental treatment as provided in section 17.161 of this chapter.

(b) The rating activity will consider each defective or missing tooth and each disease of the teeth and periodontal tissues separately to determine whether the condition was incurred or aggravated in line of duty during active service. When applicable, the rating activity will determine whether the condition is due to combat or other in-service trauma, or whether the veteran was interned as a prisoner of war.

(c) In determining service connection, the condition of teeth and periodontal tissues at the time of entry into active duty will be considered. Treatment during service, including filling or extraction of a tooth, or placement of a prosthesis, will not be considered evidence of aggravation of a condition that was noted at entry, unless additional pathology developed after 180 days or more of active service.

(d) The following principles apply to dental conditions noted at entry and treated during service:

(1) Teeth noted as normal at entry will be service-connected if they were filled or extracted after 180 days or more of active service.

(2) Teeth noted as filled at entry will be service-connected if they were extracted, or if the existing filling was replaced, after 180 days or more of active service.

(3) Teeth noted as carious but restorable at entry will not be service connected on the basis that they were filled during service. However, new caries that developed 180 days or more after such a tooth was filled will be service-connected.

(4) Teeth noted as carious but restorable at entry, whether or not filled, will be service-connected if extraction was required after 1 80 days or more of active service.

(5) Teeth noted at entry as non-restorable will not be service-connected, regardless of treatment during service.

(6) Teeth noted as missing at entry will not be service connected, regardless of treatment during service.

(e) The following will not be considered service-connected for treatment purposes:

(1) calculus;

(2) acute periodontal disease;

(3) third molars, unless disease or pathology of the tooth developed after 180 days or more of active service, or was due to combat or in-service trauma;

(4) impacted or malposed teeth, and other developmental defects, unless disease or pathology of these teeth developed after 180 days or more of active service.

(f) Chronic periodontal disease. Teeth extracted because of chronic periodontal disease will be service-connected only if they were extracted after 180 days or more of active service.

(Authority: 38 U.S.C. 1712)

§ 3.382 Evidence to establish service connection for dental disabilities. [Removed]

3. Section 3.382 is removed and reserved.

PART 4 SCHEDULE FOR RATING DISABILITIES

Dental and Oral Conditions

4. The Authority citation for part 4 continues to read as follows:

AUTHORITY: 38 U.S.C. 11 55.

§ 4.149 Rating diseases of the teeth and gums. [Removed]

5. Section 4.149 is removed and reserved.

REGULATORY AMENDMENT
4-99-2

Regulation affected: 38 CFR 4.71a.

EFFECTIVE DATE OF REGULATION: June 17, 1999

Date Secretary approved regulation: March 24, 1999

Federal Register Citation: 64 FR 32410 (June 17, 1999)

In the Federal Register of May 7, 1996 (61 FR 20438), we published an interim final rule adding a new diagnostic code, 5025, and evaluation criteria for fibromyalgia to § 4.71a of 38 CFR part 4, the rating schedule. This final rule responds to comments received in response to the interim final rule and adopts the interim final rule without change.

The Federal Register document follows.

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---------- DEPARTMENT OF VETERANS AFFAIRS
38 CFR Part 4

RIN 2900-AH05

Schedule for Rating Disabilities; Fibromyalgia

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.----------

SUMMARY: This document adopts as a final rule without change an interim final rule adding a diagnostic code and evaluation criteria for fibromyalgia to the Department of Veterans Affairs' (VA's) Schedule for Rating Disabilities. The intended effect of this rule is to insure that veterans diagnosed with this condition meet uniform criteria and receive consistent evaluations.

DATES: Effective Date: This final rule is effective June 17, 1999. The interim rule adopted as final by this document was effective May 7, 1996.

FOR FURTHER INFORMATION CONTACT: Vickie Milton, M.D., Consultant, Policy and Regulations Staff (211B), Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420, (202) 273-7230.

SUPPLEMENTARY INFORMATION: On May 7, 1996, VA published in the Federal Register an interim final rule with request for comments (61 FR 20438). The rule added a diagnostic code, 5025, and evaluation criteria for fibromyalgia to the section of the VA Schedule for Rating Disabilities (38 CFR part 4) that addresses the musculoskeletal system (38 CFR 4.71a). A 60-day comment period ended July 8, 1996, and we received three comments, one from two physicians in the Department of Medicine at The Oregon Health Sciences University, and two from VA employees.

The evaluation criteria for fibromyalgia under diagnostic code 5025 have one requisite that applies to all levels: ``[w]ith widespread musculoskeletal pain and tender points, with or without associated fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud's-like symptoms.'' The 40-, 20-, and 10-percent evaluation levels are additionally based on whether these findings are constant, or nearly so, and refractory to therapy; are episodic, but present more than one-third of the time; or require continuous medication for control. One commenter felt that the use of the phrase ``with or without'' as used in diagnostic code 5025 is confusing and might be interpreted as

rendering the symptoms that follow the phrase as superfluous and unnecessary in the evaluation of fibromyalgia.

Some individuals with fibromyalgia have only pain and tender points; others have pain and tender points plus stiffness; still others have pain and tender points plus stiffness and sleep disturbance; etc. As a shorter way of stating this, we have used the phrase ``with or without,'' followed by a list of symptoms, to indicate that any or all of these symptoms may be part of fibromyalgia, but none of them is necessarily present in a particular case. When symptoms in addition to pain and tenderness are present, they may be used as part of the assessment of whether fibromyalgia symptoms are episodic or constant. When none of the symptoms on the list is present, the determination of whether the condition is episodic or constant must be based solely on musculoskeletal pain and tender points. The term ``with or without'' is also used in Sec. 4.116 (Schedule of ratings--gynecological conditions and disorders of the breast) of the rating schedule under diagnostic code 7619, ``Ovary, removal of,'' where the criterion for a zero-percent evaluation is ``removal of one with or without partial removal of the other.'' We believe that in both cases the phrase ``with or without,'' rather than adding confusion, better defines the potential scope of the condition under evaluation. We therefore make no change based on this comment.

The same commenter questioned whether the intent is to place a ceiling of 40 percent on the evaluation of fibromyalgia despite the presence of one or more of the symptoms following the phrase ``with or without.'' As the evaluation criteria indicate, there may be multi-system complaints in fibromyalgia. If signs and symptoms due to fibromyalgia are present that are not sufficient to warrant the diagnosis of a separate condition, they are evaluated together with the musculoskeletal pain and tender points under the criteria in diagnostic code 5025 to determine the overall evaluation. The maximum schedular evaluation for fibromyalgia in such cases is 40 percent. If, however, a separate disability is diagnosed, e.g., dysthymic disorder, that is determined to be secondary to fibromyalgia, the secondary condition can be separately evaluated (see 38 CFR 3.310(a)), as long as the same signs and symptoms are not used to evaluate both the primary and the secondary condition (see 38 CFR 4.14 (Avoidance of pyramiding)). In such cases, fibromyalgia and its complications may warrant a combined evaluation greater than 40 percent. Since these rules are for general application, they need not be specifically referred to under diagnostic code 5025.

Another commenter referred to a statement in the supplementary information to the interim final rule that indicated that fibromyalgia is a benign disease that does not result in loss of musculoskeletal function. The commenter said that while it is not a malignant disease which leads to anatomic crippling, the result of persistent chronic pain is often musculoskeletal dysfunction.

The statement regarding the lack of loss of musculoskeletal function is supported by medical texts which state, for example, that objective musculoskeletal function is not impaired in fibromyalgia (``The Manual of Rheumatology and Outpatient Orthopedic Disorders'' 349 (Stephen Padgett, Paul Pellicci, John F. Beary, III, eds., 3rd ed. 1993)); that the syndrome is not accompanied by abnormalities that are visible, palpable, or measurable in any traditional sense; and that the patient must recognize the physical benignity of the problem (``Clinical Rheumatology'' 315 (Gene V. Ball, M.D. and William J. Koopman, M.D., 1986)). These medical texts confirm that fibromyalgia does not result in objective musculoskeletal pathology. The criteria we have established to evaluate disability due to fibromyalgia are therefore based on the symptoms of[[Page 32411]]fibromyalgia rather than on objective loss of musculoskeletal function.

The same commenter said that more could have been said about the wide clinical spectrum of fibromyalgia and the associated stress response which may lead to clinical problems of psychopathology, inappropriate behavior, deconditioning, hormonal imbalance, and sleep disorder.

The evaluation criteria do include a broad spectrum of possible symptoms, and sleep disturbance is one of them. As discussed above, any disability, including a mental disorder, that is medically determined to be secondary to fibromyalgia, can be separately evaluated. The rating schedule is, however, a guide to the evaluation of disability for compensation, not treatment (see 38 CFR 4.1), and it is unnecessary for that purpose to include a broad discussion of the clinical aspects of fibromyalgia. We therefore make no change based on this comment.

The same commenter said that it is important to stress that fibromyalgia may co-exist with other rheumatic disorders and have an additive effect on disability. If two conditions affecting similar functions or anatomic areas are present, and one is service-connected and one is not (a situation that is not unique to rheumatic disorders), the effects of each are separately evaluated, if feasible.

When it is not possible to separate the effects of the conditions, VA regulations at 38 CFR 3.102, which require that reasonable doubt on any issue be resolved in the claimant's favor, dictate that the effects be attributed to the service-connected condition. Since there is an established method of evaluating co-existing conditions, there is no need to stress the point that other diseases may co-exist with fibromyalgia, resulting in additive effects, and we make no change based on this comment.

The commenter also stated that the correct diagnosis of fibromyalgia and the exclusion of other rheumatic conditions are of paramount importance in ensuring a successful treatment program.

The diagnosis of fibromyalgia and exclusion of other rheumatic disorders are functions of the examiner and outside the scope of the rating schedule, which, as noted earlier, is a guide for the evaluation of disability for purposes of compensation, not treatment. We therefore make no change based on this comment.

One commenter stated that claimants with fibromyalgia will present with limitation of motion of various joints of the body, and the rating agency will have to take into consideration pain on movement and functional loss due to pain (see 38 CFR 4.40 and 4.45). The commenter felt that the proposed scheme invites separate ratings for limitation of motion of each joint.

Fibromyalgia is a ``nonarticular'' rheumatic disease (``The Merck Manual'' (1369, 16th ed. 1992)), and objective impairment of musculoskeletal function, including limitation of motion of the joints, is not present, in contrast to the usual findings in ``articular'' rheumatic diseases. Joint examinations in fibromyalgia are necessary only to exclude other rheumatic diseases because physical signs other than tender points at specific locations are lacking. The pain of fibromyalgia is not joint pain, but a deep aching, or sometimes burning pain, primarily in muscles, but sometimes in fascia, ligaments, areas of tendon insertions, and other areas of connective tissue (Ball and Koopman, 315). The evaluation criteria require that the pain be widespread, and that the symptoms be assessed based on whether they are constant or episodic, or require continuous medication, but they are not based on evaluations of individual joints or other specific parts of the musculoskeletal system. We believe the evaluation criteria make clear the basis of evaluation, and we therefore make no change based on this comment.

REGULATORY AMENDMENT
4-01-1

Regulation affected: 38 CFR 4.112 and 4.114

EFFECTIVE DATE OF REGULATION: July 2, 2001

Date Secretary approved regulation: March 5, 2001

Federal Register Citation: 66 FR 29486-89

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

This document amends 38 CFR 4.112 and certain diagnostic codes in 38 CFR 4.114, in order to address hepatitis C and its sequelae, and to update evaluation criteria for other liver disabilities.

We have made the information in § 4.112 more specific by stating that the term "substantial weight loss," for purposes of evaluating conditions in § 4.114, means a loss of greater than 20 percent of the individual's baseline weight, sustained for three months or longer; that the term "minor weight loss" means a loss of 10 to 20 percent of the individual's baseline weight, sustained for three months or longer; and that the term “inability to gain weight” means “substantial” (rather than the current term “significant”) weight loss with inability to regain it despite appropriate therapy. We have also defined "baseline weight" as the average weight for the two-year-period preceding onset of the disease.

We revised the evaluation criteria for Injury of the liver (diagnostic code 7311) to have them include not only adhesions of peritoneum (diagnostic code 7301), but also cirrhosis of liver (diagnostic code 7312) or chronic liver disease without cirrhosis (diagnostic code 7345) as options for evaluation.

We broadened the scope of diagnostic code 7312 so that the criteria apply not only to cirrhosis of the liver but also to primary biliary cirrhosis and the cirrhotic phase of sclerosing cholangitis, two conditions that are not in the current rating schedule but that have disabling effects similar to cirrhosis. We deleted the subjective and outdated terms in the evaluation criteria for diagnostic code 7312, but retained the same evaluation levels, except for adding a 10-percent level to provide an appropriate evaluation level for individuals who have symptoms due to cirrhosis but do not meet the criteria for a 30-percent evaluation, as might occur in the early stages of the disease. We have provided evaluation criteria that are similar to those formerly in the schedule, but updated. They include the presence or history of ascites, hemorrhage from varices or portal gastropathy, hepatic encephalopathy, portal hypertension, splenomegaly, jaundice, and substantial weight loss, as well as symptoms of generalized weakness, anorexia, abdominal pain, and malaise. We have also added a add a note stating that evaluation under this diagnostic code requires documentation of cirrhosis (by biopsy or imaging) and abnormal liver function tests.

We deleted diagnostic code 7313 because abscesses of the liver now ordinarily resolve without residual disability.

We updated the titles of diagnostics 7343 and 7344 and made changes in the evaluation of malignant neoplasms similar to those we have made in other sections of the rating schedule.

We changed the title of diagnostic code 7345, formerly infectious hepatitis, to chronic liver disease without cirrhosis (including hepatitis B, chronic active hepatitis, autoimmune hepatitis, hemochromatosis, drug induced hepatitis, etc., but excluding bile duct disorders and hepatitis C). This code will now encompass many chronic liver diseases that were not named in the former schedule, most importantly hepatitis B, and will exclude hepatitis A (formerly called infectious hepatitis), which is an acute disease that heals without long-term residuals. We added new diagnostic code 7354 for hepatitis C (or non-A, non-B hepatitis), a disease of rising importance in veterans.

We provided the same evaluation criteria for diagnostic codes 7345 and 7354. The evaluation of both is based either on the signs and symptoms of chronic liver disease, such as fatigue, malaise, and anorexia, or on the total duration

of incapacitating episodes (defined as a period of acute signs and symptoms severe enough to require bed rest and treatment by a physician). We changed the evaluation levels under 7345 from 100, 60, 30, 10, and zero percent to 100, 60, 40, 20, 10, and zero percent. This change was made in order to maintain internal consistency in the rating schedule, because they correspond to the levels that we proposed for the evaluation of intervertebral disc syndrome, another condition for which we proposed to use the total duration of periods of incapacitation as an alternative means of evaluation. Because chronic liver disease may in some cases be nonsymptomatic even when not healed, and would still not be disabling and therefore warrant no more than a zero-percent evaluation, we changed the evaluation criteria for the zero-percent level from "healed, nonsymptomatic" to "nonsymptomatic". This will assure that all nonsymptomatic veterans who have serologic evidence of having had a hepatitis B or C virus will be service-connected at 0% in order to assure appropriate handling of later-developing sequelae of hepatitis B and C. We removed ”depression” and “anxiety” as criteria under diagnostic code 7345 because they are not prominent symptoms of chronic liver disease, and, if a mental disorder is medically determined to be secondary to liver disease, it would be separately evaluated under the mental disorders portion of the rating schedule. We added a note under diagnostic codes 7345 and 7354 directing that sequelae of these conditions, such as cirrhosis or malignancy of the liver, be evaluated under an appropriate diagnostic code, as long as the same signs and symptoms are not used as the basis for evaluation under both 7345 or 7354 and under another diagnostic code. We added another note under 7345 to indicate that the diagnosis of hepatitis B infection must be confirmed by serologic testing. The hepatitis C criteria indicate that it too requires serologic evidence of infection.

