DEPARTMENT OF VETERANS AFFAIRS 8320-01

38 CFR Part 4

RIN 2900-AP88

Schedule for Rating Disabilities; Musculoskeletal System and Muscle Injuries

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to revise the regulations that involve the Musculoskeletal System within the VA Schedule for Rating Disabilities ("VASRD" or "Rating Schedule"). VA proposes to rename certain diagnostic codes, revise rating criteria, give new rating guidance, add new codes, and remove obsolete codes. These revisions would incorporate medical terminology more recent than the last comprehensive review, as well as simplify the rating process.

DATES: Comments must be received by VA on or before [Insert date 60 days after date of publication in the FEDERAL REGISTER].

ADDRESSES: Written comments may be submitted through www.Regulations.gov; by mail or hand-delivery to Director, Regulations Management (00REG), Department of Veterans Affairs, 810 Vermont Ave., NW, Room 1068, Washington, DC 20420; or by fax to (202) 273-9026. (This is not a toll-free number.) Comments should indicate that they are submitted in response

to “RIN 2900-AP88 – Schedule for Rating Disabilities; Musculoskeletal System and Muscle Injuries.” Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461-4902 for an appointment. (This is not a toll-free number.) In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at www.Regulations.gov.

FOR FURTHER INFORMATION CONTACT: Gary Reynolds, M.D., Regulations Staff (211C), Compensation Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420, (202) 461-9700. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: The National Defense Authorization Act of 2004, secs. 1501-07, Public Law 108-136, 117 Stat. 1392, established the Veterans’ Disability Benefits Commission (the “Commission”). Section 1502 of Public Law 108-136 mandated the Commission to study ways to improve the disability compensation system for military veterans. The Commission consulted with the Institute of Medicine (IOM) to review the medical aspects of current compensation policies. In 2007, the IOM released its report titled “A 21st Century System for Evaluating Veterans for Disability Benefits.” (Michael McGeary et al. eds.2007).

The IOM report was notable in several respects. The IOM observed that, in part, the Rating Schedule was inadequate in areas because it contained obsolete information and did not sufficiently integrate current and accepted diagnostic procedures. In addition, the IOM observed that the current body system organization of the Rating Schedule does not reflect current knowledge of the relationships between conditions and comorbidities.

Following the release of the IOM report, VA created a musculoskeletal system workgroup. The goals adopted by the workgroup were to: 1) improve and update the process that VA uses to assign levels of disability after it grants service connection; 2) improve the fairness in adjudicating disability benefits for service-connected veterans; and 3) invite public participation. The workgroup was co-chaired by the Veterans Health Administration and Veterans Benefits Administration. The workgroup was comprised of subject matter experts from VA, the Department of Defense, and medical academia. The workgroup held a public forum in Washington, DC, during August 2010, where it discussed current regulations and possible revisions. The workgroup held a second public forum in Washington, DC, during June 2012, where it shared a draft proposal for comment.

The workgroup met periodically during and after the public forums to continue its revision efforts. The regulation-drafting phase, which began in April 2012, continues through the publication of this proposed rule. With this rulemaking, VA proposes to remove obsolete diagnostic codes, modernize the

names of selected diagnostic codes, revise descriptions and criteria, and add new diagnostic codes.

The Focus of This Revision

Consistent with the IOM's recommendations, the proposed amendments rename conditions to reflect current medicine, remove obsolete conditions, clarify ambiguities in existing rating criteria, and add conditions that previously did not have diagnostic codes. However, VA experienced greater difficulty revising existing rating criteria in many areas. After significant time and research, since an earnings loss study had not been conducted in time to be considered during the workgroup and rule-drafting phases, VA concluded there was only a narrow set of circumstances where the medical literature clearly supported the proposed changes in the absence of earnings loss information.

As such, VA modified the approach recommended by the IOM for this body system. Only peer-reviewed articles where at least one measureable proxy for reduced earnings capacity was studied were deemed acceptable to justify a reduction in the level or duration of ratings for specific conditions (e.g., time to return to work, activity limitations related to work, and/or participation restriction(s) from work–related tasks). Therefore, at this time, VA proposes changes to only two codes (diagnostic codes 5054 and 5055) where the criteria changes would result in such a reduction.

I. Proposed Changes to § 4.71a

A. Nomenclature Changes to Existing Diagnostic Codes: 5003, 5012-15, 5023, 5024 and 5242

In its review of the musculoskeletal body system, VA identified a number of diagnostic codes (DCs) with terms that are outdated or unclear. As such, it proposes to retitle these DCs to reflect current medical practice and nomenclature. There are no proposed substantive changes to the rating criteria for these eight DCs.

VA proposes to retitle DC 5003, currently "Arthritis, degenerative (hypertrophic or osteoarthritis)" as "Degenerative arthritis, other than post-traumatic." No other language or criteria changes are proposed for this diagnostic code.

Current DCs 5012 and 5015 refer to "Bones, new growths of, malignant" and "Bones, new growths of, benign," respectively. VA proposes to replace the term "new growths of" in these DCs with the current medical term, "neoplasm." See S. Terry Canale and James H. Beaty, Campbell's Operative Orthopedics 859-86 (benign) and 909-45 (malignant) (12th ed. 2013). DC 5012 would be titled "Bones, neoplasm, malignant, primary or secondary" to indicate that both primary and secondary neoplasms are rated under this DC to ensure consistent and accurate evaluation. Non-substantive revisions to the language in the note under DC 5012 are also proposed; specifically, VA proposes to add the term "prescribed" to the phrase "therapeutic procedure" to ensure that readers understand VA will only consider medically-directed therapy when rating DC 5012.

VA proposes to rename DC 5013, which refers to "Osteoporosis, with joint manifestations," as "Osteoporosis, residuals of." VA proposes a similar revision to current DC 5014 by renaming "Osteomalacia" as "Osteomalacia, residuals of." Both osteoporosis and osteomalacia, in and of themselves, do not have any disabling characteristics. See Kelley's Textbook of Rheumatology 1730-1750 (Gary S. Firestein and Ralph C. Budd et al. eds.,10th ed. 2017). Rather, it is the residuals of these conditions that VA evaluates. Thus, adding the reference "residuals of" provides more accurate instruction and information to rating personnel.

Current DC 5023 refers to "Myositis ossificans." VA proposes to update this DC to reflect the latest medical terminology and rename DC 5023 as "Heterotopic ossification." See Essentials of Physical Medicine and Rehabilitation: Musculoskeletal Disorders, Pain and Rehabilitation, 691-95 (Walter R. Frontera and Julie K. Silver et al. eds., 2d ed. 2008). Additionally, VA proposes to revise DC 5024, currently named, "Tenosynovitis," to "Tenosynovitis, tendinitis, tendinosis, or tendinopathy." These newly-added conditions are commonly seen in the veteran population and represent similar forms of disability. See Kelley's Textbook of Rheumatology, supra at 587-604. This update would assist rating personnel in more quickly identifying the appropriate DC. Non-substantive revisions to the criteria of DC 5024 are also proposed.

