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section. To obtain such a review, the claimant must request it not later than 60 days after the date VA mails the notice. This 60-day time limit may not be extended. If the claimant fails to request review under this section not later than 60 days after the date VA mails the notice, VA will proceed with the traditional appellate process by issuing a Statement of the Case. A claimant may not have more than one review under this section of the same decision.

(c) The reviewer may conduct whatever development he or she considers necessary to resolve any disagreements in the Notice of Disagreement, consistent with applicable law. This may include an attempt to obtain additional evidence or the holding of an informal conference with the claimant. Upon the request of the claimant, the reviewer will conduct a hearing under §3.103(c).

(d) The reviewer may grant a benefit sought in the claim notwithstanding §3.105(b), but, except as provided in paragraph (e) of this section, may not revise the decision in a manner that is less advantageous to the claimant than the decision under review. A review decision made under this section will include a summary of the evidence, a citation to pertinent laws, a discussion of how those laws affect the decision, and a summary of the reasons for the decision.

(e) Notwithstanding any other provisions of this section, the reviewer may reverse or revise (even if disadvantageous to the claimant) prior decisions of an agency of original jurisdiction (including the decision being reviewed or any prior decision that has become final due to failure to timely appeal) on the grounds of clear and unmistakable error (see §3.105(a)).

(f) Review under this section does not limit the appeal rights of a claimant. Unless a claimant withdraws his or her Notice of Disagreement as a result of this review process, VA will proceed with the traditional appellate process by issuing a Statement of the Case.

(g) This section applies to all claims in which a Notice of Disagreement is filed on or after June 1, 2001.

(Authority: 38 U.S.C. 5109A and 7105(d))

[66 FR 21874, May 2, 2001, as amended at 67 FR 46868, July 17, 2002]

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

SOURCE: 29 FR 6718, May 22, 1964, unless otherwise noted.

Subpart A—General Policy in Rating

§4.1 Essentials of evaluative rating.

This rating schedule is primarily a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. The percentage ratings 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. Generally, the degrees of disability specified are considered adequate to compensate for considerable loss of working time from exacerbations or illnesses proportionate to the severity of the several grades of disability. For the application of this schedule, accurate and fully descriptive medical examinations are required, with emphasis upon the limitation of activity imposed by the disabling condition. Over a period of many years, a veteran's disability claim may require reratings in accordance with changes in laws, medical knowledge and his or her physical or mental condition. It is thus essential, both in the examination and in the evaluation of disability, that each disability be viewed in relation to its history.

[41 FR 11292, Mar. 18, 1976]

§4.2 Interpretation of examination reports.

Different examiners, at different times, will not describe the same disability in the same language. Features of the disability which must have persisted unchanged may be overlooked or a change for the better or worse may not be accurately appreciated or described. It is the responsibility of the rating specialist to interpret reports of examination in the light of the whole recorded history, reconciling the various reports into a consistent picture so that the current rating may accurately reflect the elements of disability present. Each disability must be considered from the point of view of the veteran working or seeking work. If a diagnosis is not supported by the findings on the examination report or if the report does not contain sufficient detail, it is incumbent upon the rating board to return the report as inadequate for evaluation purposes.

[41 FR 11292, Mar. 18, 1976]

§4.3 Resolution of reasonable doubt.

It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation, consistent, however, with the facts shown in every case. When after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding the degree of disability such doubt will be resolved in favor of the claimant. See §3.102 of this chapter.

[40 FR 42535, Sept. 15, 1975]

§4.6 Evaluation of evidence.

The element of the weight to be accorded the character of the veteran's service is but one factor entering into the considerations of the rating boards in arriving at determinations of the evaluation of disability. Every element in any way affecting the probative value to be assigned to the evidence in each individual claim must be thoroughly and conscientiously studied by each member of the rating board in the light of the established policies of the Department of Veterans Affairs to the end that decisions will be equitable and just as contemplated by the requirements of the law.

§4.7 Higher of two evaluations.

Where there is a question as to which of two evaluations shall be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating will be assigned.

§ 4.9 Congenital or developmental defects.

Mere congenital or developmental defects, absent, displaced or supernumerary parts, refractive error of the eye, personality disorder and mental deficiency are not diseases or injuries in the meaning of applicable legislation for disability compensation purposes.

[41 FR 11292, Mar. 18, 1976]

§ 4.10 Functional impairment.

The basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment. Whether the upper or lower extremities, the back or abdominal wall, the eyes or ears, or the cardiovascular, digestive, or other system, or psyche are affected, evaluations are based upon lack of usefulness, of these parts or systems, especially in self-support. This imposes upon the medical examiner the responsibility of furnishing, in addition to the etiological, anatomical, pathological, laboratory and prognostic data required for ordinary medical classification, full description of the effects of disability upon the person's ordinary activity. In this connection, it will be remembered that a person may be too disabled to engage in employment although he or she is up and about and fairly comfortable at home or upon limited activity.

[41 FR 11292, Mar. 18, 1976]

§ 4.13 Effect of change of diagnosis.

The repercussion upon a current rating of service connection when change is made of a previously assigned diagnosis or etiology must be kept in mind. The aim should be the reconciliation and continuance of the diagnosis or etiology upon which service connection for the disability had been granted. The relevant principle enunciated in § 4.125, entitled "Diagnosis of mental disorders," should have careful attention in this connection. When any change in evaluation is to be made, the rating agency should assure itself that there has been an actual change in the conditions, for better or worse, and not merely a difference in thoroughness of the examination or in use of descriptive terms. This will not, of course, preclude the correction of erroneous ratings, nor will it preclude assignment of a rating in conformity with § 4.7.

[29 FR 6718, May 22, 1964, as amended at 61 FR 52700, Oct. 8, 1996]

§ 4.14 Avoidance of pyramiding.

The evaluation of the same disability under various diagnoses is to be avoided. Disability from injuries to the muscles, nerves, and joints of an extremity may overlap to a great extent, so that special rules are included in the appropriate bodily system for their evaluation. Dyspnea, tachycardia, nervousness, fatigability, etc., may result from many causes; some may be service connected, others, not. Both the use of manifestations not resulting from service-connected disease or injury in establishing the service-connected evaluation, and the evaluation of the same manifestation under different diagnoses are to be avoided.

§ 4.15 Total disability ratings.

The ability to overcome the handicap of disability varies widely among individuals. The rating, however, is based primarily upon the average impairment in earning capacity, that is, upon the economic or industrial handicap which must be overcome and not from individual success in overcoming it. However, full consideration must be given to unusual physical or mental effects in individual cases, to peculiar effects of occupational activities, to defects in physical or mental endowment preventing the usual amount of success in overcoming the handicap of disability and to the effect of combinations of disability. Total disability will be considered to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation; *Provided*, That permanent total disability shall be taken to exist when the impairment is reasonably certain to continue throughout the life of the disabled person. The following will be considered to be permanent total disability: the permanent loss of the use of both hands, or of both feet, or of one

hand and one foot, or of the sight of both eyes, or becoming permanently helpless or permanently bedridden. Other total disability ratings are scheduled in the various bodily systems of this schedule.

§4.16 Total disability ratings for compensation based on unemployability of the individual.

(a) Total disability ratings for compensation may be assigned, where the schedular rating is less than total, when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities: *Provided* That, if there is only one such disability, this disability shall be ratable at 60 percent or more, and that, if there are two or more disabilities, there shall be at least one disability ratable at 40 percent or more, and sufficient additional disability to bring the combined rating to 70 percent or more. For the above purpose of one 60 percent disability, or one 40 percent disability in combination, the following will be considered as one disability: (1) Disabilities of one or both upper extremities, or of one or both lower extremities, including the bilateral factor, if applicable, (2) disabilities resulting from common etiology or a single accident, (3) disabilities affecting a single body system, e.g. orthopedic, digestive, respiratory, cardiovascular-renal, neuropsychiatric, (4) multiple injuries incurred in action, or (5) multiple disabilities incurred as a prisoner of war. It is provided further that the existence or degree of nonservice-connected disabilities or previous unemployability status will be disregarded where the percentages referred to in this paragraph for the service-connected disability or disabilities are met and in the judgment of the rating agency such service-connected disabilities render the veteran unemployable. Marginal employment shall not be considered substantially gainful employment. For purposes of this section, marginal employment generally shall be deemed to exist when a veteran's earned annual income does not exceed the amount established by the U.S. Department of Commerce, Bureau of the Census, as the poverty threshold for one person. Marginal employment may also be held to exist, on a facts found basis (includes but is not limited to employment in a protected environment such as a family business or sheltered workshop), when earned annual income exceeds the poverty threshold. Consideration shall be given in all claims to the nature of the employment and the reason for termination.

(Authority: 38 U.S.C. 501)

(b) It is the established policy of the Department of Veterans Affairs that all veterans who are unable to secure and follow a substantially gainful occupation by reason of service-connected disabilities shall be rated totally disabled. Therefore, rating boards should submit to the Director, Compensation and Pension Service, for extra-schedular consideration all cases of veterans who are unemployable by reason of service-connected disabilities, but who fail to meet the percentage standards set forth in paragraph (a) of this section. The rating board will include a full statement as to the veteran's service-connected disabilities, employment history, educational and vocational attainment and all other factors having a bearing on the issue.

[40 FR 42535, Sept. 15, 1975, as amended at 54 FR 4281, Jan. 30, 1989; 55 FR 31580, Aug. 3, 1990; 58 FR 39664, July 26, 1993; 61 FR 52700, Oct. 8, 1996]

§4.17 Total disability ratings for pension based on unemployability and age of the individual.

All veterans who are basically eligible and who are unable to secure and follow a substantially gainful occupation by reason of disabilities which are likely to be permanent shall be rated as permanently and totally disabled. For the purpose of pension, the permanence of the percentage requirements of §4.16 is a requisite. When the percentage requirements are met, and the disabilities involved are of a permanent nature, a rating of permanent and total disability will be assigned if the veteran is found to be unable to secure and follow substantially gainful employment by reason of such disability. Prior employment or unemployment status is immaterial if in the judgment

of the rating board the veteran's disabilities render him or her unemployable. In making such determinations, the following guidelines will be used:

(a) Marginal employment, for example, as a self-employed farmer or other person, while employed in his or her own business, or at odd jobs or while employed at less than half the usual remuneration will not be considered incompatible with a determination of unemployability, if the restriction, as to securing or retaining better employment, is due to disability.

(b) Claims of all veterans who fail to meet the percentage standards but who meet the basic entitlement criteria and are unemployable, will be referred by the rating board to the Adjudication Officer under § 3.321(b)(2) of this chapter.

(Authority: 38 U.S.C. 1155; 38 U.S.C. 3102)

[43 FR 45348, Oct. 2, 1978, as amended at 56 FR 57985, Nov. 15, 1991]

§ 4.17a Misconduct etiology.

A permanent and total disability rating under the provisions of §§ 4.15, 4.16 and 4.17 will not be precluded by reason of the coexistence of misconduct disability when:

(a) A veteran, regardless of employment status, also has innocently acquired 100 percent disability, or

(b) Where unemployable, the veteran has other disabilities innocently acquired which meet the percentage requirements of §§ 4.16 and 4.17 and would render, in the judgment of the rating agency, the average person unable to secure or follow a substantially gainful occupation.

[40 FR 42536, Sept. 15, 1975, as amended at 43 FR 45349, Oct. 2, 1978]

§ 4.18 Unemployability.