We added new diagnostic code 7351 for liver transplants, which requires a 100-percent evaluation for an indefinite period from the date of hospital admission for transplant surgery, with a mandatory VA examination one year following hospital discharge. We also provided a minimum evaluation of 30 percent following transplant, because of the need for long-term immunosuppressive medication and its associated problems.

Diagnostic codes revised	Diagnostic codes removed	Diagnostic codes added
7311	7313	7354
7312		7351
7343		
7344		
7345		

PART 4--SCHEDULE FOR RATING DISABILITIES

1. The authority citation for part 4 continues to read as follows: Authority: 38 U.S.C. 1155, unless otherwise noted.

2. Section 4.112 is revised to read as follows:

Sec. 4.112 Weight Loss.

For purposes of evaluating conditions in Sec. 4.114, the term ``substantial weight loss'' means a loss of greater than 20 percent of the individual's baseline weight, sustained for three months or longer; and the term ``minor weight loss'' means a weight loss of 10 to 20 percent of the individual's baseline weight, sustained for three months or longer. The term ``inability to gain weight'' means that there has been substantial weight loss with inability to regain it despite appropriate therapy. ``Baseline weight'' means the average weight for the two-year-period preceding onset of the disease. (Authority: 38 U.S.C. 1155)

3. Section 4.114 is amended by:

A. Revising diagnostic codes 7311, 7312, 7343, 7344, and 7345.

B. Removing diagnostic code 7313.

C. Adding diagnostic codes 7351 and 7354.

D. Adding a new authority citation at the end of the section.

The revisions and additions read as follows:

Sec. 4.114 Schedule of ratings-digestive system.

- * *

Rating

7311 Residuals of injury of the liver:
Depending on the specific residuals, separately evaluate as adhesions of peritoneum (diagnostic code 7301), cirrhosis of liver (diagnostic code 7312), and chronic liver disease without cirrhosis (diagnostic code 7345).

7312 Cirrhosis of the liver, primary biliary cirrhosis, or cirrhotic phase of sclerosing cholangitis:
Generalized weakness, substantial weight loss, and persistent jaundice,
or; with one of the following refractory to treatment: ascites,
hepatic encephalopathy, hemorrhage from varices or
portal gastropathy (erosive gastritis).....……...100
History of two or more episodes of ascites, hepatic encephalopathy,
or hemorrhage from varices or portal gastropathy (erosive gastritis),
but with periods of remission between attacks …..……..70
History of one episode of ascites, hepatic encephalopathy,
or hemorrhage from varices or portal gastropathy (erosive gastritis)……..50
Portal hypertension and splenomegaly, with weakness, anorexia,
abdominal pain, malaise, and at least minor weight loss……..30
Symptoms such as weakness, anorexia, abdominal pain, and malaise…….10

Note: For evaluation under diagnostic code 7312, documentation of cirrhosis (by biopsy or imaging) and abnormal liver function tests must be present.

* * * * *

7343 Malignant neoplasms of the digestive system, exclusive of skin growths…….100

Note: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of Sec. 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.

7344 Benign neoplasms, exclusive of skin growths:
Evaluate under an appropriate diagnostic code, depending on the predominant disability or the specific residuals after treatment.

7345 Chronic liver disease without cirrhosis (including hepatitis B,
chronic active hepatitis, autoimmune hepatitis, hemochromatosis,
drug-induced hepatitis, etc., but excluding bile duct disorders and hepatitis C):
Near-constant debilitating symptoms (such as fatigue, malaise, nausea, vomiting, anorexia,
arthralgia, and right upper quadrant pain).....…….100
Daily fatigue, malaise, and anorexia, with substantial weight loss
(or other indication of malnutrition), and hepatomegaly,

or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least six weeks during the past 12- month period, but not occurring constantly …..…… 60

Daily fatigue, malaise, and anorexia, with minor weight loss and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least four weeks, but less than six weeks, during the past 12-month period……..……..40

Daily fatigue, malaise, and anorexia (without weight loss or hepatomegaly), requiring dietary restriction or continuous medication, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least two weeks, but less than four weeks, during the past 12-month period...……...20

Intermittent fatigue, malaise, and anorexia, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least one week, but less than two weeks, during the past 12-month period..……10

Nonsymptomatic.....…….……0

Note (1): Evaluate sequelae, such as cirrhosis or malignancy of the liver, under an appropriate diagnostic code, but do not use the same signs and symptoms as the basis for evaluation under DC 7354 and under a diagnostic code for sequelae. (See Sec. 4.14.).

Note (2): For purposes of evaluating conditions under diagnostic code 7345, ``incapacitating episode'' means a period of acute signs and symptoms severe enough to require bed rest and treatment by a physician.

Note (3): Hepatitis B infection must be confirmed by serologic testing in order to evaluate it under diagnostic code 7345.

* * * * *

7351 Liver transplant:

For an indefinite period from the date of hospital admission for transplant surgery.…… …….100

Minimum.....……...30

Note: A rating of 100 percent shall be assigned as of the date of hospital admission for transplant surgery and shall continue. One year following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of Sec. 3.105(e) of this chapter.

7354 Hepatitis C (or non-A, non-B hepatitis):

With serologic evidence of hepatitis C infection and the following signs and symptoms due to hepatitis C infection:

Near-constant debilitating symptoms (such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain).....……...…….100

Daily fatigue, malaise, and anorexia, with substantial weight loss (or other indication of malnutrition), and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least six weeks during the past 12- month period, but not occurring constantly …… …….……..60

Daily fatigue, malaise, and anorexia, with minor weight loss and

hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least four weeks, but less than six weeks, during the past 12-month period……...……..40

Daily fatigue, malaise, and anorexia (without weight loss or hepatomegaly), requiring dietary restriction or continuous medication, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least two weeks, but less than four weeks, during the past 12-month period……..... 20

Intermittent fatigue, malaise, and anorexia, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least one week, but less than two weeks, during the past 12-month period..……...…10

Nonsymptomatic.....…..…….……...… 0

Note (1): Evaluate sequelae, such as cirrhosis or malignancy of the liver, under an appropriate diagnostic code, but do not use the same signs and symptoms as the basis for evaluation under DC 7354 and under a diagnostic code for sequelae. (See Sec. 4.14.).

Note (2): For purposes of evaluating conditions under diagnostic code 7354, ``incapacitating episode'' means a period of acute signs and symptoms severe enough to require bed rest and treatment by a physician.

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

REGULATORY AMENDMENT
4-02-1
3-02-3

Regulations affected: 38 CFR 3.350(a) and 38 CFR 4.116, note two and diagnostic code 7626.

EFFECTIVE DATE OF REGULATION: March 18, 2002.

Date Secretary Approved Regulation: January 9, 2002.

Federal Register Citation: 67 FR 6872-6874 (February 14, 2002).
67 FR 37695 (May 30, 2002)(Correction)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

The Veterans Benefits and Health Care Improvement Act of 2000, Public Law 106-419, 114 Stat. 1822, amended section 1114(k) by making anatomical loss of one or both breasts (including loss by mastectomy) as a result of a service-connected disability by a woman veteran a condition warranting this special monthly compensation. This regulation implements this legislation by 1) revising 38 CFR 3.350(a) to add the provision concerning anatomical loss of one or both breasts (including loss by mastectomy) in a woman veteran and to define what anatomical loss of one or both breasts means for this purpose, 2) revising note two under 38 CFR 4.116 to include anatomical loss of one or both breasts as a condition for which a rater should refer to 38 CFR 3.350(a) to determine whether special monthly compensation is warranted, and 3) annotating diagnostic code 7626 in 38 CFR 4.116 to refer to a footnote directing the rater to review for entitlement to special monthly compensation under 38 CFR 3.350.

Diagnostic codes revised	Diagnostic codes removed	Diagnostic codes added
7626	None	None

NOTE: A correction to this final rule was published in 67 FR 37695 on May 30, 2002, to correct typographical errors in the “Note” at the end of diagnostic code 7626 in 38 CFR 4.116.

REGULATORY AMENDMENT

4-02-2

Regulation affected: 38 CFR 4.71a

EFFECTIVE DATE OF REGULATION: August 26, 2002

Date Secretary approved regulation: May 16, 2002

Federal Register Citation: 67 FR 48784-48787 (July 26, 2002)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

This document amends 38 CFR 4.71a to clarify the method of evaluation of ankylosis and limitation of motion of single and multiple digits by revising and reorganizing the diagnostic codes and explanatory notes that address the evaluation of these conditions in order to assure fair and consistent evaluations of these disabilities.

We relocated the interpretive notes regarding evaluations of ankylosis and limitation of motion of the digits of the hands into a single set of instructions preceding diagnostic code 5216 and deleted notes (1), (2), (3), and (4) preceding diagnostic code 5216; notes (a), (b), and (c) following diagnostic code 5219; notes (1), (2), (3) and (4) preceding diagnostic code 5220; notes (a) and (b) following diagnostic code 5223; and the note following diagnostic code 5227.

We changed the term used for the third digit from "middle finger" to "long finger," changed "median transverse fold of the palm" to "proximal transverse crease of the palm," an anatomic landmark where the fingertips normally meet the palm when they are in full flexion, and added descriptions of the position of function of the hand and of the normal range of motion of the index, long, ring, and little fingers.

We revised the evaluation criteria under diagnostic codes 5216 through 5227 so that they address ankylosis only and added three new diagnostic codes, 5228, 5229, and 5230, for the evaluation of limitation of motion of the thumb, the index or long finger, and the ring or little finger, respectively. The evaluation criteria for the newly added conditions are derived from the material contained in former note (3) preceding diagnostic code 5216, former note (3) preceding diagnostic code 5220, and former note (a) following diagnostic code 5223. Limitation of motion of the index, long, ring, and little fingers is evaluated based on either the number of degrees by which extension is limited, or on a measurement of the gap between the fingertip and the palm when the finger is flexed to the extent possible. Limitation of motion of the thumb is evaluated based on its most important function, opposing the fingers, as measured by the gap between the thumb pad and the fingers with the thumb attempting to oppose the fingers. These criteria are consistent with § 4.71, "Measurement of ankylosis and joint motion".

An ankylosed digit is evaluated as amputation when both joints are ankylosed, and either is in extension or "full" flexion (flexion of the fingers is not possible beyond "full," or complete, flexion). We simplified diagnostic codes 5217 through 5223 by combining certain combinations of fingers or fingers and thumb.

In response to a comment on the proposed rule stating that the proposed ratings did not adequately provide for the disability that occurs when a finger ankylosed in flexion obstructs the other fingers and reduces the strength of the hand in gripping or grasping motions, we added notes following the diagnostic codes for ankylosis of individual digits directing raters to consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.

Diagnostic codes revised	Diagnostic codes removed	Diagnostic codes added
5216		5228
5217		5229
5218		5230
5219		
5221		
5222		
5223		
5224		
5225		
5226		
5227		

The pertinent portions of the final rule are as follows:

SUMMARY: This document amends the Department of Veterans Affairs (VA) Schedule for Rating Disabilities by revising the evaluation criteria for ankylosis and limitation of motion of the fingers and thumb in order to assure that veterans diagnosed with these conditions receive consistent evaluations.

SUPPLEMENTARY INFORMATION: As part of its review of the Schedule for Rating Disabilities (38 CFR part 4), VA published a proposal to amend that portion of the Schedule pertaining to ankylosis and limitation of motion of the fingers and thumb. The proposed rule was published in the Federal Register on November 2, 2001 (66 FR 55614). Interested persons were invited to submit written comments on or before January 2, 2002. We received one comment, from the Disabled American Veterans.

We proposed to change the name of the ``middle finger'' to ``long finger'' in the diagnostic codes pertaining to digit ankylosis and limitation of motion. The commenter suggested that we make the same change in diagnostic codes for finger amputations. In response, we have made that change. In addition, in current Plate III, one finger is labeled ``middle finger,'' and we will be revising that as part of the overall revision of the orthopedic system to ``long finger''. Similarly, the commenter suggested that we change ``median transverse fold of palm'' to ``proximal transverse crease of palm'' in 38 CFR 4.71, as we proposed to do in Sec. 4.71a. We have also made that change.

We proposed to evaluate an ankylosed digit as amputation when both joints are ankylosed, and either is in extension or ``full'' flexion. The commenter felt that the proposed ratings do not adequately provide for the disability that occurs when a finger ankylosed in flexion obstructs the other fingers and reduces the strength of the hand in gripping or grasping motions. The commenter expressed the belief that this disability is worse than an amputation and should receive a higher evaluation.

Digits that inhibit the use of other fingers are sometimes amputated if they inhibit hand function. Since 38 CFR 4.68, ``Amputation rule,'' however, prohibits an evaluation exceeding that which would be assigned if the finger were amputated, we have adopted another way of addressing this problem. In our judgment, if finger flexion deformity interferes with the function of other fingers or hand function overall, assessment of the other fingers or the hand overall should be taken into account in rating. This is both more appropriate than providing a higher evaluation for the ankylosed finger itself and consistent with the requirements of Sec. 4.68. Provisions #2 and #5 of this portion of the rating schedule would apply in this situation. However, to assure that raters address any additional disability due to ankylosis of a single digit, we have revised the notes following the diagnostic codes for ankylosis of individual digits, which currently direct raters to consider rating as amputation, to read ``Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand''. In our judgment, this will be sufficient to alert raters to the possibility of additional disability due to a single ankylosed digit. VA appreciates the comment submitted in response to the proposed rule. Based on the rationale stated in the proposed rule and in this document, the proposed rule is adopted with the changes noted.

* * *

For the reasons set out in the preamble, 38 CFR part 4, subpart B, is amended as set forth below:

PART 4--SCHEDULE FOR RATING DISABILITIES

Subpart B--Disability Ratings

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

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

2. In Sec. 4.71, last sentence, remove ``median transverse fold of the palm" and add, in its place, ``proximal transverse crease of palm".

3. In Sec. 4.71a under the tables MULTIPLE FINGER AMPUTATIONS and SINGLE FINGER AMPUTATIONS, remove ``middle" every place it occurs and add in each place ``long".

4. Section 4.71a is amended by removing the tables ``MULTIPLE FINGERS: UNFAVORABLE ANKYLOSIS"; MULTIPLE FINGERS: FAVORABLE ANKYLOSIS"; and ANKYLOSIS OF INDIVIDUAL FINGERS" and adding, in their place, the following table to read as follows:

Sec. 4.71a Schedule of ratings--musculoskeletal system.

* * * * *

Evaluation of Ankylosis or Limitation of Motion of Single or Multiple Digits of the Hand

	Rating	
	Major	Minor
(1) For the index, long, ring, and little fingers (digits II, III, IV, and V), zero degrees of flexion represents the fingers fully extended, making a straight line with the rest of the hand. The position of function of the hand is with the wrist dorsiflexed 20 to 30 degrees, the metacarpophalangeal and proximal interphalangeal joints flexed to 30 degrees, and the thumb (digit I) abducted and rotated so that the thumb pad faces the finger pads. Only joints in these positions are considered to be in favorable position. For digits II through V, the metacarpophalangeal joint has a range of zero to 90 degrees of flexion, the proximal interphalangeal joint has a range of zero to 100 degrees of flexion, and the distal (terminal) interphalangeal joint has a range of zero to 70 or 80 degrees of flexion.....	.....	.....
(2) When two or more digits of the same hand are affected by any combination of amputation, ankylosis, or limitation of motion that is not otherwise specified in the rating schedule, the evaluation level assigned will be that which best represents the overall disability (i.e., amputation, unfavorable or favorable ankylosis, or limitation of motion), assigning the higher level of evaluation when the level of disability is equally balanced between one level and the next higher level…….....	.....	.....
(3) Evaluation of ankylosis of the index, long, ring, and little fingers:		
(i) If both the metacarpophalangeal and proximal interphalangeal joints of a digits are ankylosed, and either is in extension or full flexion, or there is rotation or angulation of a bone, evaluate as amputation without metacarpal resection, at proximal interphalangeal joint or proximal thereto.	.....	.....
(ii) If both the metacarpophalangeal and proximal interphalangeal joints of a digit are ankylosed, evaluate as unfavorable ankylosis, even if each joint is individually fixed in a favorable position.....……...	……..	……...
(iii) If only the metacarpophalangeal or proximal interphalangeal proximal interphalangeal joint is ankylosed, and there is a gap of more than two inches (5.1 cm.) between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible, evaluate as unfavorable ankylosis.	.....	.....
(iv) If only the metacarpophalangeal or proximal interphalangeal is ankylosed, and there is a gap of two inches (5.1 cm.) or less	.....	.....

between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible, evaluate as favorable ankylosis.....……...