Finally, VA proposes to retitle DC 5242, "Degenerative arthritis of the spine" as "Degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome." This change gives rating personnel clear

guidance whenever they encounter a diagnostic imaging report that references degenerative disc disease without mention of intervertebral disc syndrome (also known as disc herniation). A non-substantive revision to the citation accompanying DC 5242 is also proposed.

B. Substantive Revisions to Existing Diagnostic Codes: 5002, 5009-5011, 5051-5056, 5120, 5160, 5170, 5201, 5202, 5255, 5257, 5262, and 5271

In addition to modernizing the names of certain DCs, VA also proposes substantive (i.e., not related to nomenclature) revisions to a number of existing DCs, to include some instances of changes in the evaluation criteria.

1. Diagnostic Code 5002

The first substantive revision proposed for § 4.71a involves DC 5002, "Arthritis rheumatoid (atrophic) As an active process." VA proposes to retitle this code as "Multi-joint arthritis (except post-traumatic and gout), 2 or more joints, as an active process." VA proposes this change to include a greater number of systemic arthritis processes that cause multisystem effects besides rheumatoid arthritis. The title would employ the phrase "multi-joint" rather than "polyarthritis" because polyarthritis requires 4 or more joints to be involved. VA would provide, in Note (1), a non-exhaustive list of conditions rated under this code (rheumatoid arthritis, psoriatic arthritis, spondyloarthropathies, etc.). See Kelley's Textbook of Rheumatology, supra at 615-616. VA would also remove the language currently in DC 5002 regarding chronic residuals and, in Note (2), provide a directive to rate chronic residuals under DC 5003. VA proposes this change because the current language used for chronic residuals in DC 5002 is very similar to DC

5003 and its removal would simplify the schedule. Finally, VA would redesignate the code's current note as Note (3) and add a prohibition that prevents combining ratings from active process with DC 5003, instead directing rating personnel to assign the higher evaluation.

2. Diagnostic Code 5009

VA proposes that diagnostic code 5009, currently titled "Arthritis, other types (specify)," be retitled as "Other specified forms of arthropathy (excluding gout)." VA proposes this change to capture other disease processes that cause joint injury, but are not necessarily captured within the rating schedule. The current language accompanying DC 5009, concerning how to rate diagnostic codes 5004-5009, would be redesignated as Note (2) and would be revised to give guidance on how to rate both acute phase and chronic residuals. A new Note (1) would provide a non-exhaustive list of conditions that should be rated under this diagnostic code. No other changes are proposed for this code.

3. Diagnostic Code 5010

Diagnostic code 5010 currently states: "Arthritis, due to trauma, substantiated by X-ray findings: Rate as arthritis, degenerative." VA proposes to change the title and criteria to "Post-traumatic arthritis: Rate as limitation of motion, dislocation, or other specified instability under the affected joint. If there are 2 or more joints affected, each rating shall be combined in accordance with § 4.25." VA proposes the title change to distinguish between joint conditions arising from traumatic causes and joint conditions resulting from systemic processes. This distinction is important, as the natural history (and ultimately the

severity of disability) differs between joint conditions stemming from trauma as opposed to joint conditions related to systemic processes.

VA proposes the change in criteria to provide a more accurate approach to rating joint injuries resulting from trauma. The trauma process is a different event for each affected joint, as opposed to a condition such as rheumatoid arthritis, where the same systemic process can affect more than one joint in the same manner. VA also proposes the directive to combine ratings for separate joints affected by traumatic injury in accordance with § 4.25 so there will be no misunderstanding for rating personnel when encountering this situation. It is important to note that, as a result of these changes, DC 5010 would no longer rate joints affected by trauma-related arthritis under the criteria of DC 5003.

4. Diagnostic Code 5011

The next proposed substantive revision to § 4.71a is DC 5011, currently named "Bones, caisson disease of." VA proposes to first revise the title of this DC to “Decompression illness” to ensure use of the most modern terminology. See Richard D. Vann et al., "Decompression Illness," 377 Lancet 153-64 (2010). VA also proposes to revise the rating criteria for DC 5011, which currently direct rating personnel to “Rate as arthritis, cord involvement, or deafness, depending on the severity of disabling manifestations.” The proposed changes would provide more detailed instructions on how to rate manifestations associated with decompression illness that are outside of the musculoskeletal system (i.e., not arthritic). It is well established among medical experts that the most common residual manifestations from decompression illness involve the vestibule-

cochlear system (e.g., hearing impairment, dizziness, vertigo), respiratory system (e.g., obstructive lung disease, pulmonary blebs) or neurologic system (e.g., peripheral neuropathy, stroke, paralysis). As such, VA proposes to direct rating personnel to consider evaluations within the auditory system for vestibular residuals, the respiratory system for pulmonary barotrauma residuals, and the neurologic system for cerebrovascular accident residuals. Id.

5. Diagnostic Codes 5051-5056

Since the last revision to the musculoskeletal system schedule, the medical community has been employing a new treatment approach, joint resurfacing, for selected joints (particularly the hip and knee). There are important similarities between joint resurfacing and prosthetic joint replacement. Joint resurfacing takes about the same time to perform and the recovery/rehabilitation periods are similar to comparable prosthetic joint replacement. This means that the impact on earnings capacity caused by the convalescence and rehabilitation from joint resurfacing is comparable to prosthetic joint replacement. However, there are significant differences with joint resurfacing, including: 1) joint resurfacing preserves more of the original anatomy; and, 2) in most cases, joint resurfacing restores more of the original joint function than the prosthetic joint replacement. Therefore, less residual disability typically results from joint resurfacing as compared to prosthetic joint replacement. Currently, VA does not compensate for the disability associated with joint resurfacing, despite the similar impact on earnings capacity as prosthetic joint replacement.

To rectify this disparity, VA proposes to incorporate joint resurfacing within DCs 5054 and 5055 (hip and knee replacement, respectively), since more research assessing convalescence, rehabilitation, and functional recovery concerns these two joints. The DC titles would be revised to incorporate resurfacing, and the 100 percent evaluation for prosthetic hip and knee replacement would also apply to resurfacing these two joints. However, after the 100 percent evaluation period ends, further evaluation would assess the limitation of motion DCs for the hip and knee, rather than the prosthetic joint replacement of either the hip or knee, because, as previously stated, there is less of an expectation of residual disability with joint resurfacing. A note would be added to DCs 5054 and 5055 directing rating personnel, at the conclusion of the 100 percent evaluation period, to evaluate hip joint resurfacing claims under DCs 5250-5255 and knee joint resurfacing claims under DCs 5256-5262.