A veteran may be considered as unemployable upon termination of employment which was provided on account of disability, or in which special consideration was given on account of the same, when it is satisfactorily shown that he or she is unable to secure further employment. With amputations, sequelae of fractures and other residuals of traumatism shown to be of static character, a showing of continuous unemployability from date of incurrence, or the date the condition reached the stabilized level, is a general requirement in order to establish the fact that present unemployability is the result of the disability. However, consideration is to be given to the circumstances of employment in individual claims, and, if the employment was only occasional, intermittent, tryout or unsuccessful, or eventually terminated on account of the disability, present unemployability may be attributed to the static disability. Where unemployability for pension previously has been established on the basis of combined service-connected and nonservice-connected disabilities and the service-connected disability or disabilities have increased in severity, § 4.16 is for consideration.

[40 FR 42536, Sept. 15, 1975, as amended at 43 FR 45349, Oct. 2, 1978]

§ 4.19 Age in service-connected claims.

Age may not be considered as a factor in evaluating service-connected disability; and unemployability, in service-connected claims, associated with advancing age or intercurrent disability, may not be used as a basis for a total disability rating. Age, as such, is a factor only in evaluations of disability not resulting from service, i.e., for the purposes of pension.

[29 FR 6718, May 22, 1964, as amended at 43 FR 45349, Oct. 2, 1978]

§ 4.20 Analogous ratings.

When an unlisted condition is encountered it will be permissible to rate under a closely related disease or injury in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous. Conjectural analogies will be avoided, as will the use of analogous ratings for conditions of doubtful diagnosis, or for those not fully supported by clinical and laboratory findings. Nor will ratings assigned to organic diseases and injuries be assigned by analogy to conditions of functional origin.

§ 4.21 Application of rating schedule.

In view of the number of atypical instances it is not expected, especially with the more fully described grades of disabilities, that all cases will show all

the findings specified. Findings sufficiently characteristic to identify the disease and the disability therefrom, and above all, coordination of rating with impairment of function will, however, be expected in all instances.

[41 FR 11293, Mar. 18, 1976]

§4.22 Rating of disabilities aggravated by active service.

In cases involving aggravation by active service, the rating will reflect only the degree of disability over and above the degree existing at the time of entrance into the active service, whether the particular condition was noted at the time of entrance into the active service, or it is determined upon the evidence of record to have existed at that time. It is necessary therefore, in all cases of this character to deduct from the present degree of disability the degree, if ascertainable, of the disability existing at the time of entrance into active service, in terms of the rating schedule, except that if the disability is total (100 percent) no deduction will be made. The resulting difference will be recorded on the rating sheet. If the degree of disability at the time of entrance into the service is not ascertainable in terms of the schedule, no deduction will be made.

§4.23 Attitude of rating officers.

It is to be remembered that the majority of applicants are disabled persons who are seeking benefits of law to which they believe themselves entitled. In the exercise of his or her functions, rating officers must not allow their personal feelings to intrude; an antagonistic, critical, or even abusive attitude on the part of a claimant should not in any instance influence the officers in the handling of the case. Fairness and courtesy must at all times be shown to applicants by all employees whose duties bring them in contact, directly or indirectly, with the Department's claimants.

[41 FR 11292, Mar. 18, 1976]

§4.24 Correspondence.

All correspondence relative to the interpretation of the schedule for rating disabilities, requests for advisory opinions, questions regarding lack of clarity or application to individual cases involving unusual difficulties, will be addressed to the Director, Compensation and Pension Service. A clear statement will be made of the point or points upon which information is desired, and the complete case file will be simultaneously forwarded to Central Office. Rating agencies will assure themselves that the recent report of physical examination presents an adequate picture of the claimant's condition. Claims in regard to which the schedule evaluations are considered inadequate or excessive, and errors in the schedule will be similarly brought to attention.

[41 FR 11292, Mar. 18, 1976]

§4.25 Combined ratings table.

Table I, Combined Ratings Table, results from the consideration of the efficiency of the individual as affected first by the most disabling condition, then by the less disabling condition, then by other less disabling conditions, if any, in the order of severity. Thus, a person having a 60 percent disability is considered 40 percent efficient. Proceeding from this 40 percent efficiency, the effect of a further 30 percent disability is to leave only 70 percent of the efficiency remaining after consideration of the first disability, or 28 percent efficiency altogether. The individual is thus 72 percent disabled, as shown in table I opposite 60 percent and under 30 percent.

(a) To use table I, the disabilities will first be arranged in the exact order of their severity, beginning with the greatest disability and then combined with use of table I as hereinafter indicated. For example, if there are two disabilities, the degree of one disability will be read in the left column and the degree of the other in the top row, whichever is appropriate. The figures appearing in the space where the column and row intersect will represent the combined value of the two. This combined value will then be converted to the nearest number divisible by 10, and combined values ending in 5 will be adjusted upward. Thus, with a 50 percent disability and a 30 percent disability, the combined value will be found to be 65 percent, but the 65 percent must be converted to 70 percent to

represent the final degree of disability. Similarly, with a disability of 40 percent, and another disability of 20 percent, the combined value is found to be 52 percent, but the 52 percent must be converted to the nearest degree divisible by 10, which is 50 percent. If there are more than two disabilities, the disabilities will also be arranged in the exact order of their severity and the combined value for the first two will be found as previously described for two disabilities. The combined value, exactly as found in table I, will be combined with the degree of the third disability (in order of severity). The combined value for the three disabilities will be found in the space where the column and row intersect, and if there are only three disabilities will be converted to the nearest degree divisible by 10, adjusting final 5's upward. Thus, if there are three disabilities ratable at 60 percent, 40 percent, and 20 percent, respectively, the combined value for the first two will be found opposite 60 and under 40 and is 76 percent. This 76 will be combined with 20 and the combined value for the three is 81 percent. This combined value will be converted to the nearest degree divisible by 10 which is 80 percent. The same procedure will be employed when there are four or more disabilities. (See table I).

(b) Except as otherwise provided in this schedule, the disabilities arising from a single disease entity, e.g., arthritis, multiple sclerosis, cerebrovascular accident, etc., are to be rated separately as are all other disabiling conditions, if any. All disabilities are then to be combined as described in paragraph (a) of this section. The conversion to the nearest degree divisible by 10 will be done only once per rating decision, will follow the combining of all disabilities, and will be the last procedure in determining the combined degree of disability.

TABLE I—COMBINED RATINGS TABLE

[10 combined with 10 is 19]

	10	20	30	40	50	60	70	80	90
19	27	35	43	51	60	68	76	84	92
20	28	36	44	52	60	68	76	84	92
21	29	37	45	53	61	68	76	84	92
22	30	38	45	53	61	69	77	84	92
23	31	38	46	54	62	69	77	85	92
24	32	39	47	54	62	70	77	85	92
25	33	40	48	55	63	70	78	85	93
26	33	41	48	56	63	70	78	85	93
27	34	42	49	56	64	71	78	85	93
28	35	42	50	57	64	71	78	86	93
29	36	43	50	57	65	72	79	86	93
30	37	44	51	58	65	72	79	86	93
31	38	45	52	59	66	72	79	86	93
32	39	46	52	59	66	73	80	86	93
33	40	46	53	60	67	73	80	87	93
34	41	47	54	60	67	74	80	87	93
35	42	48	55	61	68	74	81	87	94
36	42	49	55	62	68	74	81	87	94
37	43	50	56	62	69	75	81	87	94
38	44	50	57	63	69	75	81	88	94
39	45	51	57	63	70	76	82	88	94
40	46	52	58	64	70	76	82	88	94
41	47	53	59	65	71	76	82	88	94
42	48	54	59	65	71	77	83	88	94
43	49	54	60	66	72	77	83	89	94
44	50	55	61	66	72	78	83	89	94
45	51	56	62	67	73	78	84	89	95
46	51	57	62	68	73	78	84	89	95
47	52	58	63	68	74	79	84	89	95
48	53	58	64	69	74	79	84	90	95
49	54	59	64	69	75	80	85	90	95
50	55	60	65	70	75	80	85	90	95
51	56	61	66	71	76	80	85	90	95
52	57	62	66	71	76	81	86	90	95
53	58	62	67	72	77	81	86	91	95
54	59	63	68	72	77	82	86	91	95
55	60	64	69	73	78	82	87	91	96
56	60	65	69	74	78	82	87	91	96

TABLE I—COMBINED RATINGS TABLE—Continued

[10 combined with 10 is 19]

	10	20	30	40	50	60	70	80	90
57	61	66	70	74	79	83	87	91	96
58	62	66	71	75	79	83	87	92	96
59	63	67	71	75	80	84	88	92	96
60	64	68	72	76	80	84	88	92	96
61	65	69	73	77	81	84	88	92	96
62	66	70	73	77	81	85	89	92	96
63	67	70	74	78	82	85	89	93	96
64	68	71	75	78	82	86	89	93	96
65	69	72	76	79	83	86	90	93	97
66	69	73	76	80	83	86	90	93	97
67	70	74	77	80	84	87	90	93	97
68	71	74	78	81	84	87	90	94	97
69	72	75	78	81	85	88	91	94	97
70	73	76	79	82	85	88	91	94	97
71	74	77	80	83	86	88	91	94	97
72	75	78	80	83	86	89	92	94	97
73	76	78	81	84	87	89	92	95	97
74	77	79	82	84	87	90	92	95	97
75	78	80	83	85	88	90	93	95	98
76	78	81	83	86	88	90	93	95	98
77	79	82	84	86	89	91	93	95	98
78	80	82	85	87	89	91	93	96	98
79	81	83	85	87	90	92	94	96	98
80	82	84	86	88	90	92	94	96	98
81	83	85	87	89	91	92	94	96	98
82	84	86	87	89	91	93	95	96	98
83	85	86	88	90	92	93	95	97	98
84	86	87	89	90	92	94	95	97	98
85	87	88	90	91	93	94	96	97	99
86	87	89	90	92	93	94	96	97	99
87	88	90	91	92	94	95	96	97	99
88	89	90	92	93	94	95	96	98	99
89	90	91	92	93	95	96	87	38	99
90	91	92	93	94	95	96	97	98	99
91	92	93	94	95	96	96	97	98	99
92	93	94	94	95	96	97	98	98	99
93	94	94	95	96	97	97	98	99	99
94	95	95	96	96	97	98	98	99	99

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

[41 FR 11293, Mar. 18, 1976, as amended at 54 FR 27161, June 28, 1989; 54 FR 36029, Aug. 31, 1989]

§4.26 Bilateral factor.

When a partial disability results from disease or injury of both arms, or of both legs, or of paired skeletal muscles, the ratings for the disabilities of the right and left sides will be combined as usual, and 10 percent of this value will be added (i.e., not combined) before proceeding with further combinations, or converting to degree of disability. The bilateral factor will be applied to such bilateral disabilities before other combinations are carried out and the rating for such disabilities including the bilateral factor in this section will be treated as 1 disability for the purpose of arranging in order of severity and for all further combinations. For example, with disabilities evaluated at 60 percent, 20 percent, 10 percent and 10 percent (the two 10's representing bilateral disabilities), the order of severity would be 60, 21 and 20. The 60 and 21 combine to 68 percent and the 68 and 20 to 74 percent, converted to 70 percent as the final degree of disability.

(a) The use of the terms "arms" and "legs" is not intended to distinguish between the arm, forearm and hand, or the thigh, leg, and foot, but relates to the upper extremities and lower extremities as a whole. Thus with a compensable disability of the right thigh, for example, amputation, and one of the left foot, for example, pes planus, the bilateral factor applies, and similarly whenever there are compensable

disabilities affecting use of paired extremities regardless of location or specified type of impairment.

(b) The correct procedure when applying the bilateral factor to disabilities affecting both upper extremities and both lower extremities is to combine the ratings of the disabilities affecting the 4 extremities in the order of their individual severity and apply the bilateral factor by adding, not combining, 10 percent of the combined value thus attained.