(4) Evaluation of ankylosis of the thumb:

(i) If both the carpometacarpal and interphalangeal joints are ankylosed, and either is in extension or full flexion, or there is rotation or angulation of a bone, evaluate as amputation at metacarpophalangeal joint or through proximal phalanx…….....

(ii) If both the carpometacarpal and interphalangeal joints interphalangeal joints are ankylosed, evaluate as unfavorable ankylosis, even if each joint is individually fixed in a favorable position…….....

(iii) If only the carpometacarpal or interphalaneal joint is ankylosed, and there is a gap of more than two inches (5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers, evaluate as unfavorable ankylosis…….....

(iv) If only the carpometacarpal or interphalangeal joint is ankylosed, and there is a gap of two inches (5.1 cm.) or less between the thumb pad and the fingers, with the thumb attempting to oppose the fingers, evaluate as favorable ankylosis…….....

(5) If there is limitation of motion of two or more digits, evaluate each more digits, evaluate each digit separately and combine the evaluations.....…….....

I. Multiple Digits: Unfavorable Ankylosis

5216 Five digits of one hand, unfavorable ankylosis of ……60……..50

Note: Also consider whether evaluation as amputation is warranted.

5217 Four digits of one hand, unfavorable ankylosis of:
Thumb and any three fingers.....…… 60…….. 50
Index, long, ring, and little fingers…….....……50……..40

Note: Also consider whether evaluation as amputation is warranted.

5218 Three digits of one hand, unfavorable ankylosis of:
Thumb and any two fingers.....……..50……..40
Index, long, and ring; index, long, and little; or index, ring and little fingers…….40……..30
Long, ring, and little fingers.....……...30……..20

Note: Also consider whether evaluation as amputation is warranted.

5219 Two digits of one hand, unfavorable ankylosis of:
Thumb and any finger.....……..40……..30
Index and long; index and ring; or index and little fingers……..30……..20
Long and ring; long and little; or ring and little fingers……...20……..20

Note: Also consider whether evaluation as amputation is warranted.

II. Multiple Digits: Favorable Ankylosis

5220 Five digits of one hand, favorable ankylosis of …….. 50……. 40

5221 Four digits of one hand, favorable ankylosis of:

Thumb and any three fingers.....50……...40
Index, long, ring, and little fingers.....40……..30

5222 Three digits of one hand, favorable ankylosis of:
Thumb and any two fingers.....40……..30
Index, long, and ring; index, long, and little; or index, ring, and little finger…….30……..20
Long, ring and little fingers.....20……..20

5223 Two digits of one hand, favorable ankylosis of:
Thumb and any finger.....30……..20
Index and long; index and ring; or index and little fingers…….20……..20
Long and ring; long and little; or ring and little fingers……..10……..10

III. Ankylosis of Individual Digits

5224 Thumb, ankylosis of:
Unfavorable.....20……..20
Favorable.....10……..10

Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.

5225 Index finger, ankylosis of:
Unfavorable or favorable.....10……..10

Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.

5226 Long finger, ankylosis of:
Unfavorable or favorable.....10……..10

Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.

5227 Ring or little finger, ankylosis of:
Unfavorable or favorable..... 0……0

Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.

IV. Limitation of Motion of Individual Digits

5228 Thumb, limitation of motion:
With a gap of more than two inches (5.1 cm.) between the thumb pad and the fingers, with the thmb attempting to oppose the fingers…….20……..20
With a gap of one to two inches (2.5 to 5.1 cm.) between thumb pad and the fingers, with the thumb attempting to oppose the fingers……..10……...10
With a gap of less than one inch (2.5 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers……...0……0

5229 Index or long finger, limitation of motion:

With a gap of one inch (2.5 cm.) or more between the fingertip and the proximal transverse crease of the palm, with the finger flexed to the extent possible, or; with extension limited by more than 30 degrees……10……..10

With a gap of less than one inch (2.5 cm.)between the fingertip and the proximal transverse crease of the palm, with the finger flexed to to the extent possible, and; extension is limited by no more than 30 degrees……..0……0

5230 Ring or little finger, limitation of motion:
Any limitation of motion.....……0……0

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* * * * *

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

REGULATORY AMENDMENT

4-02-3

Regulation affected: 38 CFR 4.118

EFFECTIVE DATE OF REGULATION: August 30, 2002.

Date Secretary approved regulation: May 17, 2002.

Federal Register Citation: 67 FR 49590-49599 (July 31, 2002)
Correction: 67 FR 58448 (September 16, 2002)
Correction : 67 FR 62889 (October 9, 2002)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

As part of VA's ongoing revision of the Schedule for Rating Disabilities, we have amended section 4.118 of 38 CFR, Part 4, the section of the rating schedule that addresses disabilities of the skin. The purpose is to update this portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances that have occurred since the last review. Numerous editorial changes have also been made. More detailed explanations for substantive changes are included in the "Supplementary Information" section of both the final regulatory amendment document, which is enclosed, and the notice of proposed rulemaking, which was published in the Federal Register on January 19, 1993 (58 FR 4969).

We revised the evaluation criteria for diagnostic code (DC) 7800 by basing them on how many of eight objective characteristics of disfigurement are present (scar 5 or more inches (13 or more cm.) in length; scar at least one-quarter inch (0.6 cm.) wide at widest part; surface contour of scar elevated or depressed on palpation; scar adherent to underlying tissue; skin hypo- or hyper-pigmented in an area exceeding six square inches (39 sq. cm.); skin texture abnormal (irregular, atrophic, shiny, scaly, etc.) in an area exceeding six square inches (39 sq. cm.); underlying soft tissue missing in an area exceeding six square inches (39 sq. cm.); and skin indurated and inflexible in an area exceeding six square inches (39 sq. cm.)) and whether there is asymmetry or gross distortion of features. We provided evaluation levels of 10, 30, 50 and 80 percent for this condition.

We changed the scope of DC's 7801 and 7802 from being limited to burn scars to include scars from other causes, such as chemical injury, with DC 7801 now for evaluating scars of a certain size other than face, head, or neck that are deep (meaning there is underlying soft tissue damage) or that cause limited motion and DC 7802 for evaluating scars of a certain size other than face, head, or neck that are superficial (meaning not associated with underlying soft tissue damage) and do not cause limited motion. The range of evaluations for DC 7801 is 10 to 40 percent. There is a single 10-percent evaluation under DC 7802.

We retitled DC 7803 as "Scars, superficial, unstable" and defined an unstable scar as meaning one where there is frequent loss of covering of skin over the scar. We retitled DC 7804 as "Scars, superficial, painful on examination" and defined a superficial scar as meaning one that is not associated with underlying soft tissue damage. Evaluations under DC 7803 and 7804 are limited to 10 percent.

We retitled DC 7806 as "Dermatitis or eczema," changed the evaluation levels to zero, 10, 30, and 60 percent, and provided identical evaluation criteria for this condition as for DC's 7815 (bullous disorders), 7816 (psoriasis), 7821 (cutaneous manifestations of collagen-vascular diseases not listed elsewhere (a newly added condition), and 7822 (papulosquamous disorders not listed elsewhere). Evaluation is now based on the extent (in percentage) to which the entire body or exposed areas are affected by the condition or on the treatment required. Alternatively, these conditions can be evaluated as disfigurement of the head, face, or neck or as scars.

Discoid lupus (DC 7809) is now evaluated as disfigurement or dermatitis, depending on the predominant disability. Exfoliative dermatitis (DC 7817, formerly dermatitis exfoliativa) is now evaluated at levels of zero, 10, 30, 60, or 100 percent based on the extent of involvement of the skin, whether there are also systemic manifestations, and the type and duration of treatment.

We revised the evaluation criteria for benign skin neoplasms, DC 7819, to base them on impairment of function as well as on scars or disfigurement. We added DC 7820, Infections of the skin not listed elsewhere (including bacterial, fungal, viral, treponemal and parasitic diseases), with evaluation based on disfigurement of the head, face, or neck or dermatitis, depending on the predominant disability. Vitiligo (DC 7823), a new code, is evaluated at zero or ten percent based on whether or not exposed areas are affected.

Another condition we added to the Schedule, diseases of keratinization (DC 7824) is evaluated at zero, 10, 30, or 60 percent based on therapy requirements, the extent of cutaneous involvement, and whether the skin involvement is constant or episodic.

Leishmaniasis, both American (DC 7807) and Old World (DC 7808), are now evaluated based on disfigurement, scars, or dermatitis, whichever is the predominant disability.

We made changes in the evaluation of malignant neoplasms of the skin (DC 7818). They were formerly rated as scars, disfigurement, etc., on the extent of constitutional symptoms, physical impairment. Now they are evaluated based on disfigurement of the head, face, or neck, on scars, or on impairment of function. However, malignancies of the skin sometimes require systemic treatment that is comparable to that given for other types of malignancies. Therefore, we added a note indicating that if a skin malignancy undergoes treatment that is similar to that used for internal malignancies, such as chemotherapy or radiation therapy more extensive than to the skin, or if surgery more extensive than wide local excision is used, a 100-percent evaluation will be assigned from onset of treatment and will continue with a mandatory VA examination six months following the completion of antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination subject to the provisions of 38 CFR 3.105(e). If treatment is confined to the skin, the provisions for a 100-percent evaluation do not apply. We added a separate diagnostic code, 7833, to the rating schedule for malignant melanoma of the skin with the same evaluation criteria as for other skin malignancies.

We also added urticaria to the rating schedule under DC 7825, with evaluation levels of 10, 30, and 60 percent based on frequency and severity of episodes and treatment. We added DC 7826, primary cutaneous vasculitis, and DC 7827, erythema multiforme (toxic epidermal necrolysis), with identical evaluation criteria and evaluation levels of 10, 30, and 60 percent based on the frequency of debilitating episodes and the type and frequency of treatment. Alternatively, these conditions can be evaluated as disfigurement of the head, face, or neck or as scars, depending on the predominant disability.

We added DC 7828 for the evaluation of acne and DC 7829 for the evaluation of chloracne with identical evaluation criteria and evaluation levels of zero, 10 and 30 percent based on the extent of involvement by acne, its location, and whether it is deep or superficial. Alternatively, these conditions can be evaluated as disfigurement of the head, face, or neck or as scars, depending on the predominant disability.

We added DC 7830, scarring alopecia, with evaluation levels of zero, 10, and 20 percent based on the percent of scalp affected. We also added DC 7831, alopecia areata, with evaluation levels of zero and 10 percent based on the extent of hair loss.

We revised the title of DC 7813, Dermatophytosis, to include "(ringworm: of body, tinea corporis; of head, tinea capitis; of feet, tinea pedis; of beard area, tinea barbae; of nails, tinea unguium; of inguinal area (jock itch), tinea cruris)" to clarify what is included.

We added DC 7832, hyperhidrosis (which is excessive sweating) with evaluation levels of zero and 30 percent based on whether or not an individual can handle paper or tools and response to therapy.

Diagnostic codes revised	Diagnostic codes removed	Diagnostic codes added
7800	7810	7820
7801	7812	7821
7802	7814	7822
7803		7823
7804		7824
7806		7825
7807		7826
7808		7827
7809		7828
7811		7829
7813		7830
7815		7831
7816		7832
7817		7833
7818		
7819		

Note: A correction published on September 16, 2002 made corrections to diagnostic codes 7802, 7807, 7808, 7809, 7811, 7818, 7819, 7820, and 7833.

Note: A correction published on October 9, 2002 made a correction to the language of the preamble.

The pertinent portions of the final rule are as follows:

SUMMARY: This document amends that portion of the Department of Veterans Affairs (VA) Schedule for Rating Disabilities that addresses the Skin. The intended effect of this action is to update the portion of the rating schedule that deals with skin to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances that have occurred since the last review.

SUPPLEMENTARY INFORMATION: As part of a comprehensive review of the rating schedule, VA published a proposal to amend 38 CFR 4.118, which addresses disabilities of the skin, in the Federal Register of January 19, 1993 (58 FR 4969). Comments were received from the American Legion, Paralyzed Veterans of America, Veterans of Foreign Wars, Disabled American Veterans, and VA employees.

One commenter suggested that VA withdraw the proposed regulations and reissue them based on more objective standards, and also made specific suggestions for changes to many diagnostic codes.

We do not agree that the proposed regulations should be withdrawn

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We made the process of revision as open as possible. For example, prior to publication of the proposed amendment, we published an advance notice of proposed rulemaking in the Federal Register to receive public comments about the revision. We also contracted with an outside consultant, who convened a panel of non-VA physician specialists in skin diseases to make recommendations for revisions of this section of the rating schedule. We asked the Veterans Health Administration to review our proposed changes. We published the proposed revision only after reviewing all of these sources of information. We received several other comments on the proposed rule after it was published in the Federal Register, but none of the commenters suggested withdrawing the proposed revision. In response to comments, we have however, made further revisions to some of the criteria for the sake of clarity and more objectivity and have added definitions and explanatory notes under some conditions. These added changes are discussed in more

detail below. The same commenter who suggested withdrawing the proposed revision also made specific suggestions for changes to many diagnostic codes. With the additional changes we have made in the final revision, we believe we have made the evaluation criteria for skin conditions reasonably clear and objective
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Under diagnostic code (DC) 7800, disfigurement of the head, face, or neck, the former rating schedule provided evaluation levels of 50, 30, 10, and zero percent based on whether there is repugnant deformity of one or both sides of the face, whether the disfigurement is ``severe,'' producing a marked and unsightly deformity of eyelids, lips, or auricles, and on whether the disfigurement is ``moderate'' or ``slight.'' Following these criteria was a note stating that each level could be increased to the next higher evaluation level on the basis of marked discoloration or color contrast and that the most repugnant, disfiguring conditions, including scars and diseases of the skin, could be submitted with photographs for central office rating. The proposed amendment added an 80-percent evaluation level and deleted the part of the note that provided authority to elevate evaluations in the presence of marked discoloration or color contrast based on the rationale that these criteria are subject to inconsistent interpretations. The proposed evaluation criteria were based at 80 percent on whether disfigurement is so disfiguring as to preclude occupational interaction with the public, at 50 percent on whether it is repugnant on casual inspection, at 30 percent on whether it is disagreeable on casual inspection, at 10 percent on whether it is noticeable on casual inspection, and at zero percent on whether it is noticeable, but only on close inspection.

One commenter felt that the deleted note should be retained. Another commenter, while offering no alternative language for us to consider, stated that the words ``repugnant,'' disagreeable,'' and ``noticeable,'' used to describe degrees of disfigurement, are too subjective to be useful and are not based on medical criteria. In a similar vein, another commenter said that we should establish objective criteria for rating scars that should include evaluation of size, configuration, color,etc. One commenter felt that the difference between casual and close inspection, part of the criteria used to determine disfigurement, is a distinction that is difficult to understand.