VA currently evaluates total joint replacements by assigning a 100 percent evaluation for 1 year following implantation of a prosthesis. After 1 year, VA assigns a minimum evaluation, with higher evaluations for complications or residuals such as weakness, pain, and limitation of motion. The evaluations assigned under these DCs are intended to encompass all musculoskeletal residuals under § 4.71a. Separate evaluations may be assigned for residuals such as scars or neurological deficits pursuant to § 4.14.

VA proposes two modifications in this regard. First, a note prior to DCs 5051 to 5056 would clarify that separate evaluations may not be assigned under § 4.71a for the joint that was resurfaced or replaced by a prosthesis unless

otherwise directed. This note is intended to clarify current practice and ensure consistent application of these DCs among rating personnel.

In addition, for DCs 5054 and 5055, VA proposes to reduce the 100 percent evaluation period from 1 year to 4 months. Current medical practice for these conditions has recovery timelines that in most cases permit return to work well short of 1 year. In a review of studies looking at factors affecting return to work, the average time for return to work was between 1.1 and 13.9 weeks for hip arthroplasty and between 8.0 and 12.0 weeks for knee arthroplasty. See Claire Tilbury et al., "Return to work after total hip and knee arthroplasty: a systematic review," 53 Rheumatology 512-525 (2014).

6. Diagnostic Code 5120

VA currently evaluates amputations of the arm that involve disarticulation under DC 5120 as 90 percent disabling regardless of dominant arm involvement At the outset, VA proposes to revise the name of this DC to "Complete amputation, upper extremity," as this is a more accurate description of the amputation level and site.

Second, VA proposes to create two levels of disability under DC 5120 for rating purposes. One level would be titled "Disarticulation (involving complete removal of the humerus only)" and would provide a 90 percent compensation level for either major or minor extremity involvement; this level would be consistent with the current compensation level under DC 5120. However, the second level, to be titled "Forequarter amputation (involving complete removal of the humerus along with any portion of the scapula, clavicle, and/or ribs)," would

provide for 100 percent compensation for either dominant or non-dominant extremity involvement. See Canale, supra at 659-71. Although both levels represent complete amputation of the upper extremity, VA believes a higher level of compensation is warranted for forequarter amputation because it is a more extensive amputation than disarticulation and results in a more significant occupational impact.

7. Diagnostic Code 5160

For reasons similar to those discussed immediately above, VA proposes two revisions of DC 5160, which pertains to amputation of the thigh at the level of disarticulation with loss of extrinsic pelvic girdle muscles. First, VA proposes to retitle this DC to "Complete amputation, lower extremity" to more accurately describe the amputation level and site.

VA also proposes to create two levels of criteria for rating purposes. One would be titled "Disarticulation (involving complete removal of the femur and intrinsic pelvic musculature only)" and would provide a 90 percent rating that is consistent with the current rating under DC 5160. The second level, titled "Trans-pelvic amputation (involving complete removal of the femur and intrinsic pelvic musculature along with any portion of the pelvic bones)," would provide for a 100 percent rating. See Canale, supra at 651-58. VA believes that a higher level of compensation is warranted for trans-pelvic amputation because it is a more extensive amputation than disarticulation and results in a more significant occupational impact.

VA also proposes to insert a note under DC 5160 directing rating personnel to separately evaluate residuals involving other body systems, such as bowel or bladder impairment, under the appropriate diagnostic code.

8. Diagnostic Code 5170

Current DC 5170 refers to “Toes, all, amputation of, without metatarsal loss.” VA proposes to add the phrase “or transmetatarsal, amputation of, with up to half of metatarsal loss" to include a residual of toe amputation that causes similar disability. See Canale, supra at 622-23. No change to the current level of compensation is proposed.

9. Diagnostic Code 5201

VA currently assigns ratings for limitation of motion of the arm at the shoulder where motion is limited to 25 degrees from the side, 45 degrees (midway between the side and shoulder level), or 90 degrees (at the shoulder level).

VA proposes to clarify the terminology used in these criteria by adding ranges of motion of the shoulder. Specifically, VA proposes to assign a 40 percent rating for a major joint, or 30 percent for a minor joint, where flexion and/or abduction is limited to 25 degrees from the side. VA also proposes to assign a 30 percent rating for a major joint, or 20 percent for a minor joint, where motion is limited to “midway between side and shoulder level,” defined as flexion and/or abduction limited to 45 degrees or less. Finally, VA proposes to assign a 20 percent rating for a major or minor joint where motion is limited “at shoulder level,” defined as flexion and/or abduction limited to 90 degrees or less.

These changes are not intended to alter the rating criteria. The proposed changes simply clarify the specific ranges of motion that qualify as limitations to ensure rating personnel consistently apply these criteria.

10. Diagnostic Code 5202

Currently, VA assigns a 20 percent rating for either shoulder joint when there are infrequent episodes of dislocation of the humerus at the scapulohumeral joint, with guarding of movement only at the shoulder level. VA proposes to define "the shoulder level" as flexion and/or abduction at 90 degrees. This change is not intended to alter the rating criteria. The proposed change simply clarifies the specific ranges of motion that qualify as limitations to ensure rating personnel consistently apply these criteria.

11. Diagnostic Code 5255

VA currently evaluates malunion of the femur by assigning a 30 percent rating for a "marked knee or hip disability," a 20 percent rating for a "moderate knee or hip disability," and a 10 percent rating for a "slight knee or hip disability." These criteria are subjective and the terminology is vague, resulting in inconsistent ratings.

Therefore, VA proposes removing this terminology and replacing it with an instruction to rate malunion of the femur as a knee or hip disability, whichever is predominant, under existing DCs that contain objective criteria. Specifically, this condition may be rated under DCs 5256 (Knee, ankylosis of), 5257 (Knee, other impairment of), 5260 (Leg, limitation of flexion of), 5261 (Leg, limitation of extension of), 5250 (Hip, ankylosis of), 5251 (Thigh, limitation of extension of),

5252 (Thigh, limitation of flexion of), 5253 (Thigh, impairment of), or 5254 (Hip, flail joint). This change would ensure that rating personnel consistently evaluate this disability based on objective criteria.

12. Diagnostic Code 5257

VA currently assigns ratings for recurrent subluxation or lateral instability of the knee based on whether the condition is slight (10 percent), moderate (20 percent), or severe (30 percent). These criteria are subjective and the terminology is vague, resulting in VA assigning inconsistent ratings.

When the condition involves patellar instability of the knee (due to recurrent patellar subluxation or patellar dislocation), one can determine the severity of functional impairment in large part by 1) the presence, or absence of, anatomic abnormalities (e.g., direct damage to patellofemoral ligament complex, "flake" fractures, or abnormalities affecting the patella and/or femoral trochlea); and 2) whether conservative treatment prevents recurrent instability. See Alexis C. Colvin and Robin V. West, "Current Concepts Review: Patellar Instability," J. Bone & Joint Surgery – Am. Volume 90: 2751-62 (2008).