(c) The bilateral factor is not applicable unless there is partial disability of compensable degree in each of 2 paired extremities, or paired skeletal muscles.

§ 4.27 Use of diagnostic code numbers.

The diagnostic code numbers appearing opposite the listed ratable disabilities are arbitrary numbers for the purpose of showing the basis of the evaluation assigned and for statistical analysis in the Department of Veterans Affairs, and as will be observed, extend from 5000 to a possible 9999. Great care will be exercised in the selection of the applicable code number and in its citation on the rating sheet. No other numbers than these listed or hereafter furnished are to be employed for rating purposes, with an exception as described in this section, as to unlisted conditions. When an unlisted disease, injury, or residual condition is encountered, requiring rating by analogy, the diagnostic code number will be "built-up" as follows: The first 2 digits will be selected from that part of the schedule most closely identifying the part, or system, of the body involved; the last 2 digits will be "99" for all unlisted conditions. This procedure will facilitate a close check of new and unlisted conditions, rated by analogy. In the selection of code numbers, injuries will generally be represented by the number assigned to the residual condition on the basis of which the rating is determined. With diseases, preference is to be given to the number assigned to the disease itself; if the rating is determined on the basis of residual conditions, the number appropriate to the residual condition will be added, preceded by a hyphen. Thus, rheumatoid (atrophic) arthritis rated as ankylosis of the lumbar spine should be coded "5002–5289." In this way, the exact source of each rating can be easily identified. In the citation of disabilities on rating sheets, the diagnostic terminology will be that of the medical examiner, with no attempt to translate the terms into schedule nomenclature. Residuals of diseases or therapeutic procedures will not be cited without reference to the basic disease.

[41 FR 11293, Mar. 18, 1976]

§ 4.28 Prestabilization rating from date of discharge from service.

The following ratings may be assigned, in lieu of ratings prescribed elsewhere, under the conditions stated for disability from any disease or injury. The prestabilization rating is not to be assigned in any case in which a total rating is immediately assignable under the regular provisions of the schedule or on the basis of individual unemployability. The prestabilization 50-percent rating is not to be used in any case in which a rating of 50 percent or more is immediately assignable under the regular provisions.

	Rating
Unstabilized condition with severe disability—	
Substantially gainful employment is not feasible or advisable	100
Unhealed or incompletely healed wounds or injuries—	
Material impairment of employability likely	50

NOTE (1): Department of Veterans Affairs examination is not required prior to assignment of prestabilization ratings; however, the fact that examination was accomplished will not preclude assignment of these benefits. Prestabilization ratings are for assignment in the immediate postdischarge period. They will continue for a 12-month period following discharge from service. However, prestabilization ratings may be changed to a regular schedular total rating or one authorizing a greater benefit at any time. In each prestabilization rating an examination will be requested to be accomplished not earlier than 6 months nor more than 12 months following discharge. In those prestabilization ratings in which following examination reduction in evaluation is found to be warranted, the higher evaluation will be continued to the end of the 12th month following discharge or to the end of the period provided under § 3.105(e) of this chapter, whichever is later. Special monthly compensation should be assigned concurrently in these

cases whenever records are adequate to establish entitlement.

NOTE (2): Diagnosis of disease, injury, or residuals will be cited, with diagnostic code number assigned from this rating schedule for conditions listed therein.

[35 FR 11906, July 24, 1970]

§4.29 Ratings for service-connected disabilities requiring hospital treatment or observation.

A total disability rating (100 percent) will be assigned without regard to other provisions of the rating schedule when it is established that a service-connected disability has required hospital treatment in a Department of Veterans Affairs or an approved hospital for a period in excess of 21 days or *hospital observation at Department of Veterans Affairs expense* for a service-connected disability for a period in excess of 21 days.

(a) Subject to the provisions of paragraphs (d), (e), and (f) of this section this increased rating will be effective the first day of continuous hospitalization and will be terminated effective the last day of the month of hospital discharge (regular discharge or release to non-bed care) or effective the last day of the month of termination of treatment or observation for the service-connected disability. A temporary release which is approved by an attending Department of Veterans Affairs physician as part of the treatment plan will not be considered an absence.

(1) An authorized absence in excess of 4 days which begins during the first 21 days of hospitalization will be regarded as the equivalent of hospital discharge effective the first day of such authorized absence. An authorized absence of 4 days or less which results in a total of more than 8 days of authorized absence during the first 21 days of hospitalization will be regarded as the equivalent of hospital discharge effective the ninth day of authorized absence.

(2) Following a period of hospitalization in excess of 21 days, an authorized absence in excess of 14 days or a third consecutive authorized absence of 14 days will be regarded as the equivalent of hospital discharge and will interrupt hospitalization effective on the last day of the month in which either the authorized absence in excess of 14 days or the third 14 day period begins, except where there is a finding that convalescence is required as provided by paragraph (e) or (f) of this section. The termination of these total ratings will not be subject to §3.105(e) of this chapter.

(b) Notwithstanding that hospital admission was for disability not connected with service, if during such hospitalization, hospital treatment for a service-connected disability is instituted and continued for a period in excess of 21 days, the increase to a total rating will be granted from the first day of such treatment. If service connection for the disability under treatment is granted after hospital admission, the rating will be from the first day of hospitalization if otherwise in order.

(c) The assignment of a total disability rating on the basis of hospital treatment or observation will not preclude the assignment of a total disability rating otherwise in order under other provisions of the rating schedule, and consideration will be given to the propriety of such a rating in all instances and to the propriety of its continuance after discharge. Particular attention, with a view to proper rating under the rating schedule, is to be given to the claims of veterans discharged from hospital, regardless of length of hospitalization, with indications on the final summary of expected confinement to bed or house, or to inability to work with requirement of frequent care of physician or nurse at home.

(d) On these total ratings Department of Veterans Affairs regulations governing effective dates for increased benefits will control.

(e) The total hospital rating if convalescence is required may be continued for periods of 1, 2, or 3 months in addition to the period provided in paragraph (a) of this section.

(f) Extension of periods of 1, 2 or 3 months beyond the initial 3 months may be made upon approval of the Adjudication Officer.

(g) Meritorious claims of veterans who are discharged from the hospital with less than the required number of days but need post-hospital care and a prolonged period of convalescence will

be referred to the Director, Compensation and Pension Service, under § 3.321(b)(1) of this chapter.

[29 FR 6718, May 22, 1964, as amended at 41 FR 11294, Mar. 18, 1976; 41 FR 34256, Aug. 13, 1976; 54 FR 4281, Jan. 30, 1989; 54 FR 34981, Aug. 23, 1989]

§ 4.30 Convalescent ratings.

A total disability rating (100 percent) will be assigned without regard to other provisions of the rating schedule when it is established by report at hospital discharge (regular discharge or release to non-bed care) or outpatient release that entitlement is warranted under paragraph (a) (1), (2) or (3) of this section effective the date of hospital admission or outpatient treatment and continuing for a period of 1, 2, or 3 months from the first day of the month following such hospital discharge or outpatient release. The termination of these total ratings will not be subject to § 3.105(e) of this chapter. Such total rating will be followed by appropriate schedular evaluations. When the evidence is inadequate to assign a schedular evaluation, a physical examination will be scheduled and considered prior to the termination of a total rating under this section.

(a) Total ratings will be assigned under this section if treatment of a service-connected disability resulted in:

(1) Surgery necessitating at least one month of convalescence (Effective as to outpatient surgery March 1, 1989.)

(2) Surgery with severe postoperative residuals such as incompletely healed surgical wounds, stumps of recent amputations, therapeutic immobilization of one major joint or more, application of a body cast, or the necessity for house confinement, or the necessity for continued use of a wheelchair or crutches (regular weight-bearing prohibited). (Effective as to outpatient surgery March 1, 1989.)

(3) Immobilization by cast, without surgery, of one major joint or more. (Effective as to outpatient treatment March 10, 1976.)

A reduction in the total rating will not be subject to § 3.105(e) of this chapter. The total rating will be followed by an open rating reflecting the appropriate schedular evaluation; where the evidence is inadequate to assign the schedular evaluation, a physcial examination will be scheduled prior to the end of the total rating period.

(b) A total rating under this section will require full justification on the rating sheet and may be extended as follows:

(1) Extensions of 1, 2 or 3 months beyond the initial 3 months may be made under paragraph (a) (1), (2) or (3) of this section.

(2) Extensions of 1 or more months up to 6 months beyond the initial 6 months period may be made under paragraph (a) (2) or (3) of this section upon approval of the Adjudication Officer.

[41 FR 34256, Aug. 13, 1976, as amended at 54 FR 4281, Jan. 30, 1989]

§ 4.31 Zero percent evaluations.

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.

[58 FR 52018, Oct. 6, 1993]

Subpart B—Disability Ratings

THE MUSCULOSKELETAL SYSTEM

§ 4.40 Functional loss.

Disability of the musculoskeletal system is primarily the inability, due to damage or infection in parts of the system, to perform the normal working movements of the body with normal excursion, strength, speed, coordination and endurance. It is essential that the examination on which ratings are based adequately portray the anatomical damage, and the functional loss, with respect to all these elements. The functional loss may be due to absence of part, or all, of the necessary bones, joints and muscles, or associated structures, or to deformity, adhesions, defective innervation, or other pathology, or it may be due to pain, supported by adequate pathology and evidenced by the visible behavior of the claimant undertaking the motion. Weakness is as important as limitation of motion, and a part which becomes

painful on use must be regarded as seriously disabled. A little used part of the musculoskeletal system may be expected to show evidence of disuse, either through atrophy, the condition of the skin, absence of normal callosity or the like.

§4.41 History of injury.

In considering the residuals of injury, it is essential to trace the medical-industrial history of the disabled person from the original injury, considering the nature of the injury and the attendant circumstances, and the requirements for, and the effect of, treatment over past periods, and the course of the recovery to date. The duration of the initial, and any subsequent, period of total incapacity, especially periods reflecting delayed union, inflammation, swelling, drainage, or operative intervention, should be given close attention. This consideration, or the absence of clear cut evidence of injury, may result in classifying the disability as not of traumatic origin, either reflecting congenital or developmental etiology, or the effects of healed disease.

§4.42 Complete medical examination of injury cases.

The importance of complete medical examination of injury cases at the time of first medical examination by the Department of Veterans Affairs cannot be overemphasized. When possible, this should include complete neurological and psychiatric examination, and other special examinations indicated by the physical condition, in addition to the required general and orthopedic or surgical examinations. When complete examinations are not conducted covering all systems of the body affected by disease or injury, it is impossible to visualize the nature and extent of the service connected disability. Incomplete examination is a common cause of incorrect diagnosis, especially in the neurological and psychiatric fields, and frequently leaves the Department of Veterans Affairs in doubt as to the presence or absence of disabling conditions at the time of the examination.

§4.43 Osteomyelitis.

Chronic, or recurring, suppurative osteomyelitis, once clinically identified, including chronic inflammation of bone marrow, cortex, or periosteum, should be considered as a continuously disabling process, whether or not an actively discharging sinus or other obvious evidence of infection is manifest from time to time, and unless the focus is entirely removed by amputation will entitle to a permanent rating to be combined with other ratings for residual conditions, however, not exceeding amputation ratings at the site of election.

§4.44 The bones.

The osseous abnormalities incident to trauma or disease, such as malunion with deformity throwing abnormal stress upon, and causing malalignment of joint surfaces, should be depicted from study and observation of all available data, beginning with inception of injury or disease, its nature, degree of prostration, treatment and duration of convalescence, and progress of recovery with development of permanent residuals. With shortening of a long bone, some degree of angulation is to be expected; the extent and direction should be brought out by X-ray and observation. The direction of angulation and extent of deformity should be carefully related to strain on the neighboring joints, especially those connected with weight-bearing.