In response to these comments, we have further revised the evaluation criteria for DC 7800 by basing them on the number of objective characteristics of disfigurement that are present and whether there is asymmetry or gross distortion of the features. We provided a new note following DC 7800 describing the eight specific characteristics of disfigurement, for purposes of evaluation under Sec. 4.118: Scar 5 or more inches (13 or more cm.) in length; scar at least one-quarter inch (0.6 cm.) wide at widest part; surface contour of scar elevated or depressed on palpation; scar adherent to underlying tissue; skin hypo- or hyper-pigmented in an area exceeding six square inches (39 sq. cm.); skin texture abnormal (irregular, atrophic, shiny, scaly, etc.) in an area exceeding six square inches (39 sq. cm.); underlying soft tissue missing in an area exceeding six square inches (39 sq. cm.); and skin indurated and inflexible in an area exceeding six square inches (39 sq. cm.). For an 80-percent evaluation, there must be visible or palpable tissue loss and either gross distortion or asymmetry of three or more features or paired sets of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or six or more characteristics of disfigurement must be present. For a 50-percent evaluation, there must be visible or palpable tissue loss and either gross distortion or asymmetry of two features or paired sets of features, or four or more haracteristics of disfigurement must be present. For a 30-percent evaluation, there must be visible or palpable tissue loss and either gross distortion or asymmetry of one feature or set of paired features, or two or three characteristics of disfigurement must be present. For a 10-percent evaluation, one characteristic of disfigurement must be present. In our judgment, these further revised criteria are sufficiently clear and objective to assure that evaluations take into account the most significant characteristics of disfigurement and will be consistent from veteran to veteran. We have provided two additional notes under DC 7800, one directing the rater to rate tissue loss of the auricle under DC 6207 (loss of auricle) and anatomical loss of the eye under DC 6061 (anatomical loss of both eyes) or DC 6063 (anatomical loss of one eye), as appropriate; and the second directing the rater to take into consideration unretouched color photographs.

The former rating schedule designated DC 7801 as ``scars, burns, third degree,'' and DC 7802 as ``scars, burns, second degree.'' We proposed to revise these codes so that they additionally addressed scars from causes other than burns and so that the conditions would be evaluated based on actual residual disability, i.e., the size of the area of underlying soft tissue damage or limitation of motion, rather than on the initial assessment of the severity of a burn. We proposed to redesignate DC 7801 as ``scars, other than head, face, or neck, with underlying soft tissue damage causing deep contour defect or limited motion'' and

DC 7802 as `scars, other than head, face, or neck, that are superficial and that do not cause limited motion." We proposed that under DC 7801 scars with an area or areas exceeding 144 square inches (929 sq. cm.) receive a 40-percent evaluation; with area or areas exceeding 72 square inches (465 sq. cm.) a 30-percent evaluation; with area or areas exceeding 12 square inches (77 sq. cm.) a 20-percent evaluation; and with area or areas exceeding 6 square inches (39 sq. cm.) a 10-percent evaluation. We proposed that under DC 7802 scars with area or areas approximating 144 square inches (929 sq. cm.) receive a 10-percent evaluation. A commenter felt that historical precedent requires continuation of the wording ``third degree" and ``second degree" under DC's 7801 and 7802, formerly burn scars.

We disagree. One objective of the rating schedule revision is to incorporate medical advances and to delete obsolete concepts and conditions. Our consultants, a panel of non-VA physician specialists in skin diseases, as well as medical textbooks such as ``Christopher's Textbook of Surgery" 140-41 (Loyal Davis, M.D., ed., 9th ed. 1968), indicate that the clinical estimation of the degree of a burn is not always accurate and does not necessarily relate to long-term disability. The severity of residual scarring from burns of all depths varies. Furthermore, burn scars that are not caused by thermal injury, but by chemical, electrical, or friction injury, as well as scars resulting from non-burn injuries that permanently alter the skin, can lead to comparable residuals. For these reasons, a determination of disability that is based on the extent of the scarring itself and its effects, rather than on the etiology of the scarring, is preferable because it will result in wider application of these criteria and afford consistency in the evaluation of comparable scarring, whatever the etiology. For more clarity and consistency of language, we have, however, modified the titles slightly, for better differentiation of superficial and deep scars, as discussed below.

We proposed that DC 7801 (formerly titled ``scars, burns, third degree") be retitled ``scars, other than head, face, or neck, with underlying soft tissue damage causing deep contour defect or limited motion." According to one commenter, the term ``deep contour defect" is confusing. When there is soft tissue damage beneath the skin, in addition to scarring of the skin, the overlying scar shows a greater anatomical change in contour than when there is skin damage alone. The defect that appears in a scarred area when there is underlying soft tissue damage is known as a deep contour defect and could also be called a deep scar. The lesser change that results in a scarred area when there is skin damage alone, without soft tissue damage beneath the skin, is known as a superficial contour defect and could also be called a superficial scar. A superficial scar may have an irregular surface that is either raised or depressed, but the abnormal contour goes no deeper than the skin. To make the distinction between the scars to be evaluated under DC's 7801 and 7802 clearer, we have removed the term ``deep contour defect" and have retitled DC 7801 ``scars, other than head, face, or neck, that are deep or that cause limited motion" and retitled DC 7802 ``scars, other than head, face, or neck, that are superficial and that do not cause limited motion." We have also added a definition of deep scar, as one associated with underlying soft tissue damage, in a note under DC 7801 and of superficial scar, as one not associated with underlying soft tissue damage, in a note under DC 7802.

We proposed to retitle DC 7803 (formerly titled ``scars, superficial, poorly nourished, with repeated ulceration") ``scars, superficial, unstable with frequent loss of epidermal covering." One commenter felt that the meaning of ``unstable" under DC 7803 is unclear, and wondered whether this means that the wound is infected or unhealed.

The term ``unstable" in the title of DC 7803 does not imply a specific etiology but only indicates that there is frequent loss of covering of the skin over the scar. An unstable scar may result from anumber of causes, including poor healing or infection. For further clarity, we have added a note under DC 7803 defining unstable scar as one where, for any reason, there is frequent loss of covering of skin over the scar. We have also removed the term ``with frequent loss of epidermal covering" from the title and repeated the definition of superficial scar under this code.

One commenter suggested that we not repeat identical criteria when several different conditions are evaluated using the same criteria.

While it is feasible to use general rating formulas when related conditions are listed consecutively, we have repeated criteria under a number of diagnostic codes in this section for several reasons. First, conditions evaluated under identical criteria in this section are not consecutive diagnostic codes. The

repetition of criteria will save time by eliminating the need to seek the appropriate evaluation criteria, lessen the chance of error by eliminating the need to search other pages of the rating schedule, and eliminate the ``double references'' that are present under some diagnostic codes (where the schedule says to see a certain diagnostic code and there is a reference under that diagnostic code to see yet another diagnostic code). Additionally, while rating specialists may readily locate the appropriate rating criteria, others who use the schedule may find it more difficult. While eliminating the repetition of criteria would save space, we believe that the advantages gained favor their repetition in this case. Where a general rating formula applies to several diagnostic codes that are listed consecutively, the proximity of the conditions and the rating formula eliminates most of the potential problems discussed above.

In the former schedule, DC 7806 (dermatitis or eczema) was evaluated at levels of 50, 30, 10, or zero percent. The criteria called for a 50-percent evaluation for ulceration or extensive exfoliation or crusting, with systemic or nervous manifestations, or being exceptionally repugnant; a 30-percent evaluation for constant exudation or itching, with extensive lesions, or with marked disfigurement; a 10-percent evaluation for exfoliation, exudation or itching, if involving an exposed surface or extensive area; and a zero-percent evaluation for slight, if any, exfoliation, exudation or itching, if on a nonexposed surface or small area. DC's 7809 (discoid lupus erythematosus), 7815 (bullous disorders), 7816 (psoriasis), and 7817 (exfoliative dermatitis) did not include specific evaluation criteria, but were ordinarily rated as analogous conditions, using the same criteria as for DC 7806. We proposed to evaluate all five of these conditions, plus four new conditions-cutaneous manifestations of collagen-vascular diseases not listed elsewhere (DC 7821), papulosquamous disorders not listed elsewhere (DC 7822), vitiligo (DC 7823), and diseases of keratinization (DC 7824)--under identical criteria, with evaluation levels of 100, 50, 30, 10, and zero percent. We proposed a 100-percent evaluation for generalized scaling, crusting, systemic manifestations, pruritus and for being so disfiguring as to preclude interaction with the public; a 50-percent evaluation for ulceration or extensive exfoliation or crusting, and systemic manifestations, or being so disfiguring as to be repugnant on casual inspection; a 30-percent evaluation for exudation or constant itching, or extensive lesions, or being so disfiguring as to be disagreeable on casual inspection; a 10-percent evaluation for exfoliation, exudation, or itching, if involving an exposed surface or extensive area; and a zero-percent evaluation for minimal exfoliation, exudation or itching, if on a nonexposed surface or small area. We proposed to evaluate a second group of skin disorders-disfigurement of the head, face, or neck (DC 7800), acne (DC 7828), chloracne (DC 7829), scarring alopecia (DC 7830), and alopecia areata (DC 7831)--solely on the basis of disfigurement, as described above under the discussion of DC 7800, and made 80 percent the maximum evaluation for this group based on disfigurement that precludes occupational interaction with the public. There were several comments regarding similarities between the proposed criteria for a 100-percent evaluation for the first group (DC 7806 and conditions rated under the same criteria) and the criterion for an 80-percent evaluation for the second group (DC 7800 and conditions rated under the same criteria).

One commenter objected to the fact that when interaction with the public is precluded, one group of skin conditions may be assigned an evaluation of 100 percent and another group may be assigned no more than 80 percent. Another commenter suggested that we add an intermediate evaluation level between 50 and 100 percent for the skin conditions for which we proposed evaluation levels of 100, 50, 30, 10, and zero percent. An evaluation of 60 percent or more for a single disability would allow a veteran to advance a claim under 38 CFR 4.16(a), which allows a claim for individual unemployability in cases where there is a service-connected disability rating that is less than total but which renders an individual unable to secure or follow a substantially gainful occupation.

In response to these comments, and because the more specific criteria we have provided for DC 7800 are not as readily applicable to other skin conditions as those we proposed, we have further revised the criteria for DC's 7806, 7809, 7815, 7816, 7817, 7821, 7822, 7823, and 7824. We have removed the proposed criteria, which were the same for all these conditions and have provided criteria that are more objective and more specific for each condition.

For dermatitis or eczema, DC 7806, instead of the proposed evaluation levels of 100, 50, 30, 10, and zero percent based on the presence of scaling, crusting, whether there are systemic manifestations, itching, exudation, exfoliation, etc., or, alternatively, on the extent of disfigurement, we have now provided

evaluation levels of 60, 30, 10, and zero percent, as the commenter suggested. As part of the more condition-specific criteria we have provided, we have also removed the 100-percent evaluation level because dermatitis is rarely totally disabling. However, since a 60-percent evaluation level may now be assigned, a claim for individual unemployability, when appropriate, is feasible under 38 CFR 4.16 (a) for those individuals unable to secure or follow a substantially gainful occupation as a result of service-connected skin disease. The criteria are based on the extent (in percentage) to which the entire body or exposed areas are affected by the condition or on the treatment required. For a 60-percent evaluation for dermatitis, more than 40 percent of the entire body or more than 40 percent of exposed areas must be affected, or constant or near-constant systemic therapy such as corticosteroids or other immunosuppressive drugs is required. For a 30-percent evaluation, 20 to 40 percent of the entire body or 20 to 40 percent of exposed areas must be affected, or systemic therapy for a total duration of six weeks or more, but not constantly, during the past 12-month period is required. For a 10-percent evaluation, at least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent, of exposed areas must be affected, or intermittent systemic therapy for a total duration of less than six weeks during the past 12-month period is required. For a zero-percent evaluation, less than 5 percent of the entire body or less than 5 percent of exposed areas must be affected, with no more than topical therapy required during the past 12-month period. We also added analternative direction to rate as disfigurement of the head, face, or neck(DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability. This will provide an alternative means of evaluation in cases, for example, where the active disease has been controlled but there are significant residuals, such as scarring. These criteria are much more objective than the proposed criteria and will assuremore consistent evaluations. We had proposed criteria identical to those for DC 7806 for DC's 7815 (Bullous disorders (including pemphigus vulgaris, pemphigus foliaceous, bullous pemphigoid, dermatitis herpetiformis, epidermolysis bullosa acquisita, benign chronic familial pemphigus (Hailey-Hailey), and porphyria cutanea tarda)); 7816 (Psoriasis); 7821 (Cutaneous manifestations of collagen-vascular diseases not listed elsewhere (including scleroderma, calcinosis cutis, and dermatomyositis)); and 7822 (Papulosquamous disorders not listed elsewhere (including lichen planus, large or small plaque parapsoriasis, pityriasis lichenoides et varioliformis acuta (PLEVA), lymphomatoid papulosus, and pityriasis rubra pilaris (PRP))). The further revised evaluation criteria we have provided for DC 7806 remain appropriate for those four conditions, and we have provided identical criteria under each diagnostic code.

We also proposed to provide evaluation criteria identical to those for DC 7806 for the evaluation of DC's 7809 (Discoid lupus erythematosus or subacute cutaneous lupus erythematosus), 7817 (Exfoliative dermatitis (erythroderma)), 7823 (Vitiligo), and 7824 (Diseases of keratinization). However, the proposed criteria were not specific enough to these conditions to assure consistent evaluations, and the revised criteria for DC 7806 are also not appropriate for their evaluation. We have therefore provided more disease-specific evaluation criteria for these conditions, and also revised the evaluation levels in order to make them appropriate for the usual range of severity of each individual condition. The evaluation criteria for each of these conditions is discussed in more detail below.

Discoid lupus erythematosus (DC 7809) can present in a number of different ways (scaling, plaques, atrophy, erythema, scars, etc.), and we have therefore directed that it be rated as disfigurement (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.

Exfoliative dermatitis (DC 7817) is a disease that may be very severe, and its treatment is different from that of most other skin conditions. It may require the use of corticosteroids, immunosuppressive retinoids, PUVA (psoralen with long-wave ultraviolet-A light) or UVB (ultraviolet-B light) treatments, or electron beam therapy. It may also be associated with systemic manifestations, such as fever, weight loss, and hypoproteinemia (low level of protein in the blood, often associated with edema). We have provided evaluation levels of 100, 60, 30, 10, and zero percent for this condition, based on the extent of involvement of the skin, whether there are also systemic manifestations, and the type and duration of treatment. For a 100-percent evaluation, generalized involvement of the skin, plus systemic manifestations (such as fever, weight loss, and hypoproteinemia) must be present, and constant or near-constant systemic therapy such as therapeutic doses of corticosteroids, immunosuppressive retinoids, PUVA (psoralen with long-wave ultraviolet-A light) or UVB (ultraviolet-B light) treatments, or electron beam therapy during the past 12-

month period is required. For a 60-percent evaluation, generalized involvement of the skin without systemic manifestations must be present, and constant or near-constant systemic therapy during the past 12-month period is required. For a 30-percent evaluation, there can be any extent of involvement of the skin, and systemic therapy for a total duration of six weeks or more, but not constantly, during the past 12-month period is required. For a 10-percent evaluation, there can be any extent of involvement of the skin, and systemic therapy for a total duration of less than six weeks during the past 12-month period is required. For a zero-percent evaluation, there can be any extent of involvement of the skin with no more than topical therapy required during the past 12-month period. These criteria are specific to this condition and are more objective than the proposed criteria.

We proposed to evaluate vitiligo (DC 7823) under the same evaluation criteria as those we proposed for DC 7806 (dermatitis or eczema). Vitiligo is a condition in which the only abnormal finding is hypopigmented skin; the only treatment for it is cosmetic. The proposed criteria, however, included findings such as ulceration, itching, crusting, exfoliation, and systemic manifestations, none of which is specific to, or even occurs in, vitiligo. It is unlikely that an evaluation higher than zero percent could have been assigned for vitiligo using those criteria. Disfigurement was another of the proposed criteria under DC 7806. Of the characteristics of disfigurement described under DC 7800, only one--hypopigmentation--is present in vitiligo, and that is its only disabling effect. For one characteristic of disfigurement of the head, face, or neck under DC 7800, a 10-percent evaluation is assigned. We have therefore provided evaluation levels for vitiligo of ten and zero percent, providing ten percent if exposed areas are affected, and zero percent if they are not. These criteria will assure consistent evaluations for vitiligo, and they are internally consistent with the evaluations for disfigurement of the head, face, or neck, where the maximum evaluation based on the presence of hypopigmentation alone is 10 percent.