Instability or laxity of the knee that involves other stabilizing structures of the knee such as the collateral ligaments (medial or lateral) or the cruciate ligaments (anterior or posterior) are given a "grade" depending upon the amount of translation, in millimeters, of the joint (e.g., a grade 1 injury of the posterior cruciate ligament (PCL) is represented by 0 to 5 millimeters (mm) of translation). T. K. Kakarlapudi et al., "Knee instability: isolated and complex," 34 Br. J. Sports Med. 395-400 (2000). Resulting functional impairment depends upon the grade

of the injury and whether surgical intervention is required. Id. The higher the number grade is, the more severe the injury; that is, grade 1 would represent the least severe injury, grade 2 would be a more severe injury, and grade 3 would be the most severe injury.

Therefore, VA proposes replacing the current subjective terms with the following objective criteria: a 30 percent rating would be assigned for persistent grade 3 instability despite operative intervention and for which ambulation requires both bracing and an assistive device (e.g., cane(s), crutch(es), or a walker), as prescribed by a physician; or, in the case of patellar instability, persistent instability despite surgical repair (whether after the primary subluxation/dislocation event or due to recurrent instability). A 20 percent would be assigned for persistent grade 3 instability without operative intervention, but when ambulation requires both bracing and an assistive device (e.g., cane(s), crutch(es), or a walker), as prescribed by a physician; or, in the case of patellar instability, recurrent instability persists due to one or more documented underlying anatomic abnormalities, without surgical repair. A 10 percent evaluation would be assigned for persistent grade 1, 2, or 3 instability which requires an ambulation assistive device or bracing, as prescribed by a physician; or, in the case of patellar instability, recurrent instability persists without documented underlying anatomic abnormalities, without surgical repair. These criteria would take into account both the grade of the injury, as well as functional impairment resulting from the injury.

VA also proposes a note defining the grading of instability. Note (1) would specify that grade 1 instability requires 0-5 mm of joint translation, while grade 2 requires translation of 6-10 mm, and grade 3 requires joint translation equal to or greater than 11 mm. These levels of instability or laxity are based upon modern medical practice. See Campbell's Operative Orthopedics, supra at 2157.

VA proposes a second note to clarify what constitutes surgical repair of patellar instability. Note (2) would specify that any operative procedure which does not involve actual anatomical structural repair would not qualify as surgical repair for the purposes of compensation. This note is specifically designed to exclude procedures that are not designed to repair instability or subluxation, such as joint aspiration, arthroscopy to remove loose bodies, and so forth.

In addition, DC 5257 currently refers to “lateral instability.” Under current practice, any instability or laxity of the knee is evaluated under this code. Therefore, VA proposes to remove the term “lateral,” so that this code also encompasses other specified forms of instability and/or laxity.

13. Diagnostic Code 5262

VA currently rates malunion of the tibia and fibula by assigning a 30 percent rating for a “marked knee or ankle disability,” a 20 percent rating for a “moderate knee or ankle disability,” and a 10 percent rating for a “slight knee or ankle disability.” These criteria are subjective and the terminology is vague. This results in rating personnel assigning inconsistent ratings under these criteria.

Therefore, VA proposes removing this terminology and replacing it with an instruction to rate malunion of the tibia or fibula as a knee or ankle disability,

whichever is predominant, under existing DCs that contain objective criteria. Specifically, this condition may be evaluated under DCs 5256 (Knee, ankylosis of), 5257 (Knee, other impairment of), 5260 (Leg, limitation of flexion of), 5261 (Leg, limitation of extension of), 5270 (Ankle, ankylosis of), or 5271 (Ankle, limited motion of). This change would ensure that rating personnel consistently assign evaluations based on objective criteria.

Another condition commonly claimed for disability compensation is medial tibial stress syndrome (MTSS), also known as "shin splints." It is a benign but painful condition that is typically diagnosed simply by history and physical examination, though imaging studies such as plain radiographs, bone scans, or magnetic resonance imaging (MRI) can be used in borderline cases, as well as to diagnose other conditions. The vast majority of cases respond to conservative therapy, such as rest, shock-absorbing insoles, and electrowave shock therapy. The rare persistent cases that do not respond to conservative treatment can be treated with surgical intervention. To that end, VA proposes to modify the criteria for DC 5262 to account for MTSS as well as associated conditions. See M. Reshef and D. Guelich, "Medial Tibial Stress Syndrome," 31 Clinical Sports Med. 273-90 (2012).

14. Diagnostic Code 5271

VA currently assigns ratings for limited motion of the ankle depending upon whether the limitation is moderate (10 percent) or marked (20 percent). These criteria are subjective and the terminology is vague, resulting in inconsistent evaluations.

Therefore, VA proposes to define marked limitation of motion as less than 5 degrees dorsiflexion or less than 10 degrees plantar flexion. VA also proposes to define moderate limitation of motion as less than 15 degrees dorsiflexion or less than 30 degrees plantar flexion. As VA currently uses these standards to define marked and moderate, this change is intended as a clarification of current policy and would ensure consistent application of these criteria among rating personnel.

C. Proposed New Diagnostic Codes

1. Diagnostic Code 5244

The current Rating Schedule does not provide instructions for rating complete traumatic paralysis, i.e., paraplegia or quadriplegia; however, this disability is not uncommon in the veteran population. As such, VA proposes the addition of DC 5244, "Traumatic paralysis, complete."

The proposed criteria for DC 5244 would direct personnel to rate paraplegia, or functional loss of the lower limbs and trunk, under DC 5110. DC 5110 applies to loss of use of both feet and provides for a 100 percent disability rating with entitlement to special monthly compensation. Proposed DC 5244 would also provide instructions for rating quadriplegia, or paralysis of all four limbs (i.e., the entire body below the neck). Specifically, VA proposes to rate quadriplegia under both DC 5109, loss of use of both hands, and DC 5110, loss of use of both feet, and combine. In practice, a veteran with service-connected quadriplegia would be entitled to two 100 percent ratings, which combine under

38 CFR 4.25 to a total evaluation of 100 percent. The veteran would also be entitled to special monthly compensation.

2. Diagnostic Code 5285

VA currently evaluates foot injuries not specifically listed in § 4.71a under DC 5284 as "Foot injuries, other." Plantar fasciitis, a foot disability seen in the veteran population, is generally rated under this DC. However, unlike other unlisted foot injuries and conditions, which can often result in a variety of signs and symptoms with varying degrees of disability, plantar fasciitis, and its functional effects, are very well defined. See Sports Medicine and Arthroscopic Surgery of the Foot and Ankle 83-93 (Amol Saxena ed., 2013). Plantar fasciitis, also known as "jogger's heel," is generally characterized by heel pain due to inflammation. Craig C. Young et al., "Plantar fasciitis," Medscape Reference (Feb. 4, 2014), http://emedicine.medscape.com/article/86143-overview (last visited April 15, 2014). However, even at its most severe, this condition involves an otherwise structurally intact foot.