§4.45 The joints.

As regards the joints the factors of disability reside in reductions of their normal excursion of movements in different planes. Inquiry will be directed to these considerations:

(a) Less movement than normal (due to ankylosis, limitation or blocking, adhesions, tendon-tie-up, contracted scars, etc.).

(b) More movement than normal (from flail joint, resections, nonunion of fracture, relaxation of ligaments, etc.).

(c) Weakened movement (due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.).

(d) Excess fatigability.

(e) Incoordination, impaired ability to execute skilled movements smoothly.

(f) Pain on movement, swelling, deformity or atrophy of disuse. Instability of station, disturbance of locomotion, interference with sitting, standing and weight-bearing are related considerations. For the purpose of rating disability from arthritis, the shoulder, elbow, wrist, hip, knee, and ankle are considered major joints; multiple involvements of the interphalangeal, metacarpal and carpal joints of the upper extremities, the interphalangeal, metatarsal and tarsal joints of the lower extremities, the cervical vertebrae, the dorsal vertebrae, and the lumbar vertebrae, are considered groups of minor joints, ratable on a parity with major joints. The lumbosacral articulation and both sacroiliac joints are considered to be a group of minor joints, ratable on disturbance of lumbar spine functions.

§ 4.46 Accurate measurement.

Accurate measurement of the length of stumps, excursion of joints, dimensions and location of scars with respect to landmarks, should be insisted on. The use of a goniometer in the measurement of limitation of motion is indispensable in examinations conducted within the Department of Veterans Affairs. Muscle atrophy must also be accurately measured and reported.

[41 FR 11294, Mar. 18, 1976]

§§ 4.47–4.54 [Reserved]

§ 4.55 Principles of combined ratings for muscle injuries.

(a) A muscle injury rating will not be combined with a peripheral nerve paralysis rating of the same body part, unless the injuries affect entirely different functions.

(b) For rating purposes, the skeletal muscles of the body are divided into 23 muscle groups in 5 anatomical regions: 6 muscle groups for the shoulder girdle and arm (diagnostic codes 5301 through 5306); 3 muscle groups for the forearm and hand (diagnostic codes 5307 through 5309); 3 muscle groups for the foot and leg (diagnostic codes 5310 through 5312); 6 muscle groups for the pelvic girdle and thigh (diagnostic codes 5313 through 5318); and 5 muscle groups for the torso and neck (diagnostic codes 5319 through 5323).

(c) There will be no rating assigned for muscle groups which act upon an ankylosed joint, with the following exceptions:

(1) In the case of an ankylosed knee, if muscle group XIII is disabled, it will be rated, but at the next lower level than that which would otherwise be assigned.

(2) In the case of an ankylosed shoulder, if muscle groups I and II are severely disabled, the evaluation of the shoulder joint under diagnostic code 5200 will be elevated to the level for unfavorable ankylosis, if not already assigned, but the muscle groups themselves will not be rated.

(d) The combined evaluation of muscle groups acting upon a single unankylosed joint must be lower than the evaluation for unfavorable ankylosis of that joint, except in the case of muscle groups I and II acting upon the shoulder.

(e) For compensable muscle group injuries which are in the same anatomical region but do not act on the same joint, the evaluation for the most severely injured muscle group will be increased by one level and used as the combined evaluation for the affected muscle groups.

(f) For muscle group injuries in different anatomical regions which do not act upon ankylosed joints, each muscle group injury shall be separately rated and the ratings combined under the provisions of § 4.25.

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

[62 FR 30237, June 3, 1997]

§ 4.56 Evaluation of muscle disabilities.

(a) An open comminuted fracture with muscle or tendon damage will be rated as a severe injury of the muscle group involved unless, for locations such as in the wrist or over the tibia, evidence establishes that the muscle damage is minimal.

(b) A through-and-through injury with muscle damage shall be evaluated as no less than a moderate injury for each group of muscles damaged.

(c) For VA rating purposes, the cardinal signs and symptoms of muscle disability are loss of power, weakness, lowered threshold of fatigue, fatigue-pain, impairment of coordination and uncertainty of movement.

(d) Under diagnostic codes 5301 through 5323, disabilities resulting from muscle injuries shall be classified as slight, moderate, moderately severe or severe as follows:

(1) *Slight disability of muscles*—(i) *Type of injury.* Simple wound of muscle without debridement or infection.

(ii) *History and complaint.* Service department record of superficial wound with brief treatment and return to duty. Healing with good functional results. No cardinal signs or symptoms of muscle disability as defined in paragraph (c) of this section.

(iii) *Objective findings.* Minimal scar. No evidence of fascial defect, atrophy, or impaired tonus. No impairment of function or metallic fragments retained in muscle tissue.

(2) *Moderate disability of muscles*—(i) *Type of injury.* Through and through or deep penetrating wound of short track from a single bullet, small shell or shrapnel fragment, without explosive effect of high velocity missile, residuals of debridement, or prolonged infection.

(ii) *History and complaint.* Service department record or other evidence of in-service treatment for the wound. Record of consistent complaint of one or more of the cardinal signs and symptoms of muscle disability as defined in paragraph (c) of this section, particularly lowered threshold of fatigue after average use, affecting the particular functions controlled by the injured muscles.

(iii) *Objective findings.* Entrance and (if present) exit scars, small or linear, indicating short track of missile through muscle tissue. Some loss of deep fascia or muscle substance or impairment of muscle tonus and loss of power or lowered threshold of fatigue when compared to the sound side.

(3) *Moderately severe disability of muscles*—(i) *Type of injury.* Through and through or deep penetrating wound by small high velocity missile or large low-velocity missile, with debridement, prolonged infection, or sloughing of soft parts, and intermuscular scarring.

(ii) *History and complaint.* Service department record or other evidence showing hospitalization for a prolonged period for treatment of wound. Record of consistent complaint of cardinal signs and symptoms of muscle disability as defined in paragraph (c) of this section and, if present, evidence of inability to keep up with work requirements.

(iii) *Objective findings.* Entrance and (if present) exit scars indicating track of missile through one or more muscle groups. Indications on palpation of loss of deep fascia, muscle substance, or normal firm resistance of muscles compared with sound side. Tests of strength and endurance compared with sound side demonstrate positive evidence of impairment.

(4) *Severe disability of muscles*—(i) *Type of injury.* Through and through or deep penetrating wound due to high-velocity missile, or large or multiple low velocity missiles, or with shattering bone fracture or open comminuted fracture with extensive debridement, prolonged infection, or sloughing of soft parts, intermuscular binding and scarring.

(ii) *History and complaint.* Service department record or other evidence showing hospitalization for a prolonged period for treatment of wound. Record of consistent complaint of cardinal signs and symptoms of muscle disability as defined in paragraph (c) of this section, worse than those shown for moderately severe muscle injuries, and, if present, evidence of inability to keep up with work requirements.

(iii) *Objective findings.* Ragged, depressed and adherent scars indicating wide damage to muscle groups in missile track. Palpation shows loss of deep fascia or muscle substance, or soft flabby muscles in wound area. Muscles swell and harden abnormally in contraction. Tests of strength, endurance, or coordinated movements compared with the corresponding muscles of the uninjured side indicate severe impairment of function. If present, the following are also signs of severe muscle disability:

(A) X-ray evidence of minute multiple scattered foreign bodies indicating intermuscular trauma and explosive effect of the missile.

(B) Adhesion of scar to one of the long bones, scapula, pelvic bones, sacrum or vertebrae, with epithelial sealing over the bone rather than true skin covering in an area where bone is normally protected by muscle.

(C) Diminished muscle excitability to pulsed electrical current in electrodiagnostic tests.

(D) Visible or measurable atrophy.

(E) Adaptive contraction of an opposing group of muscles.

(F) Atrophy of muscle groups not in the track of the missile, particularly of the trapezius and serratus in wounds of the shoulder girdle.

(G) Induration or atrophy of an entire muscle following simple piercing by a projectile.

(Authority: 38 U.S.C. 1155

[62 FR 30238, June 3, 1997]

§ 4.57 Static foot deformities.

It is essential to make an initial distinction between bilateral flatfoot as a congenital or as an acquired condition. The congenital condition, with depression of the arch, but no evidence of abnormal callosities, areas of pressure, strain or demonstrable tenderness, is a congenital abnormality which is not compensable or pensionable. In the acquired condition, it is to be remembered that depression of the longitudinal arch, or the degree of depression, is not the essential feature. The attention should be given to anatomical changes, as compared to normal, in the relationship of the foot and leg, particularly to the inward rotation of the superior portion of the os calcis, medial deviation of the insertion of the Achilles tendon, the medial tilting of the upper border of the astragalus. This is an unfavorable mechanical relationship of the parts. A plumb line dropped from the middle of the patella falls inside of the normal point. The forepart of the foot is abducted, and the foot everted. The plantar surface of the foot is painful and shows demonstrable tenderness, and manipulation of the foot produces spasm of the Achilles tendon, peroneal spasm due to adhesion about the peroneal sheaths, and other evidence of pain and limited motion. The symptoms should be apparent without regard to exercise. In severe cases there is gaping of bones on the inner border of the foot, and rigid valgus position with loss of the power of inversion and adduction. Exercise with undeveloped or unbalanced musculature, producing chronic irritation, can be an aggravating factor. In the absence of trauma or other definite evidence of aggravation, service connection is not in order for pes cavus which is a typically congenital or juvenile disease.

§ 4.58 Arthritis due to strain.

With service incurred lower extremity amputation or shortening, a disabling arthritis, developing in the same extremity, or in both lower extremities, with indications of earlier, or more severe, arthritis in the injured extremity, including also arthritis of the lumbosacral joints and lumbar spine, if associated with the leg amputation or shortening, will be considered as service incurred, provided, however, that arthritis affecting joints not directly subject to strain as a result of the service incurred amputation will not be granted service connection. This will generally require separate evaluation of the arthritis in the joints directly subject to strain. Amputation, or injury to an upper extremity, is not considered as a causative factor with subsequently developing arthritis, except in joints subject to direct strain or actually injured.

§ 4.59 Painful motion.

With any form of arthritis, painful motion is an important factor of disability, the facial expression, wincing, etc., on pressure or manipulation, should be carefully noted and definitely related to affected joints. Muscle spasm will greatly assist the identification. Sciatic neuritis is not uncommonly caused by arthritis of the spine. The intent of the schedule is to recognize painful motion with joint or periarticular pathology as productive of disability. It is the intention to recognize actually painful, unstable, or malaligned joints, due to healed injury, as entitled to at least the minimum

compensable rating for the joint. Crepitation either in the soft tissues such as the tendons or ligaments, or crepitation within the joint structures should be noted carefully as points of contact which are diseased. Flexion elicits such manifestations. The joints involved should be tested for pain on both active and passive motion, in weight-bearing and nonweight-bearing and, if possible, with the range of the opposite undamaged joint.

§4.60 [Reserved]

§4.61 Examination.

With any form of arthritis (except traumatic arthritis) it is essential that the examination for rating purposes cover all major joints, with especial reference to Heberden's or Haygarth's nodes.

§4.62 Circulatory disturbances.

The circulatory disturbances, especially of the lower extremity following injury in the popliteal space, must not be overlooked, and require rating generally as phlebitis.

§4.63 Loss of use of hand or foot.

Loss of use of a hand or a foot, for the purpose of special monthly compensation, will be held to exist when no effective function remains other than that which would be equally well served by an amputation stump at the site of election below elbow or knee with use of a suitable prosthetic appliance. The determination will be made on the basis of the actual remaining function of the hand or foot, whether the acts of grasping, manipulation, etc., in the case of the hand, or of balance and propulsion, etc., in the case of the foot, could be accomplished equally well by an amputation stump with prosthesis.