We also proposed to evaluate DC 7824, diseases of keratinization (including icthyoses, Darier's disease, and palmoplantar keratoderma) under the same evaluation criteria as those we proposed for DC 7806 (dermatitis or eczema). The further revised criteria for DC 7806 are not entirely appropriate for evaluating diseases of keratinization. We have therefore provided evaluation levels of 60, 30, 10, and zero percent for diseases of keratinization, based on requirements for therapy, the extent of cutaneous involvement, whether there are systemic manifestations, and whether the skin involvement is constant or episodic. A 60-percent evaluation requires either generalized cutaneous involvement or systemic manifestations and constant or near-constant systemic medication, such as immunosuppressive retinoids, during the past 12-month period. A 30-percent evaluation requires either generalized cutaneous involvement or systemic manifestations and intermittent systemic medication, such as immunosuppressive retinoids, for a total duration of six weeks or more, but not constantly, during the past 12-month period. A 10-percent evaluation requires localized or episodic cutaneous involvement and intermittent systemic medication, such as immunosuppressive retinoids, for a total duration of less than six weeks during the past 12-month period. A zero-percent evaluation is assigned if no more than topical therapy was required during the past 12-month period. These criteria are more appropriate for the evaluation of diseases of keratinization. In addition, we have added to the title some of the specific diseases that make up the category of diseases of keratinization-icthyoses, Darier's disease, and palmoplantar keratoderma. Under the former schedule, leishmaniasis, both American (DC 7807) and Old World (DC 7808), were ordinarily evaluated under the same criteria as DC 7806 (eczema). We proposed to evaluate leishmaniasis as disfigurement, scars, or dermatitis, depending upon the predominant disability. One commenter suggested that we include evaluation criteria for systemic manifestations of the disease under these codes. In our judgment, there is no need to include criteria for the systemic forms of leishmaniasis here, because evaluation criteria for visceral leishmaniasis are provided under DC 6301, in the section of the rating schedule on infectious diseases, immune disorders and nutritional deficiencies (38 CFR 4.88b). However, as a reminder to rating specialists, we have added a note under each of these codes directing that non-cutaneous (visceral) leishmaniasis be evaluated under DC 6301 (visceral leishmaniasis).

In the former schedule and in the proposed rule, DC 7811 (tuberculosis luposa (lupus vulgaris), active or inactive) was directed to be rated under Secs. 4.88b or 4.89. Section 4.88b was redesignated Sec. 4.88c in a separate rulemaking, so we have corrected the reference under DC 7811 to codes to be used for the evaluation of tuberculosis of the skin to Secs. 4.88c and 4.89.

Malignant neoplasms of the skin (DC 7818) were evaluated on scars, disfigurement, etc., on the extent of constitutional symptoms, and on physical impairment, in the former schedule. We proposed to evaluate based on impairment of function, disfigurement, or scars. One commenter stated that these criteria are inadequate for malignant melanoma because the condition is potentially lethal.

On further consideration, we have added a separate diagnostic code, 7833, to the rating schedule for malignant melanoma of the skin because it is a common malignancy and often behaves differently, particularly more aggressively, than other skin malignancies. All residuals that might occur from any skin malignancy can be evaluated under the proposed criteria for malignant neoplasms of the skin because ``impairment of function'' covers virtually any disability that might result, and we propose to provide the same evaluation criteria for malignant melanoma as for other skin malignancies. However, malignant melanoma, and at times other malignancies of the skin, may require a level of antineoplastic treatment that is similar to that used for internal malignancies. We have therefore added a note under DC's 7818 and 7833 stating that if a skin malignancy requires therapy that is comparable to that used for internal malignancies, i.e., systemic chemotherapy, X-ray therapy more extensive than to the skin, or surgery more extensive than wide local excision, a 100-percent evaluation will be assigned from the date of onset of treatment, and will continue, with a mandatory VA examination six months following the completion of such antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination subject to the provisions of 38 CFR 3.105(e). Those provisions require a 60-day notice before VA reduces an evaluation and an additional 60-day notice before the reduced evaluation takes effect. The revision requires a current examination to assure that all residuals are documented, and also offers the veteran more contemporaneous notice of any proposed action and expands the veteran's opportunity to present evidence showing that the proposed action should not be taken. If there has been no local recurrence or metastasis, evaluation will then be made on residuals. This will assure that the evaluation of these neoplasms, when they require treatment that is comparable to the treatment of internal malignancies, is commensurate with that type of treatment and is consistent with the method of evaluating malignancies in other systems. If treatment is confined to the skin, the provisions for a 100-percent evaluation do not apply. Since we have provided a separate diagnostic code for malignant melanoma, we added to the title of malignant skin neoplasms (DC 7818) for clarity, ``other than malignant melanoma.'' We proposed to add urticaria to the rating schedule as DC 7825, with evaluation levels of 40, 20, and zero percent. We proposed to call for a 40-percent evaluation if there is either a need for regular immunosuppressive therapy or the presence of uncontrollable episodes despite therapy; a 20-percent evaluation if there is a need for frequent immunosuppressive therapy; and a zero-percent evaluation if the condition is occasional or asymptomatic. We received two comments about these criteria. One commenter said that urticaria should be evaluated at 60 percent if it is uncontrollable despite any therapy, and at 50 percent if it requires frequent treatment. The other said that urticaria should be evaluated higher than 40 percent if it is uncontrolled by systemic immunosuppressive therapy and that we should replace the words ``frequent,'' ``regular,'' and ``occasional'' with more objective criteria.

We agree that a higher level of evaluation is warranted and have therefore added a 60-percent evaluation level for urticaria when there are at least four debilitating episodes during the past 12-month period despite continuous immunosuppressive therapy. In conjunction with this change, we made the next lower evaluation level 30 percent instead of 40 percent, and based it on debilitating episodes occurring at least four times during the past 12-month period but requiring only intermittent systemic immunosuppressive therapy for control, and made the level below that 10 percent instead of 20 percent, and based it on recurrent episodes occurring at least four times during the past 12-month period and that respond to treatment with antihistamines or sympathomimetics. These evaluation levels are consistent with the ranges for other skin diseases, and these criteria respond to the comments by providing a higher evaluation level for the most severe cases of urticaria, and by providing more objective criteria. The more objective criteria will assure more consistent evaluations. We proposed to add primary cutaneous vasculitis as DC 7826, to be evaluated on the basis of disfigurement, scars, or urticaria, depending upon the predominant disability. Because the revised evaluation criteria for disfigurement (DC 7800) and urticaria (DC 7825) are more specific to those conditions than the proposed criteria were, they are less appropriate for the evaluation of primary cutaneous vasculitis, which is a chronic, but episodic, condition. We have therefore provided a separate set of more objective criteria with evaluation levels of 60, 30, and 10 percent for primary cutaneous vasculitis, based on the frequency of debilitating episodes and the type and

frequency of treatment. A 60-percent evaluation calls for recurrent debilitating episodes occurring at least four times during the past 12-month period despite continuous immunosuppressive therapy; a 30-percent evaluation calls for recurrent debilitating episodes occurring at least four times during the past 12-month period and requiring intermittent systemic immunosuppressive therapy for control; and a ten-percent evaluation calls for recurrent episodes occurring one to three times during the past 12-month period and requiring intermittent systemic immunosuppressive therapy for control. These criteria are more specificto this condition and will result in more consistent evaluations. We have also provided an alternative direction to rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability. These are consistent with the criteria recommended by our consultants.

Similarly, we proposed to add erythema multiforme (toxic epidermal.necrolysis) as DC 7827, with evaluation based on disfigurement, scars, or urticaria, depending upon the predominant disability. Because the revised evaluation criteria for disfigurement (DC 7800) and urticaria (DC 7825) are more specific to those conditions than the proposed criteria were, they are less appropriate for the evaluation of erythema multiforme. We have therefore provided a separate set of more objective criteria for erythema multiforme, which is an episodic condition, with levels of 60, 30, and 10 percent, based on the frequency of debilitating episodes and the type and frequency of treatment. A 60-percent evaluation calls for recurrent debilitating episodes at least four times during the past 12-month period despite ongoing immunosuppressive therapy; a 30-percent evaluation calls for recurrent debilitating episodes at least four times during the past 12-month period despite ongoing immunosuppressive therapy; and a ten-percent evaluation calls for recurrent episodes that respond to treatment with antihistamines or sympathomimetics. We also provided an alternative direction to rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability. These criteria are identical to the criteria for DC 7826, since both conditions are episodic and require similar treatment, and they are consistent with the criteria recommended by our consultants.

We proposed that acne (DC 7828) and chloracne (DC 7829), which have similar manifestations, be evaluated under the same criteria as DC 7800 (disfigurement of the head, face, or neck). One commenter suggested that acne on nonexposed areas may warrant a compensable evaluation if there are extensive painful cysts. The proposed criteria did not provide for a compensable evaluation for such manifestations.

We agree that acne involving nonexposed areas may be disabling, more because of the inflammatory aspects than the disfiguring aspects. We have therefore established evaluation criteria for acne and chloracne that are based on the extent of involvement by acne, its location, and whether it is deep or superficial. We have provided a 30-percent evaluation for deep acne (meaning deep inflamed nodules and pus-filled cysts) affecting 40 percent or more of the face and neck; a 10-percent evaluation for deep acne affecting less than 40 percent of the face and neck, or deep acne other than on the face and neck; and a zero-percent evaluation for superficial acne (comedones, papules, pustules, superficial cysts) of any extent. We have provided an alternative direction to rate acne and chloracne as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability. This change will allow more leeway in assessing which type of disability best represents the findings in a particular case of acne or chloracne.

We proposed to evaluate scarring alopecia (DC 7830) and alopecia areata (DC 7831) on the basis of disfigurement. One commenter suggested that the criteria for DC's 7830 and 7831 take into account the ability or inability to improve appearance with a hairpiece or wig. We have reconsidered the criteria for these types of alopecia in view of our changed disfigurement criteria, which are not appropriate for these conditions, and have provided evaluation criteria based instead on the extent of involvement by alopecia. We have provided evaluation levels of 20, 10, and zero percent for scarring alopecia and ten and zero percent for alopecia areata. These levels are commensurate with the range of disability these conditions produce, according to our contract consultant specialists, who reviewed the rating schedule and made recommendations for changes to help fulfill the goals of revising and updating the medical criteria. For scarring alopecia, which usually follows injury, infection, burns, etc., and shows tissue loss and scarring, we have provided a 20-percent evaluation if the condition affects more than 40 percent of the scalp; a 10-percent evaluation if it affects 20 to 40 percent of the scalp; and a zero-percnt evaluation if it affects less

than 20 percent of the scalp. For alopecia areata, where scarring and atrophic changes are not present, we have provided a 10-percent evaluation for generalized involvement of the body, and a zero-percent evaluation if the condition is limited to the scalp and face. These criteria are clear and objective and will assure consistency in evaluation. They do not take into account the potential improvement of appearance with a hairpiece or wig, which would require a subjective assessment, but are based instead on the objectively determinable effects of the condition and are consistent with the recommendations of our consultants.

We edited the language of the note regarding under painful superficial scars (DC 7804) for clarity, and the notes under DC's 7801 and 7802 regarding scars in widely separated areas for the same reason, but these are not substantive changes.

For more clarity and objectivity, we have revised the language in DC 7802 from ``area or areas approximating 144 square inches (929 sq. cm.)'' to ``area or areas of 144 square inches (929 sq. cm.) or greater.'' We revised the title of DC 7813, Dermatophytosis, to include ``(ringworm: of body, tinea corporis; of head, tinea capitis; of feet, tinea pedis; of beard area, tinea barbae; of nails, tinea unguium; of inguinal area (jock itch), tinea cruris)'' to clarify what is included.

VA appreciates the comments submitted in response to the proposed rule, which is now adopted with the amendments noted above.

For the reasons set out in the preamble, 38 CFR part 4, subpart B, is amended as set forth below:

PART 4--SCHEDULE FOR RATING DISABILITIES

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

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

Subpart B--Disability Ratings

2. Section 4.118 is revised to read as follows:

Sec. 4.118 Schedule of ratings--skin.

Rating
7800 Disfigurement of the head, face, or neck:
With visible or palpable tissue loss and either gross distortion or asymmetry of three or more features or paired sets of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with six or more characteristics of disfigurement……80
With visible or palpable tissue loss and either gross distortion or asymmetry of two features or paired sets of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with four or five characteristics of disfigurement……..50
With visible or palpable tissue loss and either gross distortion or asymmetry of one feature or paired set of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with two or three characteristics of disfigurement…….30
With one characteristic of disfigurement……...10

Note (1):The 8 characteristics of disfigurement, for purposes of evaluation under Sec. 4.118, are:
Scar 5 or more inches (13 or more cm.) in length.
Scar at least one-quarter inch (0.6 cm.) wide at widest part.
Surface contour of scar elevated or depressed on palpation.

Scar adherent to underlying tissue.
Skin hypo-or hyper-pigmented in an area exceeding six square inches (39 sq. cm.).
Skin texture abnormal (irregular, atrophic, shiny, scaly, etc.) in an area exceeding six square inches (39 sq. cm.).
Underlying soft tissue missing in an area exceeding six square inches (39 sq. cm.).
Skin indurated and inflexible in an area exceeding six square inches (39 sq. cm.).

Note (2): Rate tissue loss of the auricle under DC 6207 (loss of auricle) and anatomical loss of the eye under DC 6061 (anatomical loss of both eyes) or DC 6063 (anatomical loss of one eye), as appropriate.

Note (3): Take into consideration unretouched color photographs when evaluating under these criteria.

7801 Scars, other than head, face, or neck, that are deep or that cause limited motion:
Area or areas exceeding 144 square inches (929 sq.cm.)…….. 40
Area or areas exceeding 72 square inches (465 sq. cm.)……30
Area or areas exceeding 12 square inches (77 sq. cm.)……. 20
Area or areas exceeding 6 square inches (39 sq. cm.)…….. 10

Note (1): Scars in widely separated areas, as on two or more extremities or on anterior and posterior surfaces of extremities or trunk, will be separately rated and combined in accordance with Sec. 4.25 of this part.

Note (2): A deep scar is one associated with underlying soft tissue damage.

7802 Scars, other than head, face, or neck, that are superficial and that do not limited motion: Area or areas of 144 square inches (929 sq. cm.) or greater…….10

Note (1): Scars in widely separated areas, as on two or more extremities or on anterior and posterior surfaces of extremities or trunk, will be separately rated and combined in accordance with Sec. 4.25 of this part.

Note (2): A superficial scar is one not associated with underlying soft tissue damage.

7803 Scars, superficial, unstable.....……..…10

Note (1): An unstable scar is one where, for any reason, there is frequent loss of covering of skin over the scar.

Note (2): A superficial scar is one not associated with underlying soft tissue damage.
7804 Scars, superficial, painful on examination.....……...10

Note (1): A superficial scar is one not associated with underlying soft tissue damage.

Note (2): In this case, a 10-percent evaluation will be assigned for a scar on the tip of a finger or toe even though amputation of the part would not warrant a compensable evaluation.
(See Sec. 4.68 of this part on the amputation rule.)

7805 Scars, other;
Rate on limitation of function of affected part.

7806 Dermatitis or eczema.
More than 40 percent of the entire body or more than 40 percent of exposed of exposed areas affected, or; constant or near-constant systemic therapy such as corticosteroids or other immunosuppressive drugs required during the past 12-month period……60
20 to 40 percent of the entire body or 20 to 40 percent of exposed areas

affected, or; systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of six weeks more, but not constantly, during the past 12-month period……30

At least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent, of exposed areas affected, or; intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of less than six weeks during the past 12-month period…….10

Less than 5 percent of the entire body or less than 5 percent of exposed areas affected, and; no more than topical therapy required during the past 12-month period……..…0

Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depeding upon the predominant disability.

7807 American (New World) leishmaniasis (mucocutaneous, espundia): Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.

Note: Evaluate non-cutaneous (visceral) leishmaniasis under DC 6301 (visceral leishmaniasis).

7808 Old World leishmaniasis (cutaneous, Oriental sore):
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.

Note: Evaluate non-cutaneous (visceral) leishmaniasis under DC 6301 (visceral leishmaniasis).