There are a variety of both surgical and non-surgical treatments that may relieve the primary symptoms of plantar fasciitis. Conservative measures are always employed first, and frequently include icing, stretching, non-steroidal anti-inflammatory drug (NSAID) therapy, strapping and taping, and/or over-the-counter orthotics. Id. at http://emedicine.medscape.com/article/86143-treatment. Other nonsurgical treatments may include injections, physical therapy, and custom orthotics. Id. Studies have reported a resolution incidence of up to 90

percent with nonsurgical measures. Id. In severe cases, non-surgical measures fail and surgery is required.

Individuals who respond to treatment, whether surgical or non-surgical, have generally no more than slight functional limitation due to plantar fasciitis. Further, such limitation is more associated with the treatment(s) required to check the pain (e.g., limitation of physical activities (such as running), injections, icing, use of NSAIDS, surgical residuals, etc.) than with the actual disability itself. For individuals who do not respond to treatment, the resulting limitations may vary, but are generally more pronounced for those who have bilateral, rather than unilateral, plantar fasciitis.

Given the foregoing, VA proposes to create a new DC, namely DC 5285, "Plantar fasciitis," to rate this condition. VA intends to evaluate this disability based on a combination of extent (one foot or both feet) and response to treatment (responsive or nonresponsive). For individuals whose plantar fasciitis does not respond to both surgical and non-surgical treatment, VA proposes to award 30 percent disability rating if both feet are affected and a 20 percent disability rating if one foot is affected. For an individual whose plantar fasciitis (either unilateral or bilateral) is responsive to treatment (either non-surgical or surgical), VA proposes a 10 percent disability rating.

Finally, consistent with other foot injuries and disabilities, VA intends to include a note with DC 5285 that would instruct rating personnel to assign a 40 percent rating in cases where there is actual loss of use of the foot. In cases where a veteran's bilateral plantar fasciitis has not improved following surgery

and there is actual loss of use of one foot, this would result in a 40 percent evaluation for that foot and a 20 percent evaluation for the other foot that was not responsive to treatment, but did not result in loss of use.

D. Removal of Existing Diagnostic Codes

VA proposes to remove three obsolete codes from § 4.71a. The first two, DC 5018 and DC 5020, refer to "Hydrarthrosis, intermittent" and "Synovitis," respectively. Both hydrarthrosis and synovitis are signs found on physical examination. The disability from a specific condition that causes either hydrarthrosis or synovitis (e.g., rheumatoid arthritis, psoriatic arthritis, or pseudogout) is captured within current evaluation criteria for the specific disabling condition. See Kelley's Textbook of Rheumatology, supra at 588. Given that VA's disability compensation system is designed to compensate for disabilities, it is not appropriate to list either sign as its own DC.

For similar reasons, VA proposes to remove DC 5022, "Periostitis." Current medical terminology refers to "periosteal reaction" in order to include all of the possible causes, such as bleeding, infection, or tumor. In contrast, "periostitis" refers to a non-specific inflammatory process due to a number of diagnoses that could potentially result in service connection. Since an evaluation should be conducted under the primary diagnosis, rather than a radiographic finding such as periostitis, VA intends to remove DC 5022. See Radiologic-Pathologic Correlations from Head to Toe: Understanding the Manifestations of Disease 668 (Nicholas C. Gourtsoyiannis and Pablo R. Ros eds., 2005).

II. Proposed Changes to § 4.73

Section 4.73 provides VA's schedule for rating muscle injuries. Following its review of this body system, VA proposes the addition of two DCs for conditions that previously required analogous rating.

The first proposed code, DC 5330, would apply to residuals of rhabdomyolysis, in which muscle tissue breaks down rapidly. See Janice L. Zimmerman and Michael C. Shen, "Rhabdomyolysis," 144(3) CHEST 1058-65 (2013). Although VA proposes to rate this condition based on residual impairment to the affected muscle group(s), it believes that a specific DC is needed as there is no current instruction to rating personnel as to how to evaluate this condition. Furthermore, in addition to provide rating instructions to evaluate each affected muscle group, VA proposes to include a note directing rating personnel to separately evaluate any chronic renal complications that may be associated with this condition.

The second DC VA proposes to add to § 4.73 is DC 5331, "Compartment syndrome." Similar to DC 5330, VA proposes to rate compartment syndrome, a condition in which there is increased pressure within the muscles, according to the affected muscle group(s). See Canale, supra at 2311-21. The addition of this DC would provide clear instructions to rating personnel; it would also eliminate the need for analogous coding for a condition seen in the veteran population.

In addition, VA proposes to add a second note at the beginning of § 4.73 directing that rating personnel consider the objective criteria contained in § 4.56

when determining whether a muscle disability is slight, moderate, moderately severe, or severe under DCs 5301 to 5323. Although § 4.56 references these DCs, the levels of severity are not defined in § 4.73, nor does that section currently reference § 4.56. Therefore, VA proposes to add this note for a cross-reference.

Executive Orders 12866 and 13563.

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a "significant regulatory action," which requires review by the Office of Management and Budget (OMB), as "any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user

fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order."

VA has examined the economic, interagency, budgetary, legal, and policy implications of this proposed rule, and it has been determined not to be a significant regulatory action under Executive Order 12866.

VA's impact analysis can be found as a supporting document at http://www.regulations.gov, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its impact analysis are available on VA's Web site at http://www1.va.gov/orpm/, by following the link for "VA Regulations Published."

Unfunded Mandates

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

Paperwork Reduction Act

Although this document contains provisions constituting a collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C.

3501 et seq.), no new or proposed revised collections of information are associated with this proposed rule. The information collection requirements are currently approved by the Office of Management and Budget (OMB) and have been assigned OMB control numbers 2900-0747, 2900-0776, 2900-0778, and 2900-0802 through 2900-0813. While no modifications to these forms are made by this rulemaking, the total incremental cost to all respondents is estimated to be $198,002.21 during the first year. See Regulatory Impact Analysis for a full explanation.

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would 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. This proposed rule would not affect any small entities. Only VA beneficiaries could be directly affected. Therefore, pursuant to 5 U.S.C. 605(b), this proposed rule would be exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance Numbers and Titles

The Catalog of Federal Domestic Assistance program numbers and titles for this rule are 64.013, Veterans Prosthetic Appliances; 64.109, Veterans Compensation for Service-Connected Disability; and 64.110, Veterans Dependency and Indemnity Compensation for Service-Connected Death.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Gina S. Farrisee, Deputy Chief of Staff, Department of Veterans Affairs, approved this document on June 20, 2017, for publication.

Dated: July 21, 2017.

_____

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

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

For the reasons set out in the preamble, VA proposes to amend 38 CFR part 4 as follows:

PART 4 — SCHEDULE FOR RATING DISABILITIES

Subpart B – Disability Ratings

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

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

2. Amend § 4.71a as follows:

a. Revise diagnostic codes 5002, 5003, 5009-5015, 5023-5024, 5054, 5055, 5120, 5160, 5170, 5201, 5202, 5242, 5255, 5257, 5262, and 5271.

b. Remove diagnostic codes 5018, 5020, and 5022.

c. Add new introduction note to diagnostic codes 5051 through 5056 and add new diagnostic codes 5244 and 5285.