(a) Extremely unfavorable complete ankylosis of the knee, or complete ankylosis of 2 major joints of an extremity, or shortening of the lower extremity of 3½ inches (8.9 cms.) or more, will be taken as loss of use of the hand or foot involved.

(b) Complete paralysis of the external popliteal nerve (common peroneal) and consequent, footdrop, accompanied by characteristic organic changes including trophic and circulatory disturbances and other concomitants confirmatory of complete paralysis of this nerve, will be taken as loss of use of the foot.

[29 FR 6718, May 22, 1964, as amended at 43 FR 45349, Oct. 2, 1978]

§4.64 Loss of use of both buttocks.

Loss of use of both buttocks shall be deemed to exist when there is severe damage to muscle Group XVII, bilateral (diagnostic code number 5317) and additional disability rendering it impossible for the disabled person, without assistance, to rise from a seated position and from a stooped position (fingers to toes position) and to maintain postural stability (the pelvis upon head of femur). The assistance may be rendered by the person's own hands or arms, and, in the matter of postural stability, by a special appliance.

§4.65 [Reserved]

§4.66 Sacroiliac joint.

The common cause of disability in this region is arthritis, to be identified in the usual manner. The lumbosacral and sacroiliac joints should be considered as one anatomical segment for rating purposes. X-ray changes from arthritis in this location are decrease or obliteration of the joint space, with the appearance of increased bone density of the sacrum and ilium and sharpening of the margins of the joint. Disability is manifest from erector spinae spasm (not accounted for by other pathology), tenderness on deep palpation and percussion over these joints, loss of normal quickness of motion and resiliency, and postural defects often accompanied by limitation of flexion and extension of the hip. Traumatism is a rare cause of disability in this connection, except when superimposed upon congenital defect or upon an existent arthritis; to permit assumption of pure traumatic origin, objective evidence of damage to the joint, and history of trauma sufficiently severe to injure this extremely strong and practically immovable joint is required. There should be careful consideration of lumbosacral sprain, and the various

symptoms of pain and paralysis attributable to disease affecting the lumbar vertebrae and the intervertebral disc.

§ 4.67 Pelvic bones.

The variability of residuals following these fractures necessitates rating on specific residuals, faulty posture, limitation of motion, muscle injury, painful motion of the lumbar spine, manifest by muscle spasm, mild to moderate sciatic neuritis, peripheral nerve injury, or limitation of hip motion.

§ 4.68 Amputation rule.

The combined rating for disabilities of an extremity shall not exceed the rating for the amputation at the elective level, were amputation to be performed. For example, the combined evaluations for disabilities below the knee shall not exceed the 40 percent evaluation, diagnostic code 5165. This 40 percent rating may be further combined with evaluation for disabilities above the knee but not to exceed the above the knee amputation elective level. Painful neuroma of a stump after amputation shall be assigned the evaluation for the elective site of reamputation.

§ 4.69 Dominant hand.

Handedness for the purpose of a dominant rating will be determined by the evidence of record, or by testing on VA examination. Only one hand shall be considered dominant. The injured hand, or the most severely injured hand, of an ambidextrous individual will be considered the dominant hand for rating purposes.

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

[62 FR 30239, June 3, 1997]

§ 4.70 Inadequate examinations.

If the report of examination is inadequate as a basis for the required consideration of service connection and evaluation, the rating agency may request a supplementary report from the examiner giving further details as to the limitations of the disabled person's ordinary activity imposed by the disease, injury, or residual condition, the prognosis for return to, or continuance of, useful work. When the best interests of the service will be advanced by personal conference with the examiner, such conference may be arranged through channels.

§ 4.71 Measurement of ankylosis and joint motion.

Plates I and II provide a standardized description of ankylosis and joint motion measurement. The anatomical position is considered as 0°, with two major exceptions: (a) Shoulder rotation—arm abducted to 90°, elbow flexed to 90° with the position of the forearm reflecting the midpoint 0° between internal and external rotation of the shoulder; and (b) supination and pronation—the arm next to the body, elbow flexed to 90°, and the forearm in midposition 0° between supination and pronation. Motion of the thumb and fingers should be described by appropriate reference to the joints (See Plate III) whose movement is limited, with a statement as to how near, in centimeters, the tip of the thumb can approximate the fingers, or how near the tips of the fingers can approximate the proximal transverse crease of palm.

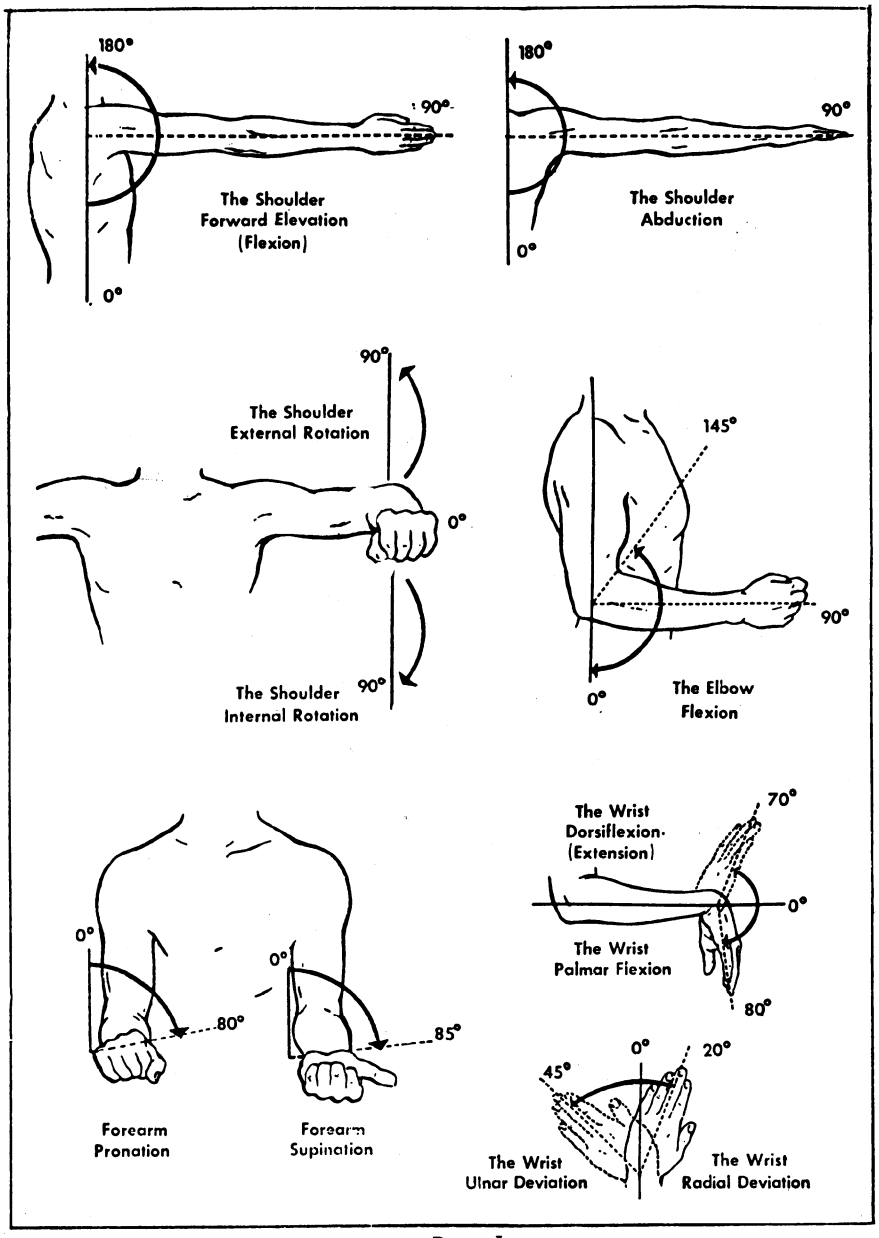

180°
90°
0°
The Shoulder
Forward Elevation
(Flexion)
180°
90°
0°
The Shoulder
Abduction
90°
0°
90°
The Shoulder
External Rotation
The Shoulder
Internal Rotation
145°
90°
0°
The Elbow
Flexion
The Wrist
Dorsiflexion
(Extension)
70°
0°
The Wrist
Palmar Flexion
80°
0°
80°
Forearm
Pronation
0°
85°
Forearm
Supination
0°
20°
45°
The Wrist
Ulnar Deviation
The Wrist
Radial Deviation

PLATE I

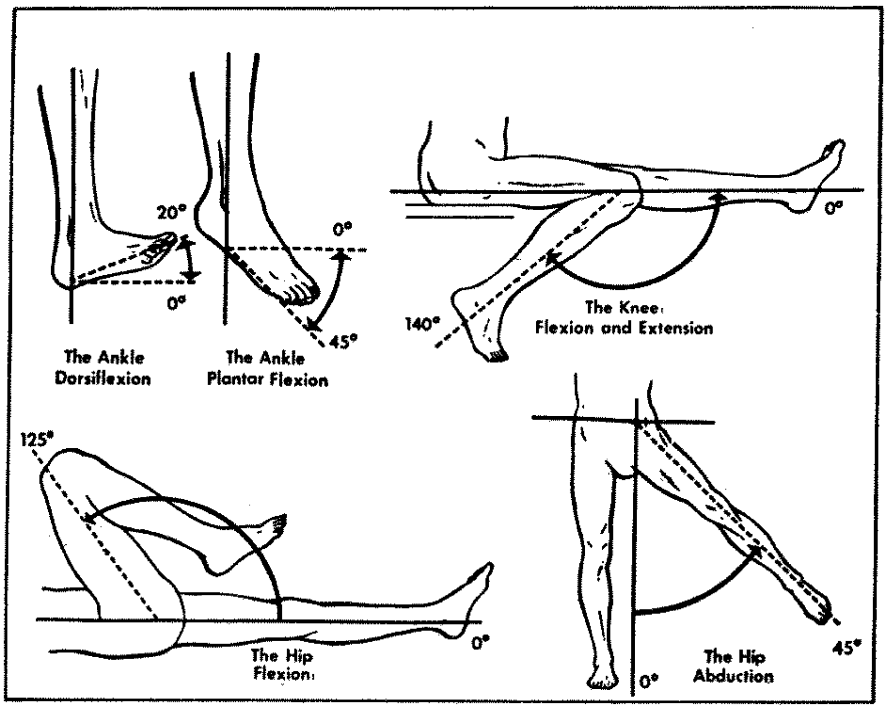


PLATE II

[29 FR 6718, May 22, 1964, as amended at 43 FR 45349, Oct. 2, 1978; 67 FR 48785, July 26, 2002]

§ 4.71a Schedule of ratings—musculoskeletal system.

ACUTE, SUBACUTE, OR CHRONIC DISEASES

	Rating
5000 Osteomyelitis, acute, subacute, or chronic:	
Of the pelvis, vertebrae, or extending into major joints, or with multiple localization or with long history of intractability and debility, anemia, amyloid liver changes, or other continuous constitutional symptoms	100
Frequent episodes, with constitutional symptoms	60
With definite involucrum or sequestrum, with or without discharging sinus	30
With discharging sinus or other evidence of active infection within the past 5 years	20
Inactive, following repeated episodes, without evidence of active infection in past 5 years	10

ACUTE, SUBACUTE, OR CHRONIC DISEASES—Continued

	Rating
NOTE (1): A rating of 10 percent, as an exception to the amputation rule, is to be assigned in any case of active osteomyelitis where the amputation rating for the affected part is no percent. This 10 percent rating and the other partial ratings of 30 percent or less are to be combined with ratings for ankylosis, limited motion, nonunion or malunion, shortening, etc., subject, of course, to the amputation rule. The 60 percent rating, as it is based on constitutional symptoms, is not subject to the amputation rule. A rating for osteomyelitis will not be applied following cure by removal or radical resection of the affected bone.	