7809 Discoid lupus erythematosus or subacute cutaneous lupus erythematosus: Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability. Do not combine with ratings under DC 6350.

7811 Tuberculosis luposa (lupus vulgaris), active or inactive: Rate under Secs. 4.88c or 4.89, whichever is appropriate.

7813 Dermatophytosis (ringworm: of body, tinea corporis; of head, tinea capitis; of feet, tinea pedis; of beard area, tinea barbae; of nails, tinea unguium; of inguinal area (jock itch), tinea cruris): Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.

7815 Bullous disorders (including pemphigus vulgaris, pemphigus foliaceous, bullous pemphigoid, dermatitis herpetiformis, epidermolysis bullosa acquisita, benign chronic familial pemphigus (Hailey-Hailey), and porphyria cutanea tarda):

More than 40 percent of the entire body or more than 40 percent of exposed areas affected, or; constant or near-constant systemic therapy such as corticosteroids or other immunosuppressive drugs required during the past 12-month period……..60

20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected, or; systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of six weeks or or more, but not constantly, during the past 12-month period……...30

At least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent or exposed areas affected, or; intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of less than six weeks during the past 12-month period……10

Less than 5 percent of the entire body or exposed areas affected, and; no more than topical therapy required during the past 12-month period…….0

Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.

7816 Psoriasis:

More than 40 percent of the entire body or more than 40 percent or exposed areas affected, or; constant or near-constant systermic therapy such as corticosteroids or other immunosuppressive drugs required during the past 12-month period……....60

20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected, or; systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of six weeks or more, but not constantly, during the past 12-month period……30

At least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent, of exposed areas affected, or; intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of less than six weeks during the past 12-month period……10

Less than 5 percent of the entire body or exposed areas affected, and; no…….. 0 more than topical therapy required during the past 12-month period.

Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.

7817 Exfoliative dermatitis (erythroderma):

Generalized involvement of the skin, plus systemic manifestations (such as fever, weight loss, and hypopreteinemia), and; constant or near-constant systemic therapy such as therapeutic doses of systemic therapy such as therapeutic doses of costicosteroids, immunosuppressive retinoids, PUVA (psoralen with long-wave ultraviolet-A light) or UVB (ultraviolet-B light) treatments, or electron beam therapy required during the past 12-month period……100

Generalized involvement of the skin without systemic manifestations, and; constant or near-constant systemic therapy such as therapeutic doses of corticosteroids, immunosuppressive retinoids, PUVA (psoralen with long-wave ultraviolet-A light) or UVB (ultraviote-B light) treatments, or electron beam therapy required during the past 12-month period…….60

Any extent of involvement of the skin, and; systemic therapy such as as therapeutic doses of corticosteroids, immunosuppressive retinoids, PUVA (psoralen with long- wave ultraviolet-A light) or UVB (ultraviolet-B light) treatments, or electron beam therapy required for a total duration of six weeks or more, but not constantly, during the past 12-month period……30

Any extent of involvement of the skin, and; systemic therapy such as therapeutic doses of corticosteroids, immunosuppressive retinoids, PUVA (psoralen with long-wave ultraviolet-A light) or UVB (ultraviolet-B light) treatments, or UVB treatments, or electron beam therapy required for a total duration of less than six weeks during the past 12-month period……10

Any extent of involvement of the skin, and; no more than topical therapy required during the past 12-month period……..0

7818 Malignant skin neoplasms (other than malignant melanoma):

Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or impairment of function.

Note: If a skin malignancy requires therapy that is comparable to that used for systemic malignancies, i.e., systemic chemotherapy, X-ray therapy more extensive than to the skin, or surgery more extensive

than wide local excision, a 100-percent evaluation will be assigned from the date of onset of treatment, and will continue, with a mandatory VA examination six months following the completion of such antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination will be subject to the provisions of Sec. 3.105(e) of this chapter. If there has been no local recurrence or metastasis, evaluation will then be made on residuals. If treatment is confined to the skin, the provisions for a 100-percent evaluation do not apply.

7819 Benign skin neoplasms: Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or impairmeny of function.

7820 Infections of the skin not listed elsewhere (including bacterial, fungal, viral, treponemal and parasitic diseases): Rate as disfigurement of the head, face, or nect (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.

7821 Cutaneous manifestations of collagen-vascular diseases not listed elsewhere (including scleroderma, calcinosis cutis, and dermatomyositis):
More than 40 percent of the entire body or more than 40 percent of exposed areas affected, or; constant or near-constant systemic therapy such as corticosteroids or other immunosuppressive drugs required during the past 12-month period…….60
20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected, or; systemic therapy such as conrticosteroids or other immunosuppressive drugs required for a total duration of six weeks or more, but not constantly, during the past 12-month period……..30
At least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent, of exposed areas affected, or; intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of less than six weeks during the past 12-month period…….10
Less than 5 percent of the entire body or exposed areas affected, and; no more than topical therapy required during the past 12-month period……0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.

7822 Papulosquamous disorders not listed elsewhere (including lichen planus, large or small plaque parapsoriasis, pityriasis lichenoides et varioliformis acuta (PLEVA), lymphomatoid papulosus, and pityriasis rubra pilaris (PRP)):
More than 40 percent of the entire body or more than 40 percent of exposed areas affected, and; constant or near-constant systemic medications or intensive light therapy required during the past 12-month period…….60
20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected, or; systemic therapy or intensive light therapy required for a total duration of six weeks or more, but not constantly, during the past 12-month period…….30
At least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent, of exposed areas affected, or; systemic therapy or intensive light therapy required for a total total duration of less than six weeks during the past 12-month period…….10
Less than 5 percent of the entire body or exposed areas affected, and; no more than topical therapy required during the past 12-month period.....……0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.

7823 Vitiligo:
With exposed areas affected.....…….10

With no exposed areas affected.....…… 0

7824 Diseases of keratinization (including icthyoses, Darier's disease, and palmoplantar keratoderma):
With either generalized cutaneous involvement or systemic manifestations, and; constant or near-constant systemic medication, such as immunosuppressive retinoids, required during the past 12-month period……60
With either generalized cutaneous involvement or systemic manifestations, and; intermittent systemic medication, such as immunosuppressive retinoids, required for a total duration of six weeks or more, but not but not constantly, during the past 12-month period…….30
With localized or episodic cutaneous involvement and intermittent systemic medication, such as immunosuppressive retinoids, required for a total duration of less than six weeks during the past 12- month period……10
No more than topical therapy required during the past 12-month period…… 0

7825 Urticaria:
Recurrent debilitating episodes occurring at least four times during the past 12-month period despite continuous immunosuppressive therapy……..60
Recurrent debilitating episodes occurring at least four times during the past 12-month period, and; requiring intermittent systemic immunosuppressive therapy for control…….30
Recurrent episodes occurring at least four times during the past 12-month period, and; responding to treatment with antihistamines or sympathomimetics…….10

7826 Vasculitis, primary cutaneous:
Recurrent debilitating episodes occurring at least four times during the past 12-month period despite continuous immunosuppressive therapy……
60
Recurrent debilitating episodes occurring at least four times during the past 12-month period, and; requiring intermittent systemic immunosuppressive therapy for
control…….30
Recurrent episodes occurring one to three times during the past 12-month period, and; requiring intermittent systemic immunosuppressive therapy for
control…….10
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803 7804, or 7805), depending upon the predominant disability.

7827 Erythema multiforme; Toxic epidermal necrolysis:
Recurrent debilitating episodes occurring at least four times during the past 12-month period despite ongoing immunosuppressive therapy……60

Recurrent episodes occurring at least four times during the past 12-month period, and; requiring intermittent systemic immunosuppressive therapy……...30
Recurrent episodes occurring during the past 12-month period that respond to treatment with antihistamines or sympathomimetics, or; one to three episodes occurring during the past 12-monht period requiring intermittent systemic immunosuppressive therapy…….10
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.

7828 Acne:
Deep acne (deep inflamed nodules and pus-filled cysts) affecting 40 percent or more of the face and neck……30
Deep acne (deep inflamed nodules and pus-filled cysts)affecting less than 40 percent of the face and neck, or; deep acne other than on the face and neck……...10
Superficial acne (comedones, papules, pustules, superficial cysts) of any extent…….0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.

7829 Chloracne:
Deep acne (deep inflamed nodules and pus-filled cysts) affecting 40 percent or more of the face and neck...……..30
Deep acne (deep inflamed nodules and pus-filled cysts) affecting less than 40 percent of the face and neck, or; deep acne other than on the face and neck……...10
Superficial acne (comedones, papules, pustules, superficial cysts of any extent……
0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.

7830 Scarring alopecia:
Affecting more than 40 percent of the scalp.....…… 20
Affecting 20 to 40 percent of the scalp.....……..10
Affecting less than 20 percent of the scalp.....……..0

7831 Alopecia areata:
With loss of all body hair.....…….10
With loss of hair limited to scalp and face.....……...0

7832 Hyperhidrosis:
Unable to handle paper or tools because of moisture, and unresponsive to therapy……
30
Able to handle paper or tools after therapy.....…….
0

7833 Malignant melanoma: Rate as scars (DC's 7801, 7802, 7803, 7804 0r 7805), disfigurement of the head, face, or neck (DC 7800), or impairment of function (under the appropriate body system).
Note: If a skin malignancy requires therapy that is comparable to that used for systemic malignancies, i.e., systemic chemotherapy, X-ray therapy more extensive than to the skin, or surgery more extensive than wide local excision, a 100-percent evaluation will be assigned from the date of onset of treatment, and will continue, with a mandatory VA examination six months following the completion of such antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination will be subject to the provisions of Sec. 3.105(e). If there has been no local recurrence or metastasis, evaluation will then be made on residuals. If treatment is confined to the skin, the provisions for a 100-percent evaluation do not apply.

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

Correction, published September 16, 2002:

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900-AF00

Schedule for Rating Disabilities; the Skin

Correction

In rule document 02-19331 beginning on page 49590 in the issue of Wednesday, July 31, 2002 make the following correction:

Sec. 4.118 [Corrected]

1. On page 49596, the Rate Schedule for 7802 is corrected to read as follows:

Rating

7802 Scars, other than head, face, or neck, that are superficial and that do not cause limited motion:
Area or areas of 144 square inches (929 sq. cm.) or greater……10

Note (1): Scars in widely separated areas, as on two or more extremities or on anterior and posterior surfaces of extremities or trunk, will be separately rated and combined in accordance with Sec. 4.25 of this part.

Note (2): A superficial scar is one not associated with underlying soft tissue damage.

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2. On the same page, the Rate Schedule for 7807, 7808 and 7809 is corrected to read as follows:

Rating

7807 American (New World) leishmaniasis (mucocutaneous, espundia):
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.

Note: Evaluate non-cutaneous (visceral) leishmaniasis under DC 6301 (visceral leishmaniasis).

7808 Old World leishmaniasis (cutaneous, Oriental sore):
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803,

7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.

Note: Evaluate non-cutaneous (visceral) leishmaniasis under DC 6301 (visceral leishmaniasis).

7809 Discoid lupus erythematosus or subacute cutaneous lupus erythematosus:
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.
Do not combine with ratings under DC 6350.

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3. On page 49597, the Rate Schedule for 7811 is corrected to read as follows:

Rating
7811 Tuberculosis luposa (lupus vulgaris), active or inactive Rate under Sec. Sec. 4.88c or 4.89, whichever is appropriate.

[[Page 58449]]

4. On the same page, the Rate Schedule for 7813 is corrected to read as follows:

Rating
7813 Dermatophytosis (ringworm: of body, tinea corporis; of head, tinea capitis; of feet, tinea pedis; of beard area, tinea barbae; of nails, tinea unguium; of inguinal area (jock itch), tinea cruris): Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.

5. On the same page, the Rate Schedule for 7818, 7819, and 7820 is corrected to read as follows:

Rating
7818 Malignant skin neoplasms (other than malignant melanoma): Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or impairment of function. Note: If a skin malignancy requires therapy that is comparable to that used for systemic malignancies, i.e., systemic chemotherapy, X-ray therapy more extensive than to the skin, or surgery more extensive than wide local excision, a 100-percent evaluation will be assigned from the date of onset of treatment, and will continue, with a mandatory VA examination six months following the completion of such antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination will be subject to the provisions of Sec. 3.105(e) of this chapter. If there has been no local recurrence or

metastasis, evaluation will then be made on residuals. If treatment is confined to the skin, the provisions for a 100-percent evaluation do not apply.

7819 Benign skin neoplasms:
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or impairment of function.

7820 Infections of the skin not listed elsewhere (including bacterial, fungal, viral, treponemal and parasitic diseases):
Rate as disfigurement of the head, face, or neck (DC7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.

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6. On page 49599, the Rate Schedule for 7833 is corrected to read as follows:

Rating

7833 Malignant melanoma:
Rate as scars (DC's 7801, 7802, 7803, 7804, or 7805), disfigurement of the head, face, or neck (DC 7800), or impairment of function (under the appropriate body system).

Note: If a skin malignancy requires therapy that is comparable to that used for systemic malignancies, i.e., systemic chemotherapy, X-ray therapy more extensive than to the skin, or surgery more extensive than wide local excision, a 100-percent evaluation will be assigned from the date of onset of treatment, and will continue, with a mandatory VA examination six months following the completion of such antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination will be subject to the provisions of Sec. 3.105(e). If there has been no local recurrence or metastasis, evaluation will then be made on residuals. If treatment is confined to the skin, the provisions for a 100-percent evaluation do not apply.

REGULATORY AMENDMENT

4-02-4

Regulation affected: 38 CFR 4.71a

EFFECTIVE DATE OF REGULATION: September 23, 2002.

Date Secretary approved regulation: June 24, 2002.

Federal Register Citation: 67 FR 54345-49 (August 22, 2002).

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

This document amends diagnostic code 5293 of 38 CFR 4.71a in order to update and clarify the evaluation of intervertebral disc syndrome to assure consistent evaluations. For more detailed information, review the preambles to the attached final regulatory amendment and the notice of proposed rulemaking, which was published in the Federal Register on February 24, 1997 (62 FR 8204).

Intervertebral disc syndromes, both pre-operative and post-operative, are now evaluated in one of two ways. Those that are primarily disabling because of periods of acute symptoms that require bedrest are evaluated according to the cumulative amount of time over the course of a year that the patient is incapacitated, i.e., requires bed rest and treatment by a physician. Those that are disabling primarily because of chronic orthopedic manifestations (e.g., painful muscle spasm or limitation of motion), chronic neurologic manifestations (e.g., footdrop, muscle atrophy, or sensory loss), or a combination of both, are evaluated by assigning separate evaluations for the orthopedic and neurologic manifestations. There are evaluation levels of 60, 40, 20, and 10 percent. When an intervertebral disc syndrome is disabling both because of incapacitating episodes and chronic orthopedic or neurologic manifestations, evaluation will be based on whichever alternative method of evaluation results in a higher evaluation.

If intervertebral disc syndrome is present in more than one spinal segment, provided that the effects in each spinal segment are clearly distinct, each affected segment may be separately evaluated based on: (1) incapacitating episodes, (2) chronic manifestations; or (3) one affected segment may be evaluated based on incapacitating episodes and another segment may be evaluated based on chronic manifestations, whichever method results in a higher evaluation for that segment.

Diagnostic code revised
5293

The pertinent portion of the final rule is as follows:

SUMMARY: This document amends that portion of the Department of Veterans Affairs (VA) Schedule for Rating Disabilities that addresses intervertebral disc syndrome. The effect of this action is to clarify the criteria to ensure that veterans diagnosed with this condition meet uniform criteria and receive consistent evaluations.

SUPPLEMENTARY INFORMATION: VA published a proposal to amend the evaluation criteria for diagnostic code 5293, intervertebral disc syndrome (IVDS), in the Federal Register of February 24, 1997 (62 FR 8204). Interested persons were invited to submit written comments on or before April 25, 1997. We received comments from the Vietnam Veterans of America, Disabled American Veterans, Paralyzed Veterans of America, and two concerned individuals.