The revisions and additions read as follows:

§ 4.71a Schedule of ratings–musculoskeletal system.

ACUTE, SUBACUTE, OR CHRONIC DISEASES	
	Rating
* * * *	* * *

5002 Multi-joint arthritis (except post-traumatic and gout), 2 or more joints, as an active process: *….*….* * One or two exacerbations a year in a well-established diagnosis……	* * * 20
Note (1): Examples of conditions rated using this diagnostic code include, but are not limited to, rheumatoid arthritis, psoriatic arthritis, and spondyloarthropathies. Note (2): For chronic residuals, rate under diagnostic code 5003. Note (3): The ratings for the active process will not be combined with the residual ratings for limitation of motion, ankylosis, or diagnostic code 5003. Instead, assign the higher evaluation.	
5003 Degenerative arthritis, other than post-traumatic: * * * *	* * *
5009 Other specified forms of arthropathy (excluding gout). Note (1): Other specified forms of arthropathy include, but are not limited to, Charcot neuropathic, hypertrophic, crystalline, and other autoimmune arthropathies. Note (2): With the types of arthritis, diagnostic codes 5004 through 5009, rate the acute phase under diagnostic code 5002; rate any chronic residuals under diagnostic code 5003. 5010 Post-traumatic arthritis: Rate as limitation of motion, dislocation, or other specified instability under the affected joint. If there are 2 or more joints affected, each rating shall be combined in accordance with § 4.25. 5011 Decompression illness: Rate manifestations under the appropriate diagnostic code within the affected body system, such as arthritis for musculoskeletal residuals; auditory system for vestibular residuals; respiratory system for pulmonary barotrauma residuals; and neurologic system for cerebrovascular accident residuals. 5012 Bones, neoplasm, malignant, primary or	100

secondary……..

NOTE: The 100 percent rating will be continued for 1 year following the cessation of surgical, X-ray, antineoplastic chemotherapy or other prescribed therapeutic procedure. If there has been no local recurrence or metastases, rate based on residuals.

5013 Osteoporosis, residuals of.

5014 Osteomalacia, residuals of.

5015 Bones, neoplasm, benign.

* * *

* * * *

5023 Heterotopic ossification.

5024 Tenosynovitis, tendinitis, tendinosis or tendinopathy.

Evaluate the diseases under diagnostic codes 5013 through 5024 as degenerative arthritis, based on limitation of motion of affected parts. However, evaluate gout under diagnostic code 5003.

* * * * * * *

PROSTHETIC IMPLANTS AND RESURFACING		
	Rating	
	Major	Minor
Note: When an evaluation is assigned for joint resurfacing or the prosthetic replacement of a joint under diagnostic codes 5051-5056, an additional rating under § 4.71a may not also be assigned for that joint, unless otherwise directed.		
* * * * * * *		
5054 Hip, resurfacing or replacement (prosthesis) Prosthetic replacement of the head of the femur or of the acetabulum: For 4 months following implantation of prosthesis or resurfacing…….. Note: At the conclusion of the 100 percent evaluation period, evaluate resurfacing under diagnostic codes 5250 through 5255.		100

* * * * *	* * *	
5055 Knee, resurfacing or replacement (prosthesis) Prosthetic replacement of knee joint: For 4 months following implantation of prosthesis or resurfacing…….. Note: At the conclusion of the 100 percent evaluation period, evaluate resurfacing under diagnostic codes 5256 through 5262.		100
* * * * *	* * *	

AMPUTATIONS: UPPER EXTREMITY

	Rating	
	Major	Minor
Arm, amputation of: 5120 Complete amputation, upper extremity: Forequarter amputation (involving complete removal of the humerus along with any portion of the scapula, clavicle, and/or ribs)…….. Disarticulation (involving complete removal of the humerus only)……	100 90	100 90
* * * *	* * *	

AMPUTATIONS: LOWER EXTREMITY

	Rating
Thigh, amputation of: 5160 Complete amputation, lower extremity Trans-pelvic amputation (involving complete removal of the femur and intrinsic pelvic musculature along with any portion of the pelvic bones)……. Disarticulation (involving complete removal of the femur and intrinsic pelvic musculature only)…….. Note: Separately evaluate residuals involving other body systems (e.g., bowel impairment, bladder impairment) under the appropriate diagnostic code.	100 90
* * * *	* * *
5170 Toes, all, amputation of, without metatarsal loss or transmetatarsal, amputation of, with up to half of metatarsal loss……	30

* * * *		* * *

THE SHOULDER AND ARM

	Rating	
	Major	Minor
* * * *	* * *	
5201 Arm, limitation of motion of:	40	30
Flexion and/or abduction limited to 25° from side……	30	20
Midway between side and shoulder level (flexion and/or abduction limited to 45°)……..	20	20
At shoulder level (flexion and/or abduction limited to 90°)…… …..		
5202 Humerus, other impairment of:		
Loss of head of (flail shoulder)……	80	70
Nonunion of (false flail joint)…….	60	50
Fibrous union of……	50	40
Recurrent dislocation of at scapulohumeral joint.	30	20
With frequent episodes and guarding of all arm movements…… ….	20	20
With infrequent episodes, and guarding of movement only at shoulder level (flexion and/or abduction at 90°)……..	30 20	20 20
Malunion of:		
Marked deformity……		
Moderate deformity……		
* * * *	* * *	

THE SPINE

	Rating
General Rating Formula for Diseases and Injuries of the Spine	
* * * *	* * *
5242 Degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome (also, see diagnostic code 5003)	
* * * *	
5244 Traumatic paralysis, complete	* * *

Paraplegia: Rate under diagnostic code 5110. Quadriplegia: Rate separately under diagnostic codes 5109 and 5110 and combine evaluations in accordance with § 4.25.	
THE HIP AND THIGH	
* * * *	* * *
5255 Femur, impairment of:	
Fracture of shaft or anatomical neck of:	80
With nonunion, with loose motion (spiral or oblique fracture)……	60
With nonunion, without loose motion, weight bearing preserved with aid of brace…….	60
Fracture of surgical neck of, with false joint……	
Malunion of:	
Evaluate under diagnostic codes 5256, 5257, 5260, or 5261 for the knee, or 5250-5254 for the hip, whichever results in the highest evaluation.	
THE KNEE AND LEG	
* * * *	* * *
5257 Knee, other impairment of:	
<u>Recurrent subluxation or instability</u>:	
Persistent grade 3 instability despite operative intervention and a physician prescribes both bracing and assistive device (e.g., cane(s), crutch(es), or a walker) for ambulation……..	30
Persistent grade 3 instability without operative intervention, and a physician prescribes both bracing and assistive device (e.g., cane(s), crutch(es), or a walker) for ambulation…… …..	20
Persistent grade 1, 2, or 3 instability and a physician prescribes an assistive device (e.g., cane(s), crutch(es), or a walker) or bracing for ambulation……	10
<u>Patellar instability</u>:	