ACUTE, SUBACUTE, OR CHRONIC DISEASES—Continued

	Rating
NOTE (2): The 20 percent rating on the basis of activity within the past 5 years is not assignable following the initial infection of active osteomyelitis with no subsequent reactivation. The prerequisite for this historical rating is an established recurrent osteomyelitis. To qualify for the 10 percent rating, 2 or more episodes following the initial infection are required. This 20 percent rating or the 10 percent rating, when applicable, will be assigned once only to cover disability at all sites of previously active infection with a future ending date in the case of the 20 percent rating.	
5001 Bones and joints, tuberculosis of, active or inactive:	
Active	100
Inactive: See §§4.88b and 4.89.	
5002 Arthritis rheumatoid (atrophic) *As an active process:*	
With constitutional manifestations associated with active joint involvement, totally incapacitating	100
Less than criteria for 100% but with weight loss and anemia productive of severe impairment of health or severely incapacitating exacerbations occurring 4 or more times a year or a lesser number over prolonged periods	60
Symptom combinations productive of definite impairment of health objectively supported by examination findings or incapacitating exacerbations occurring 3 or more times a year	40
One or two exacerbations a year in a well-established diagnosis	20
For chronic residuals:	
For residuals such as limitation of motion or ankylosis, favorable or unfavorable, rate under the appropriate diagnostic codes for the specific joints involved. Where, however, the limitation of motion of the specific joint or joints involved is noncompensable under the codes a rating of 10 percent is for application for each such major joint or group of minor joints affected by limitation of motion, to be combined, not added under diagnostic code 5002. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion.	
NOTE: The ratings for the active process will not be combined with the residual ratings for limitation of motion or ankylosis. Assign the higher evaluation.	
5003 Arthritis, degenerative (hypertrophic or osteoarthritis):	
Degenerative arthritis established by X-ray findings will be rated on the basis of limitation of motion under the appropriate diagnostic codes for the specific joint or joints involved (DC 5200 etc.). When however, the limitation of motion of the specific joint or joints involved is noncompensable under the appropriate diagnostic codes, a rating of 10 pct is for application for each such major joint or group of minor joints affected by limitation of motion, to be combined, not added under diagnostic code 5003. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion. In the absence of limitation of motion, rate as below:	
With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups, with occasional incapacitating exacerbations	20
With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups	10
NOTE (1): The 20 pct and 10 pct ratings based on X-ray findings, above, will not be combined with ratings based on limitation of motion.	
NOTE (2): The 20 pct and 10 pct ratings based on X-ray findings, above, will not be utilized in rating conditions listed under diagnostic codes 5013 to 5024, inclusive.	
5004 Arthritis, gonorrheal.	
5005 Arthritis, pneumococcic.	
5006 Arthritis, typhoid.	
5007 Arthritis, syphilitic.	
5008 Arthritis, streptococcic.	
5009 Arthritis, other types (specify).	
With the types of arthritis, diagnostic codes 5004 through 5009, rate the disability as rheumatoid arthritis.	
5010 Arthritis, due to trauma, substantiated by X-ray findings: Rate as arthritis, degenerative.	
5011 Bones, caisson disease of: Rate as arthritis, cord involvement, or deafness, depending on the severity of disabling manifestations.	
5012 Bones, new growths of, malignant	100
NOTE: The 100 percent rating will be continued for 1 year following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. At this point, if there has been no local recurrence or metastases, the rating will be made on residuals.	
5013 Osteoporosis, with joint manifestations.	
5014 Osteomalacia.	
5015 Bones, new growths of, benign.	
5016 Osteitis deformans.	
5017 Gout.	
5018 Hydrarthrosis, intermittent.	
5019 Bursitis.	
5020 Synovitis.	
5021 Myositis.	
5022 Periostitis.	
5023 Myositis ossificans.	
5024 Tenosynovitis.	
The diseases under diagnostic codes 5013 through 5024 will be rated on limitation of motion of affected parts, as arthritis, degenerative, except gout which will be rated under diagnostic code 5002.	
5025 Fibromyalgia (fibrositis, primary fibromyalgia syndrome)	
With 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:	
That are constant, or nearly so, and refractory to therapy	40
That are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but that are present more than one-third of the time	20
That require continuous medication for control	10

ACUTE, SUBACUTE, OR CHRONIC DISEASES—Continued

	Rating
NOTE: Widespread pain means pain in both the left and right sides of the body, that is both above and below the waist, and that affects both the axial skeleton (i.e., cervical spine, anterior chest, thoracic spine, or low back) and the extremities.	

PROSTHETIC IMPLANTS

	Rating	
	Major	Minor
5051 Shoulder replacement (prosthesis).		
Prosthetic replacement of the shoulder joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe, painful motion or weakness in the affected extremity	60	50
With intermediate degrees of residual weakness, pain or limitation of motion, rate by analogy to diagnostic codes 5200 and 5203.		
Minimum rating	30	20
5052 Elbow replacement (prosthesis).		
Prosthetic replacement of the elbow joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe painful motion or weakness in the affected extremity	50	40
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5205 through 5208.		
Minimum evaluation	30	20
5053 Wrist replacement (prosthesis).		
Prosthetic replacement of wrist joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe, painful motion or weakness in the affected extremity	40	30
With intermediate degrees of residual weakness, pain or limitation of motion, rate by analogy to diagnostic code 5214.		
Minimum rating	20	20
NOTE: The 100 pct rating for 1 year following implantation of prosthesis will commence after initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.		
5054 Hip replacement (prosthesis).		
Prosthetic replacement of the head of the femur or of the acetabulum:		
For 1 year following implantation of prosthesis		100

PROSTHETIC IMPLANTS—Continued

	Rating	
	Major	Minor
Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches		[1] 90
Markedly severe residual weakness, pain or limitation of motion following implantation of prosthesis		70
Moderately severe residuals of weakness, pain or limitation of motion		50
Minimum rating		30
5055 Knee replacement (prosthesis).		
Prosthetic replacement of knee joint:		
For 1 year following implantation of prosthesis		100
With chronic residuals consisting of severe painful motion or weakness in the affected extremity		60
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5256, 5261, or 5262.		
Minimum rating		30
5056 Ankle replacement (prosthesis).		
Prosthetic replacement of ankle joint:		
For 1 year following implantation of prosthesis		100
With chronic residuals consisting of severe painful motion or weakness		40
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to 5270 or 5271.		
Minimum rating		20
NOTE (1): The 100 pct rating for 1 year following implantation of prosthesis will commence after initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.		
NOTE (2): Special monthly compensation is assignable during the 100 pct rating period the earliest date permanent use of crutches is established.		
COMBINATIONS OF DISABILITIES		
5104 Anatomical loss of one hand and loss of use of one foot		[1] 100
5105 Anatomical loss of one foot and loss of use of one hand		[1] 100
5106 Anatomical loss of both hands		[1] 100
5107 Anatomical loss of both feet		[1] 100
5108 Anatomical loss of one hand and one foot		[1] 100
5109 Loss of use of both hands		[1] 100
5110 Loss of use of both feet		[1] 100
5111 Loss of use of one hand and one foot		[1] 100

[1] Also entitled to special monthly compensation.

TABLE II—RATINGS FOR MULTIPLE LOSSES OF EXTREMITIES WITH DICTATOR'S RATING CODE AND 38 CFR CITATION

Impairment of one extremity	Impairment of other extremity					
	Anatomical loss or loss of use below elbow	Anatomical loss or loss of use below knee	Anatomical loss or loss of use above elbow (preventing use of prosthesis)	Anatomical loss or loss of use above knee (preventing use of prosthesis)	Anatomical loss near shoulder (preventing use of prosthesis)	Anatomical loss near hip (preventing use of prosthesis)
Anatomical loss or loss of use below elbow.	M Codes M–1 a, b, or c, 38 CFR 3.350 (c)(1)(i).	L Codes L–1 d, e, f, or g, 38 CFR 3.350(b).	M½ Code M–5, 38 CFR 3.350 (f)(1)(x).	L½ Code L–2 c, 38 CFR 3.350 (f)(1)(vi).	N Code N–3, 38 CFR 3.350 (f)(1)(xi).	M Code M–3 c, 38 CFR 3.350 (f)(1)(viii)
Anatomical loss or loss of use below knee.	.....	L Codes L–1 a, b, or c, 38 CFR 3.350(b).	L½ Code L–2 b, 38 CFR 3.350 (f)(1)(iii).	L½ Code L–2 a, 38 CFR 3.350 (f)(1)(i).	M Code M–3 b, 38 CFR 3.350 (f)(1)(iv).	M Code M–3 a, 38 CFR 3.350 (f)(1)(ii)
Anatomical loss or loss of use above elbow (preventing use of prosthesis).	.....	.....	N Code N–1, 38 CFR 3.350 (d)(1).	M Code M–2 a, 38 CFR 3.350 (c)(1)(iii).	N½ Code N–4, 38 CFR 3.350 (f)(1)(ix).	M½ Code M–4 c, 38 CFR 3.350 (f)(1)(xi)
Anatomical loss or loss of use above knee (preventing use of prosthesis).	.....	.....	.....	M Code M–2 a, 38 CFR 3.350 (c)(1)(ii).	M½ Code M–4 b, 38 CFR 3.350 (f)(1)(vii).	M½ Code M–4 a, 38 CFR 3.350 (f)(1)(v)
Anatomical loss near shoulder (preventing use of prosthesis).	.....	.....	.....	.....	O Code O–1, 38 CFR 3.350 (e)(1)(i).	N Code N–2 b, 38 CFR 3.350 (d)(3)
Anatomical loss near hip (preventing use of prosthesis).	.....	.....	.....	.....	.....	N Code N–2 a, 38 CFR 3.350 (d)(2)

NOTE.—Need for aid attendance or permanently bedridden qualifies for subpar. L. Code L–1 h, i (38 CFR 3.350(b)). Paraplegia with loss of use of both lower extremities and loss of anal and bladder sphincter control qualifies for subpar. O. Code O–2 (38 CFR 3.350(e)(2)). Where there are additional disabilities rated 50% or 100%, or anatomical or loss of use of a third extremity see 38 CFR 3.350(f) (3), (4) or (5).

(Authority: 38 U.S.C. 1115)

AMPUTATIONS: UPPER EXTREMITY

	Rating	
	Major	Minor
Arm, amputation of:		
5120 Disarticulation	[1] 90	[1] 90
5121 Above insertion of deltoid	[1] 90	[1] 80
5122 Below insertion of deltoid	[1] 80	[1] 70
Forearm, amputation of:		
5123 Above insertion of pronator teres	[1] 80	[1] 70
5124 Below insertion of pronator teres	[1] 70	[1] 60
5125 Hand, loss of use of	[1] 70	[1] 60
MULTIPLE FINGER AMPUTATIONS		
5126 Five digits of one hand, amputation of	[1] 70	[1] 60
Four digits of one hand, amputation of:		
5127 Thumb, index, long and ring	[1] 70	[1] 60
5128 Thumb, index, long and little	[1] 70	[1] 60
5129 Thumb, index, ring and little	[1] 70	[1] 60
5130 Thumb, long, ring and little	[1] 70	[1] 60
5131 Index, long, ring and little	60	50
Three digits of one hand, amputation of:		
5132 Thumb, index and long	60	50
5133 Thumb, index and ring	60	50
5134 Thumb, index and little	60	50
5135 Thumb, long and ring	60	50
5136 Thumb, long and little	60	50

AMPUTATIONS: UPPER EXTREMITY—Continued

	Rating	
	Major	Minor
5137 Thumb, ring and little	60	50
5138 Index, long and ring	50	40
5139 Index, long and little	50	40
5140 Index, ring and little	50	40
5141 Long, ring and little	40	30
Two digits of one hand, amputation of:		
5142 Thumb and index	50	40
5143 Thumb and long	50	40
5144 Thumb and ring	50	40
5145 Thumb and little	50	40
5146 Index and long	40	30
5147 Index and ring	40	30
5148 Index and little	40	30
5149 Long and ring	30	20
5150 Long and little	30	20
5151 Ring and little	30	20
(a) The ratings for multiple finger amputations apply to amputations at the proximal interphalangeal joints or through proximal phalanges..		
(b) Amputation through middle phalanges will be rated as prescribed for unfavorable ankylosis of the fingers..		