We proposed to evaluate IVDS either on its chronic neurologic and orthopedic manifestations or on the total annual duration of incapacitating episodes, whichever would result in a higher evaluation. One commenter recommended that the final rule specify whether there could be separate evaluations of the chronic manifestations of each spinal segment with IVDS; whether there could be separate evaluations based on incapacitating episodes of each spinal segment; and whether one spinal segment could be evaluated based on incapacitating episodes and another on chronic manifestations.

In response to this comment, we have added a third note specifying that IVDS in separate spinal segments will be separately evaluated as long as the effect on each segment is clearly distinct. Inherent in the rule is the concept that each affected spinal segment will be evaluated under the method that results in the highest overall evaluation. This means that affected segments may be separately evaluated based on: (1)
Incapacitating episodes, (2) chronic manifestations; or (3) one affected segment may be evaluated based on incapacitating episodes and another segment may be evaluated based on chronic manifestations.

One commenter stated that acute incapacitating symptoms are distinct from chronic symptoms involving persistent orthopedic and neurological manifestations because each has a different effect on functionality. The commenter stated that IVDS should be rated on both acute and chronic symptoms, as long as the manifestations are different, and then the ratings should be combined. The commenter stated that, if for example a veteran has foot drop as a result of IVDS that interferes with earning capacity and also requires frequent bed rest due to IVDS that affects earning capacity, the veteran has separate disabilities that should be evaluated separately and then combined, rather than rating based on the higher of the two respective evaluations.

Acute incapacitating symptoms and chronic symptoms do not necessarily represent different manifestations of IVDS. For example, IVDS may result in chronic back pain and limitation of motion (a chronic orthopedic manifestation); back pain and limitation of motion may also cause periods of acute incapacitation. Some individuals present predominantly or exclusively with acute symptoms, some with chronic symptoms, and some with both. We have provided alternative methods of evaluation that allow the use of either the chronic manifestations or the total duration of incapacitating episodes for evaluation, whichever results in a higher evaluation. But, in our view, assigning an evaluation under both methods for functional impairment due to IVDS would clearly result in duplicate evaluations of a single disability, and therefore would constitute pyramiding, which is prohibited by 38 CFR 4.14. We therefore make no change in response to this comment.

Another commenter noted that, in some individuals both IVDS and residuals of a vertebral fracture in the same spinal segment are service-connected. Diagnostic code 5285, which applies to fractures of vertebral bodies, directs that ten percent be added to a spinal evaluation if it is less than 60 percent disabling and if there is demonstrable deformity of the vertebral body. The commenter suggested that the

evaluation criteria indicate whether ten percent should be added to a rating for IVDS for either chronic residuals or incapacitating episodes.

When vertebral fracture and IVDS are present in the same spinal segment, the signs and symptoms of each condition commonly overlap and may be inseparable. For example, both conditions may cause pain and limitation of motion of the spine and neurologic disability. In such cases, a single overall evaluation for the manifestations of both disabilities would be assigned, since evaluating the same disability under two diagnoses is prohibited (see 38 CFR 4.14). Ten percent would be added to the single overall evaluation, if it is less than 60 percent disabling, when there is demonstrable vertebral deformity, because the x-ray finding that is the basis for the added ten percent does not duplicate or overlap any other evaluation criteria for either condition. This is true whether the evaluation is based on the criteria for residuals of vertebral fracture, on the total duration of incapacitating episodes of IVDS, or on the chronic orthopedic and neurologic manifestations of IVDS. There may be some cases where the effects of IVDS and vertebral fracture are clearly separable. When that happens, the fracture residuals would be evaluated under diagnostic code 5285, with ten percent added for deformity of the vertebral body when appropriate, and the IVDS would be evaluated under either alternative method, as directed. As with other complex rating issues, if the situation arises, raters may request an advisory review opinion from the Compensation and Pension Service, but we do not believe this situation arises frequently enough to warrant the addition of specific regulatory instructions. We therefore make no change based on this comment.

The same commenter asked if bed rest because of spasm warrants the added 10 percent.

The instruction under diagnostic code 5285 specifies that ten percent is to be added on the basis of demonstrable vertebral deformity due to fracture. Bed rest because of spasm therefore does not warrant an additional 10 percent.

Another commenter recommended that the rule specify whether the evaluation for incapacitating episodes is to be compared with the neurologic and orthopedic evaluations, once combined pursuant to 38 CFR 4.25, or with the higher of those evaluations if both are present.

In response to this comment, we have revised the language under diagnostic code 5293 to direct that IVDS be evaluated based either on the total duration of incapacitating episodes or on the combination of separate evaluations of its chronic orthopedic and neurologic manifestations, whichever method results in the higher evaluation.

One commenter suggested that VA increase the proposed percentage evaluations for incapacitating episodes having a total duration of at least four to six weeks during the past 12 months because, in the commenter's view, veterans who are incapacitated for four to six weeks or more over the course of a year are unemployable. Another commenter also suggested that the evaluation criteria for IVDS should include a 100-percent level.

IVDS is characterized by periods of exacerbation and remission, with a tendency toward recovery over time (``Practical Orthopedic Medicine" (Brian Corrigan and G.D. Maitland) 312, 1983). When IVDS first appears, with few exceptions, the preferred treatment is conservative and includes bed rest of approximately two to four weeks. The majority of patients with IVDS recover from the acute symptoms and have minimal residual functional or work capacity impairments (``Disability Evaluation" (Stephen L. Demeter, M.D., Gunnar B.J. Anderson, M.D., and George M, Smith, M.D.) 288, 1996). The minority in whom conservative treatment fails; or who have repeated, disabling attacks resulting in prolonged loss of time from work; or who have intractable pain or severe or progressive neurological signs, will undergo surgery (``Fundamentals of Orthopedics" (John J. Gartland, M.D.) 334, 1987). Only an occasional patient has disabling back pain and radicular symptoms after surgery (``Campbell's Operative Orthopaedics") 2114, 1980). Therefore, except for short periods of treatment, or periods of convalescence following surgery, IVDS is rarely totally disabling.

The percentage ratings in the schedule ``represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations," 38 CFR 4.1; 38 U.S.C. 1155, and, in our view, a 100 percent evaluation

level for IVDS is not warranted. If a veteran has permanent neurological or orthopedic residuals following back surgery, those residuals could alternatively be rated under other appropriate rating formula. Also, an individual who is shown by the evidence to be unemployable may be assigned a total evaluation (even though the schedule does not provide a 100-percent evaluation) under the provisions of 38 CFR 4.16, 4.17, and 4.18. In view of this fact, and the information regarding the course and outcome of IVDS after treatment, we make no change based on this comment.

Another commenter suggested that the rule clarify the meaning of incapacitating episodes ``per year'' in order to assure that the calendar year is not used.

In response to this comment, we have revised diagnostic code 5293, for the sake of clarity, to specify total duration of incapacitating symptoms ``during the past 12 months'' rather than ``per year.''

We proposed to define the term ``incapacitating episode of intervertebral disc syndrome'' to mean a period of acute symptoms (orthopedic, neurologic, or both), requiring bed rest prescribed by a physician and treatment by a physician. Such treatment by a physician would not require a visit to a physician's office or hospital but would include telephone consultation with a physician. One commenter suggested that we revise the definition to require bed rest ``prescribed by a physician,'' but eliminate the requirement for treatment.

A physician prescribing bed rest will ordinarily prescribe treatment, e.g., analgesics, muscle relaxants, or traction, as well. In our view, the requirement for treatment by a physician makes the criteria clearer, more objective, and more likely to promote consistent evaluations. We therefore make no change in response to this comment. However, in order to clarify note (1), we have added ``prescribed by a physician'' following ``bed rest.''

The same commenter suggested that we waive the requirement for medical verification of the veteran's previous episodes of incapacitating back pain in original claims for IVDS because in such cases there would otherwise be a one-year waiting period from the date of claim. Although in an original compensation claim, an award will be effective from the date of claim or the date entitlement arose, whichever is later (38 CFR 3.400(b)(2)(i)), nothing in the regulations precludes VA from considering medical evidence establishing the total duration of incapacitating episodes during the twelve-month period preceding the date of claim when evaluating the disability. Existing medical records documenting incapacitating episodes of IVDS, as defined in the regulation, during the twelve months before the veteran filed a claim, would be sufficient to establish the severity of the condition without a one-year waiting period. If there are no records of the need for bed rest and treatment, by regulation there were no incapacitating episodes. Chronic manifestations, on the other hand, could be evaluated based on an examination, regardless of whether there were any prior incapacitating episodes. We therefore make no change based on this comment.

Another commenter objected to the proposal to evaluate IVDS based only on doctor-ordered periods of bed rest and suggested that objective findings of IVDS provide a basis for evaluation and should be incorporated into the schedular criteria.

Objective findings, when present, may be used to evaluate IVDS based on chronic orthopedic and neurologic manifestations that are rating criteria under other diagnostic codes. However, some individuals with disabling IVDS exhibit few, if any, objective findings between incapacitating episodes. We have therefore provided alternative evaluation criteria based on periods of incapacitating episodes. Since we will evaluate IVDS under whichever method would result in the higher overall evaluation, we make no change based on this comment.

One commenter assumed that VA will issue companion regulations on how to rate each neurologic and orthopedic manifestation of IVDS, since chronic symptoms are not assigned evaluations in the proposed regulation. The commenter urged that such criteria accurately reflect impairment of earning capacity.

VA plans no separate regulation to address each neurologic and orthopedic manifestation of IVDS. There are existing criteria for evaluating neurologic and orthopedic disabilities, whether they result from IVDS, stroke, or other condition, in the neurologic and musculoskeletal portions of the rating schedule. Additional neurologic manifestations are addressed under diagnostic codes in the schedule for rating genitourinary or digestive systems. For further clarity, we have revised note (2) to indicate that the chronic orthopedic and neurologic manifestations of IVDS are to be evaluated under the most appropriate code or codes. Evaluating disabilities due to IVDS that are identical to disabilities of other etiology under the same criteria will assure consistency and fairness of evaluations.

Proposed note (2) stated that, when evaluating IVDS on the basis of chronic manifestations, orthopedic manifestations, such as limitation of motion of lumbar or cervical spine, paravertebral muscle spasm, or scoliosis of the spine, are to be evaluated under diagnostic code 5293 (IVDS), using evaluation criteria for an appropriate diagnostic code, and neurologic manifestations, such as footdrop, muscle atrophy, sensory loss, or neurogenic bladder, are to be evaluated separately under diagnostic code 5293, using evaluation criteria for an appropriate diagnostic code. One commenter said the note does not provide clear or objective guidance on the degree of disability to be assigned for these manifestations.

There are so many potential neurologic and orthopedic manifestations of IVDS that it would be impractical to incorporate all of them into a single set of criteria. It is not only more practical, but also consistent with the manner in which VA evaluates other conditions that may affect more than one body system, to use evaluation criteria for existing orthopedic and neurologic diagnostic codes to evaluate the specific manifestations of IVDS. We therefore make no change based on this comment.

The same commenter suggested additional chronic manifestations of IVDS that the commenter believes are more objective than the proposed criteria.

The criteria suggested by the commenter would require subjective interpretations of terms such as ``light'' or ``heavy'' labor, ``moderate'' activity, etc. In our view this language is less objective than that in the proposed criteria, and we make no change based on this comment.

One commenter asserted that proposed note (2) conflicts with Esteban v. Brown, 6 Vet. App. 259 (1994), because it precludes an evaluation for the orthopedic manifestations of the spine in addition to an evaluation for IVDS under diagnostic code 5293.

In Esteban, a case that concerned the evaluation of a facial injury, with residuals of painful scars, injury to the facial muscles, and disfigurement, the Court of Appeals for Veterans Claims (CAVC) pointed out that each of the three disabling effects of the injury could be separately evaluated unless they constitute the `same disability'' or the ``same manifestation'' under 38 CFR 4.14 (see above), or unless any of the diagnostic codes in question state that a veteran may not be rated separately for the described conditions. None of the three diagnostic codes at issue precluded separate ratings for the described conditions and the CAVC stated that the critical element in the case was that none of the symptomatology for any one of the three conditions is duplicative of, or overlapping with, the symptomatology of the other two conditions.

Diagnostic code 5293 allows for separate evaluations of chronic orthopedic and chronic neurologic manifestations of IVDS because these manifestations are separate and distinct, and do not constitute the ``same disability'' or the ``same manifestation'' under 38 CFR 4.14. However, virtually all acute incapacitating episodes rated under diagnostic code 5293 for IVDS would be the result of chronic orthopedic and/or chronic neurologic findings. We therefore believe that, if ratings for orthopedic and chronic manifestations were combined with a rating for incapacitating episodes under diagnostic code 5293, it would result in evaluation of the same disability under multiple diagnostic codes, a result which is to be avoided per 38 CFR 4.14. Also providing alternative methods for evaluating IVDS is consistent with the manner in which we evaluate other conditions. For example, lupus erythematosus, diagnostic code 6350, may be evaluated based either on an overall evaluation under 6350 or on an evaluation of its residuals under other diagnostic codes in an appropriate system or systems, whichever method results in a

higher evaluation. As a result, there is no conflict with Esteban, and we make no change based on this comment.

One commenter stated that the rule is inconsistent with the manner in which IVDS and orthopedic and/or neurologic manifestations were rated under the prior version of diagnostic code 5293. According to the commenter, prior diagnostic code 5293 allowed the maximum 60-percent rating for disability attributable to IVDS plus a separate rating for disability affecting other body parts or functions. In support of this comment, the commenter cited Bierman v. Brown, 6 Vet. App. 125, 129 (1994).

Evaluations of zero to 40 percent under the previous version of diagnostic code 5293 were based on recurring attacks and the extent of relief between attacks. The maximum evaluation of 60 percent required ``persistent symptoms compatible with sciatic neuropathy with characteristic pain and demonstrable muscle spasm, absent ankle jerk, or other neurological findings appropriate to site of diseased disc, little intermittent relief.'' In Bierman, the Board of Veterans' Appeals (BVA) denied a separate rating for neurological deficits because the veteran's 60 percent for IVDS under diagnostic code 5293 already compensated him for neurological deficits and their effects for which he was seeking a separate rating. The CAVC stated that, because the BVA failed to articulate a satisfactory statement of reasons or bases for its rating, the Court could not determine why this veteran's IVDS was not rated separately for foot drop under DC 8521, pertaining to paralysis of the popliteal nerve. The CAVC also stated that it was unclear from the rating schedule itself which functional disabilities were compensated as part of a 60-percent rating for IVDS.

Notwithstanding the commenter's interpretation of the prior evaluation criteria, a memorandum issued by the BVA Chairman, Memorandum, No. 01-92-23, dated August 10, 1992, did not interpret prior diagnostic code 5293 to allow a full 60 percent in addition to a separate evaluation for other body parts. Rather, it stated that, except for exceptional cases, a single rating of 60 percent will ordinarily be assigned when a veteran's footdrop is the result of radiculopathy attributable to IVDS. By specifying in this rulemaking that a rating for IVDS may be based either on the combined severity of the chronic neurological and orthopedic findings, or on the extent of incapacitating episodes resulting from all manifestations of the disease under diagnostic code 5293, we clarify how functional manifestations of IVDS are to be evaluated, and we make no further changes based on this comment.

The same commenter stated that the rating criteria in the proposed rule are not consistent with other ratings in the schedule because the design of the proposed rule does not provide a rating that corresponds to functional impairment.

We disagree. On the contrary, the revised rule will assure consistency with other ratings in the schedule because the same rating criteria will be used to evaluate identical disabilities, regardless of etiology. The functional impairment due to footdrop or limitation of motion of the spine, for example, will be evaluated using the same criteria, whether due to IVDS or any other cause. If both footdrop and limitation of motion of the spine are present, the combined evaluation will be the same, whether due to IVDS or any other cause. These provisions are clearly consistent with the approach and manner in which we assess functional impairment in similar disabilities, and we make no change based on this comment.