With documented surgical repair, persistent instability either after the primary subluxation/dislocation event or due to recurrent instability……	30
Without surgical repair, recurrent instability with one or more documented underlying anatomic abnormalities (e.g., direct damage to patellofemoral ligament complex, "flake" fractures, or abnormalities affecting the patella and/or femoral trochlea)……..	20 10
Without surgical repair, recurrent instability without documented underlying anatomic abnormalities……	
Note (1): Grade 1 is defined as 0-5 mm of joint translation, grade 2 is defined as 6-10 mm of joint translation, and grade 3 is defined as joint translation of equal to or greater than 11 mm.	
Note (2): For patellar instability, a surgical procedure that does not involve repair of one or more anatomic structures that contribute to the underlying instability shall not qualify as surgical repair for compensation purposes (including, but not limited to, arthroscopy to remove loose bodies and joint aspiration).	
* * * *	* * *
5262 Tibia and fibula, impairment of:	
Nonunion of, with loose motion, requiring brace……	40
Malunion of:	
Evaluate under diagnostic codes 5256, 5257, 5260, or 5261 for the knee, or 5270 or 5271 for the ankle, whichever results in the highest evaluation.	
Medial tibial stress syndrome (MTSS), or shin splints:	
With imaging evidence (X-rays, bone scan, or MRI), requiring treatment for no less than 12 consecutive months and unresponsive to shoe orthotics, other conservative treatment, or surgery, both lower extremities…….	30
With imaging evidence (X-rays, bone scan, or MRI), requiring treatment for no less than 12 consecutive	20

months, and unresponsive to shoe orthotics, other conservative treatment, or surgery, one lower extremity……..	
With imaging evidence (X-rays, bone scan, or MRI), requiring treatment for no less than 12 consecutive months, and unresponsive to both shoe orthotics and other conservative treatment, one or both lower extremities…….	10 0
Treatment less than 12 consecutive months, one or both lower extremities……	
* * * *	* * *

THE ANKLE

* * * *	* * *
5271 Ankle, limited motion of:	
Marked (less than 5 degrees dorsiflexion or less than 10 degrees plantar flexion)……..	20
Moderate (less than 15 degrees dorsiflexion or less than 30 degrees plantar flexion)……	10
* * * *	* * *

THE FOOT

* * * *	* * *
5285 Plantar fasciitis:	
With symptoms not relieved by both non-surgical and surgical treatment,	
bilateral……	30
…	20
unilateral……	
….	10
With symptoms relieved by either non-surgical or surgical treatment, unilateral or bilateral……..	
Note: With actual loss of use of the foot, rate 40 percent.	

THE SKULL	
* * * *	* * *

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

* * *

3. In § 4.73, add new introduction notes (1) and (2) and add new diagnostic codes 5330 and 5331 to read as follows:.

§ 4.73 Schedule of ratings–muscle injuries.

Note (1): When evaluating any claim involving muscle injuries resulting in loss of use of any extremity or loss of use of both buttocks (diagnostic code 5317, Muscle Group XVII), refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation.

Note (2): Ratings of slight, moderate, moderately severe, or severe for diagnostic codes 5301 through 5323 will be determined based upon the criteria contained in § 4.56.

* * * *	* * *
MISCELLANEOUS	
	Rating
* * * *	* * *
5330 Rhabdomyolysis, residuals of. Rate each affected muscle group separately and combine in accordance with § 4.25. Note: Separately evaluate any chronic renal complications within the appropriate body system.	
5331 Compartment syndrome. Rate each affected muscle group separately and combine in accordance with § 4.25.	

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

4. Amend Appendix A to Part 4 as follows:

a. In § 4.71a, revise diagnostic codes 5002, 5003, 5012, 5024, 5051-5056, 5255, 5257;

b. In § 4.71a, add diagnostic codes 5009-5011, 5013-5015, 5018, 5020, 5022-5023, 5120, 5160, 5170, 5201, 5202, 5242, 5244, 5262, 5271 and 5285;

c. In § 4.73, add new introduction note and diagnostic codes 5330 and 5331.

The revisions read as follows:

APPENDIX A TO PART 4–TABLE OF AMENDMENTS AND EFFECTIVE DATES SINCE 1946

Sec.	Diagnostic Code No.	
4.71a…..		
	* * *	* * * *
	5002	Evaluation March 1, 1963; title, criteria, note [insert effective date of final rule]
	5003	Added July 6, 1950; title [insert effective date of final rule]
	* * *	* * * *
	5009	Title, evaluation, note [insert effective date of final rule].
	5010	Title, criteria [insert effective date of final rule].
	5011	Title, criteria [insert effective date of final rule].
	5012	Criterion March 10, 1976; title, note [insert effective date of final rule].
	5013	Title [insert effective date of final rule].
	5014	Title [insert effective date of final rule].
	5015	Title [insert effective date of final rule].
	5018	Removed [insert effective date of final rule].
	5020	Removed [insert effective date of final rule].
	5022	Removed [insert effective date of final rule].
	5023	Title [insert effective date of final rule].
	5024	Criterion March 1, 1963; title, criteria [insert effective date of final rule].

* * *	* * * *
5051	Added September 22, 1978; note [insert effective date of final rule].
5052	Added September 22, 1978; note [insert effective date of final rule].
5053	Added September 22, 1978; note [insert effective date of final rule].
5054	Added September 22, 1978; title, criterion, and note [insert effective date of final rule].
5055	Added September 22, 1978; title, criterion, and note [insert effective date of final rule].
5056	Added September 22, 1978; note [insert effective date of final rule].
* * *	* * * *
5120	Title, criterion [insert effective date of final rule].
5160	Title, criterion, note [insert effective date of final rule].
* * *	* * * *
5170	Title [insert effective date of final rule].
* * *	* * * *
5201	Criterion [insert effective date of final rule].
5202	Criterion [insert effective date of final rule].
* * *	* * * *
5242	Title [insert effective date of final rule]
* * *	* * * *
5244	Added [insert effective date of final rule].
* * *	* * * *
5255	Criterion July 6, 1950; criterion [insert effective date of final rule].
* * *	* * * *
5257	Evaluation July 6, 1950; criterion and note [insert effective date of final rule].
* * *	* * * *
5262	Criterion [insert effective date of final rule].
* * *	* * * *
5271	Criterion [insert effective date of final rule].

	* * *	* * * *
	5285	Added [insert effective date of final rule].
	* * *	* * * *
4.73……..	……..	Introduction NOTE criterion July 3, 1997; second NOTE added [insert effective date of final rule].
	* * *	* * * *
	5330	Added [insert effective date of final rule].
	5331	Added [insert effective date of final rule].