AMPUTATIONS: UPPER EXTREMITY—Continued

	Rating	
	Major	Minor
(c) Amputations at distal joints, or through distal phalanges, other than negligible losses, will be rated as prescribed for favorable ankylosis of the fingers..		
(d) Amputation or resection of metacarpal bones (more than one-half the bone lost) in multiple fingers injuries will require a rating of 10 percent added to (not combined with) the ratings, multiple finger amputations, subject to the amputation rule applied to the forearm.		
(e) Combinations of finger amputations at various levels, or finger amputations with ankylosis or limitation of motion of the fingers will be rated on the basis of the grade of disability; i.e., amputation, unfavorable ankylosis, most representative of the levels or combinations. With an even number of fingers involved, and adjacent grades of disability, select the higher of the two grades.		
(f) Loss of use of the hand will be held to exist when no effective function remains other than that which would be equally well served by an amputation stump with a suitable prosthetic applicance.		
SINGLE FINGER AMPUTATIONS		
5152 Thumb, amputation of:		
With metacarpal resection	40	30
At metacarpophalangeal joint or through proximal phalanx	30	20
At distal joint or through distal phalanx	20	20
5153 Index finger, amputation of		
With metacarpal resection (more than one-half the bone lost)	30	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	20	20
Through middle phalanx or at distal joint	10	10
5154 Long finger, amputation of:		
With metacarpal resection (more than one-half the bone lost)	20	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	10	10
5155 Ring finger, amputation of:		
With metacarpal resection (more than one-half the bone lost)	20	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	10	10
5156 Little finger, amputation of:		
With metacarpal resection (more than one-half the bone lost)	20	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	10	10
NOTE: The single finger amputation ratings are the only applicable ratings for amputations of whole or part of single fingers.		

[1] Entitled to special monthly compensation.

SINGLE FINGER AMPUTATIONS

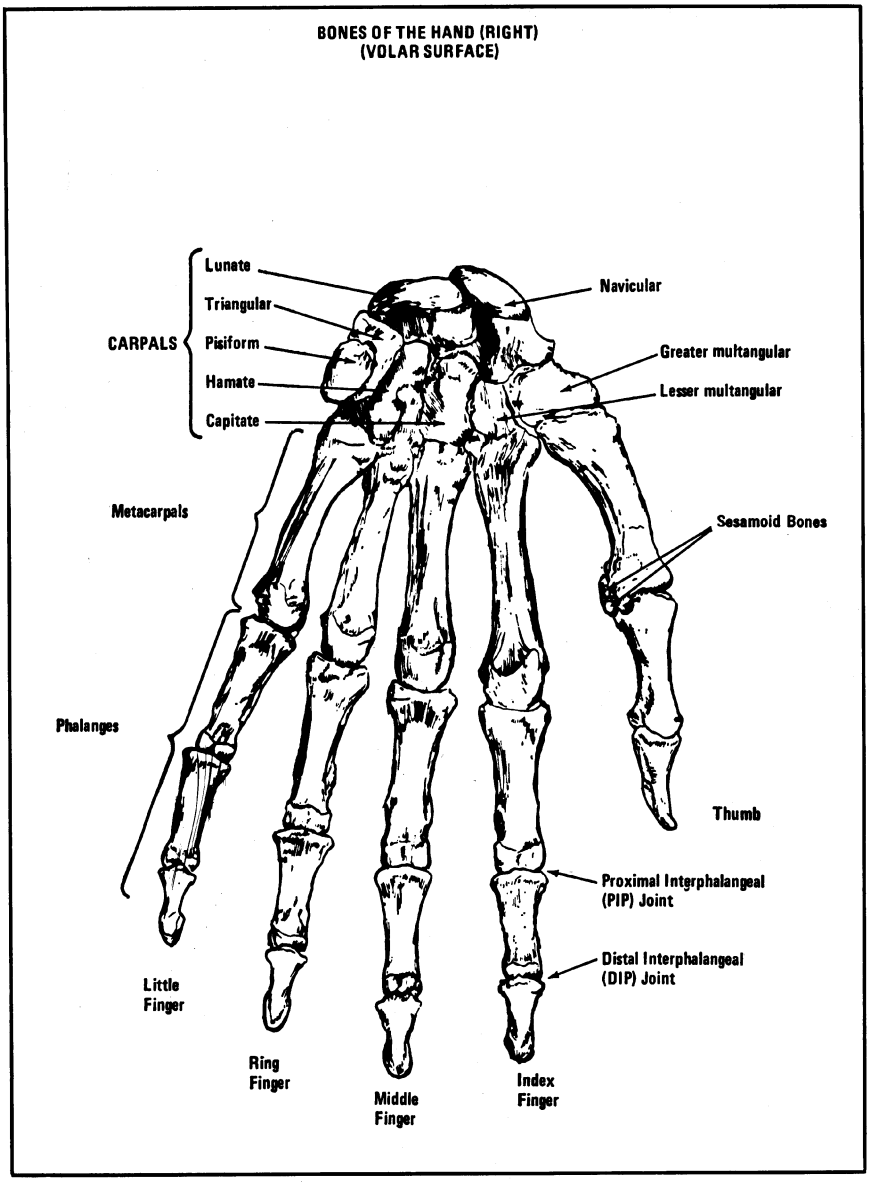


PLATE III

AMPUTATIONS: LOWER EXTREMITY

	Rating
Thigh, amputation of:	
5160 Disarticulation, with loss of extrinsic pelvic girdle muscles	[2] 90
5161 Upper third, one-third of the distance from perineum to knee joint measured from perineum	[2] 80
5162 Middle or lower thirds	[2] 60
Leg, amputation of:	
5163 With defective stump, thigh amputation recommended	[2] 60
5164 Amputation not improvable by prosthesis controlled by natural knee action	[2] 60
5165 At a lower level, permitting prosthesis	[2] 40
5166 Forefoot, amputation proximal to metatarsal bones (more than one-half of metatarsal loss)	[2] 40
5167 Foot, loss of use of	[2] 40

AMPUTATIONS: LOWER EXTREMITY—Continued

	Rating
5170 Toes, all, amputation of, without metatarsal loss	30
5171 Toe, great, amputation of:	
With removal of metatarsal head	30
Without metatarsal involvement	10
5172 Toes, other than great, amputation of, with removal of metatarsal head:	
One or two	20
Without metatarsal involvement	0
5173 Toes, three or four, amputation of, without metatarsal involvement:	
Including great toe	20
Not including great toe	10

[2] Also entitled to special monthly compensation.

AMPUTATIONS: LOWER EXTREMITY

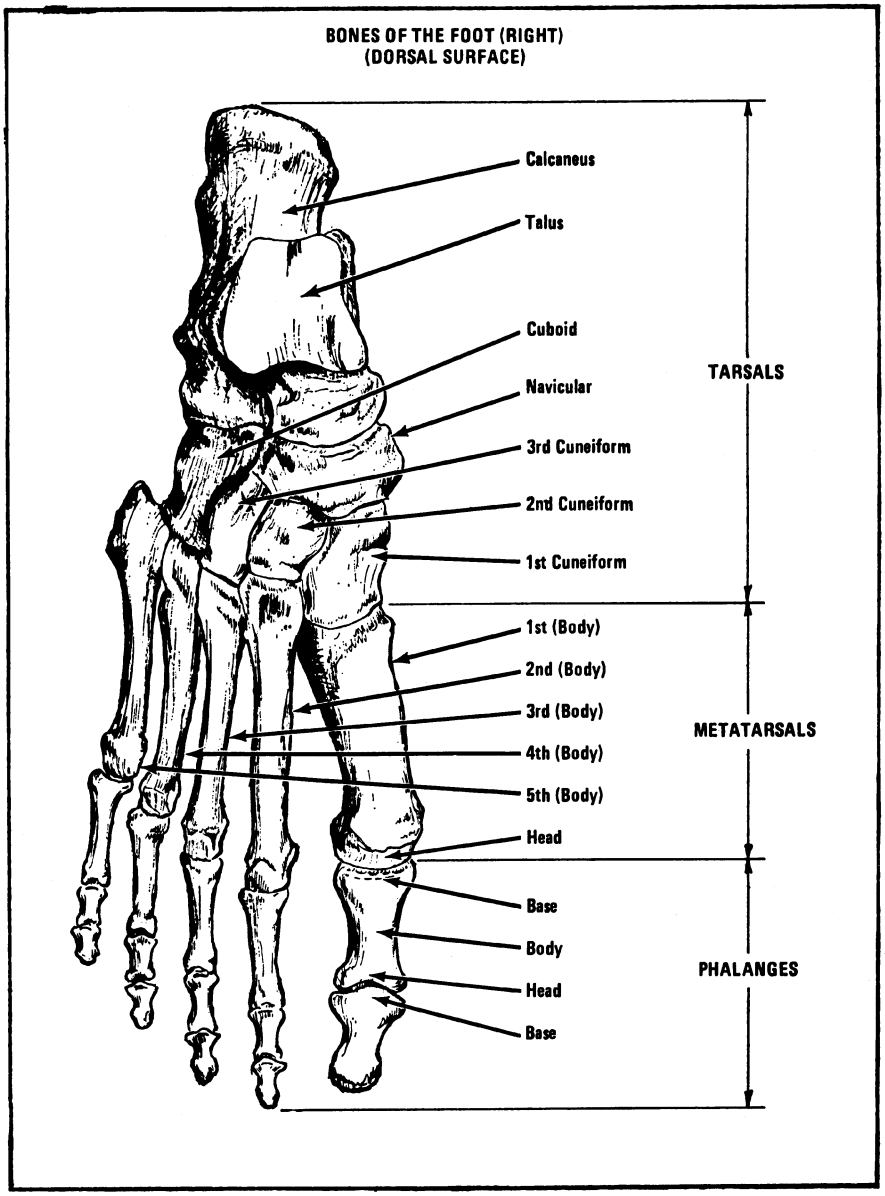


PLATE IV

THE SHOULDER AND ARM

	Rating	
	Major	Minor
5200 Scapulohumeral articulation, ankylosis of:		
NOTE: The scapula and humerus move as one piece.		
Unfavorable, abduction limited to 25° from side	50	40
Intermediate between favorable and unfavorable	40	30
Favorable, abduction to 60°, can reach mouth and head	30	20
5201 Arm, limitation of motion of:		
To 25° from side	40	30
Midway between side and shoulder level	30	20
At shoulder level	20	20
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.		
With frequent episodes and guarding of all arm movements	30	20
With infrequent episodes, and guarding of movement only at shoulder level	20	20
Malunion of:		
Marked deformity	30	20
Moderate deformity	20	20
5203 Clavicle or scapula, impairment of:		
Dislocation of	20	20
Nonunion of:		
With loose movement	20	20
Without loose movement	10	10
Malunion of	10	10
Or rate on impairment of function of contiguous joint.		