The same commenter stated that the rule must ``continue'' to recognize that secondary disabilities involving separate anatomical segments or body parts and separate functions are separately ratable and may be rated in combination with a 60-percent rating for disc syndrome itself.

As discussed above, the commenter's interpretation of the previous evaluation criteria for IVDS is not consistent with VA's interpretation. Under the new criteria, all orthopedic and neurologic disabilities that are part of IVDS, whether affecting the spine, the extremities, the bladder, or other areas, will be evaluated under one or the other of the alternative methods of evaluation. However, the revised regulation is also clear that IVDS cannot be evaluated under both sets of criteria for a single spinal segment. If the evaluation is based on the chronic orthopedic and neurologic manifestations, there will be no evaluation for ncapacitating episodes. We therefore make no change based on this comment.

We have edited the definition of incapacitating episodes for clarity and have defined ``chronic manifestations'' to mean ``orthopedic and neurologic signs and symptoms resulting from IVDS that are present constantly, or nearly so.'' These are not substantive changes.

We have also simplified note (2) by editing for clarity and by removing specific examples of chronic manifestations, which we believe are unnecessary.

VA appreciates the comments submitted in response to the proposed rule, which is now adopted with the amendments noted above.

For the reasons set forth in the preamble, 38 CFR part 4 is amended as set forth below:

PART 4--SCHEDULE FOR RATING DISABILITIES

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

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

Subpart B--Disability Ratings

2. Section 4.71a is amended by revising diagnostic code 5293 and adding an authority citation at the end of the section to read as follows:

Sec. 4.71a Schedule of ratings--musculoskeletal system.

- * * * *

The Spine

Rating
* * * * *
5293 Intervertebral disc syndrome:
Evaluate intervertebral disc syndrome (preoperatively or postoperatively) either on the total duration of incapacitating episodes over the past 12 months or by combining under Sec. 4.25 separate evaluations of its chronic orthopedic and neurologic manifestations along with evaluations for all other disabilities, whichever method results in the higher evaluation.
With incapacitating episodes having a total duration of at least six weeks during the past 12 months……60
With incapacitating episodes having a total duration of at least four weeks but less than six weeks during the past 12 months……...40
With incapacitating episodes having a total duration of at least two weeks but less than four weeks during the past 12 months……..…….20

With incapacitating episodes having a total duration of at least
one week but less than two weeks during the past 12 months……..…...10

Note (1): For purposes of evaluations under 5293, an incapacitating episode is a period of acute signs and symptoms due to intervertebral disc syndrome that requires bed rest prescribed by a physician and treatment by a physician. ``Chronic orthopedic and neurologic manifestations" means orthopedic and neurologic signs
and symptoms resulting from intervertebral disc syndrome that are present constantly, or nearly so.

Note (2): When evaluating on the basis of chronic manifestations, evaluate orthopedic disabilities using evaluation criteria for the most appropriate orthopedic diagnostic code or codes. Evaluate neurologic disabilities separately using evaluation criteria for the most appropriate neurologic diagnostic code or codes.

Note (3): If intervertebral disc syndrome is present in more than one spinal segment, provided that the effects in each spinal segment are clearly distinct, evaluate each segment on the basis of chronic orthopedic and neurologic manifestations or incapacitating episodes, whichever method results in a higher evaluation for that segment.

* * * * *

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

REGULATORY AMENDMENT

4-03-1

Regulation affected: 38 CFR 4.87

EFFECTIVE DATE OF REGULATION: June 13, 2003

Date Secretary approved regulation: April 14, 2003

Federal Register Citation: 68 FR 25822, 25823 (May 14, 2003)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

Recently, VA has received claims for two separate evaluations for tinnitus in the same individual, one for each side, when recurrent tinnitus is perceived bilaterally.

This document amends 38 CFR 4.87 to explicitly state the method of evaluation of (true) tinnitus under diagnostic code 6260 in the portion of the rating schedule that addresses evaluation of disabilities of the ear. The document does this through "Note (2)" under diagnostic code 6260 which reads, as follows: "Assign only a single evaluation for recurrent tinnitus, whether the sound is perceived in one ear, both ears, or in the head."

The intended effect of this action is to codify current standard VA practice by stating that recurrent tinnitus will be assigned only a single 10-percent evaluation whether it is perceived in one ear, both ears, or somewhere in the head.

Tinnitus is classified either as subjective or "true" tinnitus or objective tinnitus. Over 95% of tinnitus cases are true tinnitus. In true tinnitus, the sound is audible only to the patient.

VA's Audiology and Speech Pathology Service recently wrote a booklet titled Hearing Impairment, an Independent Study Course for health care providers. The section on tinnitus states that the fact that most tinnitus appears to be coming from the ear led to a belief that tinnitus was generated in the inner ear, but that this is not the case. It states that damage in the inner ear may be a precursor for subjective tinnitus, but that subjective tinnitus is generated within the central auditory pathways. It discusses current research that suggests tinnitus is similar to phantom limb syndrome where the brain creates phantom sensation (pain, or other sensation) to replace missing inputs from the amputated limb; with damage to the inner ear, the brain creates phantom sensations (true tinnitus) to replace missing inputs from the damaged inner ear.

Unlike true tinnitus where the sound is audible only to the patient, in the much rarer objective tinnitus (sometimes called extrinsic tinnitus or "pseudo-tinnitus"), the sound is audible to other people. Other people can hear the sound either simply by listening or by listening with a stethoscope. Objective tinnitus commonly has a definite cause that generates the sound, such as vascular or muscular disorders. Objective tinnitus may also be due to such nonpathologic causes as noise from the temporomandibular joints, opening of the Eustachian tubes, or repetitive muscle contractions.

With regard to objective tinnitus, this document further amends 38 CFR 4.87 to direct raters not to evaluate objective tinnitus under diagnostic code 6260, but to evaluate it as part of any underlying condition causing it. The document does this through "Note (3)" under diagnostic code 6260 which reads as follows: "Do not evaluate objective tinnitus (in which the sound is audible to other people and has a definable cause that may or may not be pathologic) under this diagnostic code, but evaluate it as part of any underlying condition causing it."

Diagnostic code (s) revised: 6260
Diagnostic code (s) removed: None
Diagnostic code (s) added: None

The pertinent portion of the final rule is as follows:

SUMMARY: This document amends the Department of Veterans Affairs (VA) Schedule for Rating Disabilities to state more explicitly the method of evaluation of tinnitus under diagnostic code 6260 in the portion of the rating schedule that addresses evaluation of disabilities of the ear. The intended effect of this action is to codify current standard VA practice by stating that recurrent tinnitus will be assigned only a single 10-percent evaluation whether it is perceived in one ear, both ears, or somewhere in the head.

SUPPLEMENTARY INFORMATION: On September 19, 2002, VA published in the Federal Register (67 FR 59033) a proposal to amend diagnostic code 6260 in 38 CFR 4.87, in order to codify current standard VA practice concerning the evaluation of tinnitus. It states that recurrent tinnitus will be assigned only a single ten-percent evaluation, whether it is perceived in one ear, both ears, or somewhere in the head. Interested persons were invited to submit written comments on or before November 18, 2002. We received two comments, one from the American Legion and one from a concerned individual.

One commenter felt that limiting tinnitus to a single ten-percent evaluation is arbitrary and inconsistent with other provisions of VA's Schedule for Rating Disabilities that deal with bilateral disabilities, such as those providing separate evaluations for each ear with hearing impairment. The same commenter felt that the proposed rule document offered no substantive rationale for maintaining the current assignment of a single evaluation for tinnitus, regardless of whether it is perceived in one or both ears.

We disagree. VA's Audiology and Speech Pathology Service recently wrote a booklet titled Hearing Impairment, an Independent Study Course for health care providers. The section on tinnitus states that the fact that most tinnitus appears to be coming from the ear led to a belief that tinnitus was generated in the inner ear, but this is not the case. It further states that damage in the inner ear may be a precursor for subjective tinnitus, but that subjective tinnitus is generated within the central auditory pathways. Comparing tinnitus, a central nervous condition, to hearing loss, a disability from damage to an organ of special sense (the ear) is not a valid comparison. We have made no change in response to this comment. Because over 200,000 veterans are currently rated for tinnitus under diagnostic code 6260 under Diseases of the Ear, for administrative efficiency, and because many are accustomed to looking in that section of the rating schedule, the current placement of tinnitus within the rating schedule will remain unchanged.

The SUPPLEMENTARY INFORMATION section of the proposed regulatory amendment explained that tinnitus is a single disability arising in the brain and that it consists of the perception of sound in the absence of an external stimulus. This definition applies whether the tinnitus is perceived in one ear, both ears, or somewhere undefined in the head. The commenter provided no information that would refute this medical explanation. The degree of disability, that is, the degree to which tinnitus impairs the veteran's earning capacity, is the same regardless of how the tinnitus is perceived. To rate each ear separately for this single disability would violate the prohibition on pyramiding, 38 CFR 4.14. Similarly, to rate each ear separately would be a violation of the principle of 38 CFR 4.25(b) that a ``single disease entity'' is to be given a single rating. A single evaluation for a single disability is appropriate. We have made no change based on this comment.

A second commenter suggested that we adopt measurable time and duration standards for the term ``recurrent.'' Because a substantive change to define the term ``recurrent'' is beyond the scope of this rulemaking, we have made no change based on this comment.

VA appreciates the comments submitted in response to the proposed rule. Based on the rationale stated in the proposed rule and in this document, the proposed rule is adopted without change.

For the reasons set out in the preamble, 38 CFR part 4, subpart B, is amended as set forth below:

PART 4--SCHEDULE FOR RATING DISABILITIES

Subpart B--Disability Ratings

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

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

2. In Sec. 4.87, diagnostic code 6260 is revised to read as follows:

Sec. 4.87 Schedule of ratings--ear.

Diseases of the Ear	Rating
* * * * *	
6260 Tinnitus, recurrent	10

Note (1): A separate evaluation for tinnitus may be combined with an evaluation under diagnostic codes 6100, 6200, 6204, or other diagnostic code, except when tinnitus supports an evaluation under one of those diagnostic codes.

Note (2): Assign only a single evaluation for recurrent tinnitus, whether the sound is perceived in one ear, both ears, or in the head.

Note (3): Do not evaluate objective tinnitus (in which the sound is audible to other people and has a definable cause that may or may not be pathologic) under this diagnostic code, but evaluate it as part of any underlying condition causing it.

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

REGULATORY AMENDMENT

4-03-2

Regulation affected: 38 CFR 4.71a

EFFECTIVE DATE OF REGULATION: September 26, 2003

Date Secretary approved regulation: June 12, 2003

Federal Register Citation: 68 FR 51454 (August 27, 2003)

The purpose of the following comment on the changes included in this amendment of VA regulations is to inform all concerned why this change is being made. This comment is not regulatory.

This document amends 38 CFR part 4, by revising that portion of the Musculoskeletal System in the Schedule for Rating Disabilities that addresses disabilities of the spine, specifically 38 CFR 4.71a and new diagnostic codes 5235 to 5243. The intended effect of this action is to update this portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances that have occurred since the last review. For more detailed information, review the preambles to the attached final regulatory amendment as well as the notice of proposed rulemaking, which was published in the Federal Register on September 4, 2002 (67 FR 56509).

Diagnostic code (s) revised: None
Diagnostic code (s) removed: 5285, 5286, 5287, 5288, 5289, 5290, 5291, 5292, and 5293
Diagnostic code (s) added: 5235, 5236, 5237, 5238, 5239, 5240, 5241, 5242, and 5243

For the reasons set out in the preamble, 38 CFR part 4, subpart B, is amended as set forth below:

PART 4--SCHEDULE FOR RATING DISABILITIES

Subpart B--Disability Ratings

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

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

2. In Sec. 4.71a, the table ``The Spine'' is revised and is transferred so that it precedes the table ``The Hip and Thigh'; and Plate V is added immediately following the table ``The Spine'', to read as follows:

Sec. 4.71a Schedule of ratings--musculoskeletal system.

* * * * *

The Spine

Rating
General Rating Formula for Diseases and Injuries of the Spine
(For diagnostic codes 5235 to 5243 unless 5243 is evaluated under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes):
With or without symptoms such as pain (whther or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease
Unfavorable ankylosis of the entire spine.....……100
Unfavorable ankylosis of the entire thoracolumbar spine…….50
Unfavorable ankylosis of the entire cervical spine; or, forward flexion of the thoracolumbar spine 30 degrees or less; or, favorable ankylosis of the entire thoracolumbar spine……40
Forward flexion of the cervical spine 15 degrees or less; or favorable ankylosis of the entire cervical spine……30
Forward flexion of the thoracolumbar spine greater than 30 degres but not greater than 60 degrees; or, forward flexion of the cervical spine greater than 15 degrees but not greater than 30 degrees; or, the combined range of motion of the thoracolumbar spine not greater than 120 degrees; or, the the combined range of motion of the cervical spine not greater greater than 170 degrees; or, muscles spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis.....……..20
Forward flexion of the thoracolumbar spine greater than 60 degrees but not greater than 85 degrees; or, forward flexion of the cervical spine greater than 30 degrees but not greater than 40 degrees; or, combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees; or, combined range of motion of the cervical spine greater than 170 degrees but not greater than 335 degrees; or, muscle spasm, guarding, or localized tenderness not resulting in abnormal gait or abnormal spinal contour; or, vertebral body fracture with loss of 50 percent or more of the height……10

Note (1): Evaluate any associated objective neurologic abnormalities, including, but not limited to, bowel or bladder impairment, separately, under an appropriate diagnostic code.

Note (2): (See also Plate V.) For VA compensation purposes, normal forward flexion of the cervical spine is zero to 45 degrees, extension is zero to 45 degrees, left and right lateral flexion are zero to 45 degrees, and left and right lateral rotation are zero to 80 degrees. Normal forward flexion of the thoracolumbar spine is zero to 90 degrees, extension is zero to 30 degrees, left and right lateral flexion are zero to 30 degrees, and left and right lateral rotation are zero to 30 degrees. The combined range of motion refers to the sum of the range of forward flexion, extension, left and right lateral flexion, and left and right rotation. The normal combined range of motion of the cervical spine is 340 degrees and of the thoracolumbar spine is 240

degrees.The normal ranges of motion for each component of spinal motion provided in this note are the maximum that can be used for calculation of the combined range of motion.
Note (3): In exceptional cases, an examiner may state that because of age, body habitus, neurologic disease, or other factors not the result of disease or injury of the spine, the range of motion of the spine in a particular individual should be considered normal for that individual, even though it does not conform to the normal range of motion stated in Note (2). Provided that the examiner supplies an explanation, the examiner's assessment that the range of motion is normal for that individual will be accepted.

Note (4): Round each range of motion measurement to the nearest five degrees.

Note (5): For VA compensation purposes, unfavorable ankylosis is a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the costal margin on the abdomen; dyspnea or dysphagia; atlantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. Fixation of a spinal segment in neutral position (zero degrees) always represents favorable ankylosis.

Note (6): Separately evaluate disability of the thoracolumbar and cervical spine segments, except when there is unfavorable ankylosis of both segments, which will be rated as a single disability.

5235 Vertebral fracture or dislocation
5236 Sacroiliac injury and weakness
5237 Lumbosacral or cervical strain
5238 Spinal stenosis
5239 Spondylolisthesis or segmental instability
5240 Ankylosing spondylitis
5241 Spinal fusion
5242 Degenerative arthritis of the spine (see also diagnostic code 5003)
5243 Intervertebral disc syndrome
Evaluate intervertebral disc syndrome (preoperatively or postoperatively) either under the General Rating Formula for Diseases and Injuries of the Spine or under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes, whichever method results in the higher evaluation when all disabilities are combined under Sec. 4.25.

Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes

With incapacitating episodes having a total duration of at least 6 weeks during the past 12 months……...60
With incapacitating episodes having a total duration of at least 4 weeks but less than 6 weeks during the past 12 months…….40
With incapacitating episodes having a total duration of at least 2 weeks but less than 4 weeks during the past 12 months…….20
With incapacitating episodes having a total duration of at least one week but less than 2 weeks during the past 12 months……...10