5. Amend Appendix B to Part 4 as follows:

a. Revise diagnostic codes 5002, 5003, 5009-5015, 5023, 5024, 5054, 5055, 5120, 5160, 5170 and 5242;

b. Add diagnostic codes 5244, 5285, 5330, and 5331; and

c. Remove diagnostic codes 5018, 5020 and 5022.

The revisions read as follows:

APPENDIX B TO PART 4-NUMERICAL INDEX OF DISABILITIES

Diagnostic Code No.	
	THE MUSCULOSKELETAL SYSTEM ACUTE, SUBACUTE, OR CHRONIC DISEASES
* * *	* * * *
5002	Multi-joint arthritis (except post-traumatic and gout), 2 or more joints, as an active process.
5003	Degenerative arthritis, other than post-traumatic.
* * *	* * * *
5009……	Other specified forms of arthropathy (excluding gout).
5010……	Post-traumatic arthritis.
5011……	Decompression illness.
5012……	Bones, neoplasm, malignant, primary or secondary.
5013……	Osteoporosis, residuals of.
5014……	Osteomalacia, residuals of.
5015……	Bones, neoplasm, benign.
* * *	* * * *

5023……	Heterotopic ossification.
5024……	Tenosynovitis, tendinitis, tendinosis or tendinopathy.
* * *	* * * *
5054	Hip, resurfacing or replacement (prosthesis).
5055	Knee, resurfacing or replacement (prosthesis).
….….*	* * * *
AMPUTATIONS: UPPER EXTREMITY	
Arm, amputation of:	
5120……	Complete amputation, upper extremity.
* * *	* * * *
AMPUTATIONS: LOWER EXTREMITY	
Thigh, amputation of:	
5160	Complete amputation, lower extremity.
* * *	* * * *
5170……	Toes, all, amputation of, without metatarsal loss or transmetatarsal, amputation of, with up to half of metatarsal loss.
* * *	* * * *
SPINE	
….….*	* * * *
5242	Degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome (also, see either 5003 or 5010).
….….*	* * * *
5244……	Traumatic paralysis, complete.
* * *	* * * *
THE FOOT	
* * *	* * * *
5285……	Plantar fasciitis.
* * *	* * * *
MUSCLE INJURIES	
* * *	* * * *
	MISCELLANEOUS
* * *	* * * *
5330……	Rhabdomyolysis, residuals of.
5331……	Compartment syndrome.
* * *	* * * *

6. Amend Appendix C to Part 4 as follows:

a. Revise the entries for Amputation, Arthritis, New growths, Myositis ossificans, Tenosynovitis, Prosthetic Implants, and Hip;

b. Add entries in alphabetical order for Spine, Traumatic paralysis, complete; Plantar fasciitis; Rhabdomyolysis; and Compartment syndrome; and

c. Remove entries for Hydroarthrosis, intermittent; Synovitis; and Periostitis.

The revisions read as follows:

APPENDIX C TO PART 4-ALPHABETICAL INDEX OF DISABILITIES

	Diagnostic Code No.
* * * * * * *	
Amputation:	
Arm:	
Complete amputation, upper extremity	5120
Above insertion of deltoid	5121
Below insertion of deltoid	5122
Digits, five of one hand	5126
Digits, four of one hand:	
Thumb, index, long and ring	5127
Thumb, index, long and little	5128
Thumb, index, ring and little	5129
Thumb, long, ring and little	5130
Index, long, ring and little	5131
Digits, three of one hand:	
Thumb, index and long	5132
Thumb, index and ring	5133
Thumb, index and little	5134
Thumb, long and ring	5135
Thumb, long and little	5136
Thumb, ring and little	5137
Index, long and ring	5138
Index, long and little	5139
Index, ring and little	5140
Long, ring and little	5141
Digits, two of one hand:	
Thumb and index	5142
Thumb and long	5143
Thumb and ring	5144

Thumb and little	5145
Index and long	5146
Index and ring	5147
Index and little	5148
Long and ring	5149
Long and little	5150
Ring and little	5151
Single finger:	
Thumb	5152
Index finger	5153
Long finger	5154
Ring finger	5155
Little finger	5156
Forearm:	
Above insertion of pronator teres	5123
Below insertion of pronator teres	5124
Leg:	
With defective stump	5163
Not improvable by prosthesis controlled by natural knee action	5164
At lower level, permitting prosthesis	5165
Forefoot, proximal to metatarsal bones	5166
Toes, all, amputation of, without metatarsal loss or transmetatarsal, amputation of, with up to half of metatarsal loss	5170
Toe, great	5171
Toe, other than great, with removal metatarsal head	5172
Toes, three or more, without metatarsal involvement	5173
Thigh:	
Complete amputation, lower extremity	5160
Upper third	5161
Middle or lower thirds	5162
* * * * * * *	
Arthritis:	
Degenerative, other than post-traumatic	5003
Gonorrheal	5004
Other specified forms (excluding gout)	5009
Pneumococcic	5005
Post-traumatic	5010
Multi-joint (except post-traumatic and gout)	5002
Streptococcic	5008
Syphilitic	5007
Typhoid	5006
Arthropathy	5009
* * * * * * *	

Bones:	
Neoplasm, benign	5015
Neoplasm, malignant, primary or secondary	5012
Shortening of the lower extremity	5275
* * * * * * *	
Colitis, ulcerative	7323
Compartment syndrome	5331
* * * * * * *	
Dacryocystitis	6031
Decompression illness	5011
* * * * * * *	
Hernia:	
Femoral	7340
Hiatal	7346
Inguinal	7338
Muscle	5326
Ventral	7339
Heterotopic ossification	5023
Hip:	
Flail joint	5254
* * * * * * *	
Hodgkin's disease	7709
Hydronephrosis	7509
* * * * * * *	
Myocardial infarction	7006
Myositis	5021
* * * * * * *	
Osteomalacia, residuals of	5014
* * * * * * *	
Osteoporosis, residuals of	5013
* * * * * * *	
Paralysis:	
Accommodation	6030
Agitans	8004
Complete, traumatic	5244
* * * * * * *	
Pericarditis	7002
Peripheral vestibular disorders	6204
* * * * * * *	
Plague	6307
Plantar fasciitis	5285
* * * * * * *	
Prosthetic implants:	
Ankle replacement	5056
Elbow replacement	5052

Hip, resurfacing or replacement	5054
Knee, resurfacing or replacement	5055
* * * * * * *	
Retinitis	6006
Rhabdomyolysis, residuals of	5330
* * * * * * *	
Spinal stenosis	5238
Spine:	
Degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome	5242
* * * * * * *	
Syndromes:	6354
Chronic Fatigue Syndrome (CFS)	7907
Cushing's	6205
Meniere's	7117
Raynaud's	6847
Sleep Apnea	
Syphilis	6310
* * * * * * *	
Tenosynovitis, tendinitis, tendinosis or tendinopathy	5024
* * * * * * *	

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