THE ELBOW AND FOREARM

	Rating	
	Major	Minor
5205 Elbow, ankylosis of:		
Unfavorable, at an angle of less than 50° or with complete loss of supination or pronation	60	50
Intermediate, at an angle of more than 90°, or between 70° and 50°	50	40
Favorable, at an angle between 90° and 70°	40	30
5206 Forearm, limitation of flexion of:		
Flexion limited to 45°	50	40
Flexion limited to 55°	40	30
Flexion limited to 70°	30	20
Flexion limited to 90°	20	20
Flexion limited to 100°	10	10
Flexion limited to 110°	0	0
5207 Forearm, limitation of extension of:		
Extension limited to 110°	50	40
Extension limited to 100°	40	30
Extension limited to 90°	30	20
Extension limited to 75°	20	20
Extension limited to 60°	10	10
Extension limited to 45°	10	10
5208 Forearm, flexion limited to 100° and extension to 45°	20	20
5209 Elbow, other impairment of Flail joint	60	50

THE ELBOW AND FOREARM—Continued

	Rating	
	Major	Minor
Joint fracture, with marked cubitus varus or cubitus valgus deformity or with ununited fracture of head of radius	20	20
5210 Radius and ulna, nonunion of, with flail false joint	50	40
5211 Ulna, impairment of:		
Nonunion in upper half, with false movement:		
With loss of bone substance (1 inch (2.5 cms.) or more) and marked deformity	40	30
Without loss of bone substance or deformity	30	20
Nonunion in lower half	20	20
Malunion of, with bad alignment	10	10
5212 Radius, impairment of:		
Nonunion in lower half, with false movement:		
With loss of bone substance (1 inch (2.5 cms.) or more) and marked deformity	40	30
Without loss of bone substance or deformity	30	20
Nonunion in upper half	20	20
Malunion of, with bad alignment	10	10
5213 Supination and pronation, impairment of:		
Loss of (bone fusion):		
The hand fixed in supination or hyperpronation	40	30
The hand fixed in full pronation	30	20
The hand fixed near the middle of the arc or moderate pronation	20	20
Limitation of pronation:		
Motion lost beyond middle of arc	30	20
Motion lost beyond last quarter of arc, the hand does not approach full pronation	20	20
Limitation of supination:		
To 30° or less	10	10
NOTE: In all the forearm and wrist injuries, codes 5205 through 5213, multiple impaired finger movements due to tendon tie-up, muscle or nerve injury, are to be separately rated and combined not to exceed rating for loss of use of hand.		

THE WRIST

	Rating	
	Major	Minor
5214 Wrist, ankylosis of:		
Unfavorable, in any degree of palmar flexion, or with ulnar or radial deviation	50	40
Any other position, except favorable	40	30
Favorable in 20° to 30° dorsiflexion	30	20
NOTE: Extremely unfavorable ankylosis will be rated as loss of use of hands under diagnostic code 5125.		
5215 Wrist, limitation of motion of:		
Dorsiflexion less than 15°	10	10
Palmar flexion limited in line with forearm	10	10

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 digit 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 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	.....	.....

EVALUATION OF ANKYLOSIS OR LIMITATION OF MOTION OF SINGLE OR MULTIPLE DIGITS OF THE HAND—Continued

	Rating	
	Major	Minor
(iv) If only the metacarpophalangeal or proximal interphalangeal joint 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 are ankylosed, evaluate as unfavorable ankylosis, even if each joint is individually fixed in a favorable position	.....	.....
(iii) If only the carpometacarpal or interphalangeal 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 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

EVALUATION OF ANKYLOSIS OR LIMITATION OF MOTION OF SINGLE OR MULTIPLE DIGITS OF THE HAND—Continued

	Rating	
	Major	Minor
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 fingers	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

EVALUATION OF ANKYLOSIS OR LIMITATION OF MOTION OF SINGLE OR MULTIPLE DIGITS OF THE HAND—Continued

	Rating	
	Major	Minor
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 thumb attempting to oppose the fingers	20	20
With a gap of one to two inches (2.5 to 5.1 cm.) between the 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 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

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

THE SPINE—Continued

	Rating
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 degrees 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 combined range of motion of the cervical spine not greater than 170 degrees; or, muscle 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.

THE SPINE—Continued

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

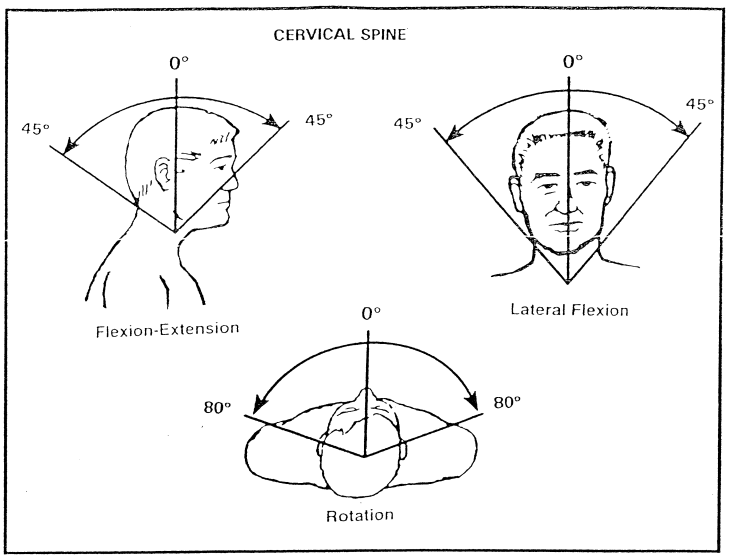
Evaluate intervertebral disc syndrome (preoperatively or postoperatively) either under the General Rating Formula for Diseases and Injuries of the Spine or under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes, whichever method results in the higher evaluation when all disabilities are combined under §4.25.

THE SPINE—Continued

	Rating
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

NOTE (1): For purposes of evaluations under diagnostic code 5243, 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.

NOTE (2): 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 incapacitating episodes or under the General Rating Formula for Diseases and Injuries of the Spine, whichever method results in a higher evaluation for that segment.



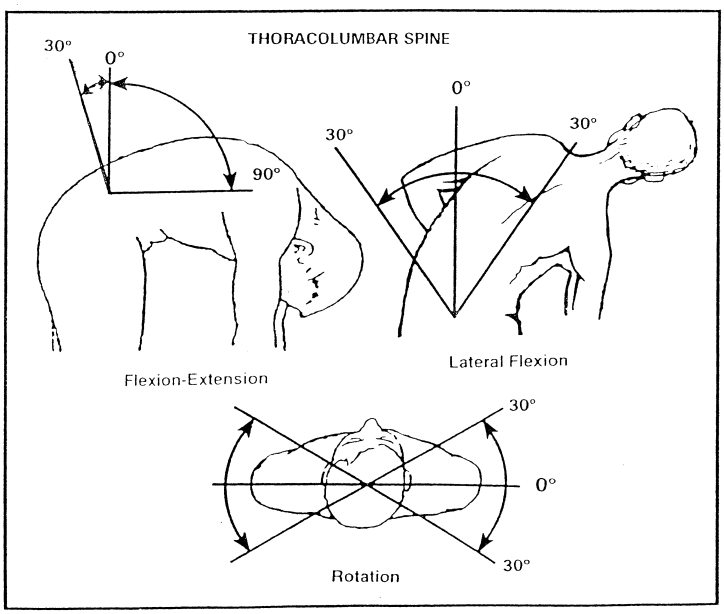


PLATE V
RANGE OF MOTION OF CERVICAL AND THORACOLUMBAR SPINE

THE HIP AND THIGH

	Rating
5250 Hip, ankylosis of:	
Unfavorable, extremely unfavorable ankylosis, the foot not reaching ground, crutches necessitated	[3] 90
Intermediate	70
Favorable, in flexion at an angle between 20° and 40°, and slight adduction or abduction	60
5251 Thigh, limitation of extension of:	
Extension limited to 5°	10
5252 Thigh, limitation of flexion of:	
Flexion limited to 10°	40
Flexion limited to 20°	30
Flexion limited to 30°	20
Flexion limited to 45°	10
5253 Thigh, impairment of:	
Limitation of abduction of, motion lost beyond 10°	20
Limitation of adduction of, cannot cross legs	10
Limitation of rotation of, cannot toe-out more than 15°, affected leg	10
5254 Hip, flail joint	80
5255 Femur, impairment of:	
Fracture of shaft or anatomical neck of:	
With nonunion, with loose motion (spiral or oblique fracture)	80
With nonunion, without loose motion, weightbearing preserved with aid of brace	60
Fracture of surgical neck of, with false joint	60
Malunion of:	
With marked knee or hip disability	30
With moderate knee or hip disability	20
With slight knee or hip disability	10

[3] Entitled to special monthly compensation.

THE KNEE AND LEG

	Rating
5256 Knee, ankylosis of:	
Extremely unfavorable, in flexion at an angle of 45° or more	60
In flexion between 20° and 45°	50
In flexion between 10° and 20°	40
Favorable angle in full extension, or in slight flexion between 0° and 10°	30
5257 Knee, other impairment of:	
Recurrent subluxation or lateral instability:	
Severe	30
Moderate	20
Slight	10
5258 Cartilage, semilunar, dislocated, with frequent episodes of "locking," pain, and effusion into the joint	20
5259 Cartilage, semilunar, removal of, symptomatic	10
5260 Leg, limitation of flexion of:	
Flexion limited to 15°	30
Flexion limited to 30°	20
Flexion limited to 45°	10
Flexion limited to 60°	0
5261 Leg, limitation of extension of:	
Extension limited to 45°	50
Extension limited to 30°	40
Extension limited to 20°	30
Extension limited to 15°	20
Extension limited to 10°	10
Extension limited to 5°	0
5262 Tibia and fibula, impairment of:	
Nonunion of, with loose motion, requiring brace	40
Malunion of:	
With marked knee or ankle disability	30

THE KNEE AND LEG—Continued

	Rating
With moderate knee or ankle disability	20
With slight knee or ankle disability	10
5263 Genu recurvatum (acquired, traumatic, with weakness and insecurity in weight-bearing objectively demonstrated)	10

THE ANKLE

	Rating
5270 Ankle, ankylosis of:	
In plantar flexion at more than 40°, or in dorsiflexion at more than 10° or with abduction, adduction, inversion or eversion deformity	40
In plantar flexion, between 30° and 40°, or in dorsiflexion, between 0° and 10°	30
In plantar flexion, less than 30°	20
5271 Ankle, limited motion of:	
Marked	20
Moderate	10
5272 Subastragalar or tarsal joint, ankylosis of:	
In poor weight-bearing position	20
In good weight-bearing position	10
5273 Os calcis or astragalus, malunion of:	
Marked deformity	20
Moderate deformity	10
5274 Astragalectomy	20

SHORTENING OF THE LOWER EXTREMITY

	Rating
5275 Bones, of the lower extremity, shortening of:	
Over 4 inches (10.2 cms.)	[3] 60
3½ to 4 inches (8.9 cms. to 10.2 cms.)	[3] 50
3 to 3½ inches (7.6 cms. to 8.9 cms.)	40
2½ to 3 inches (6.4 cms. to 7.6 cms.)	30
2 to 2½ inches (5.1 cms. to 6.4 cms.)	20
1¼ to 2 inches (3.2 cms. to 5.1 cms.)	10
NOTE: Measure both lower extremities from anterior superior spine of the ilium to the internal malleolus of the tibia. Not to be combined with other ratings for fracture or faulty union in the same extremity.	

[3] Also entitled to special monthly compensation.

THE FOOT

	Rating
5276 Flatfoot, acquired:	
Pronounced; marked pronation, extreme tenderness of plantar surfaces of the feet, marked inward displacement and severe spasm of the tendo achillis on manipulation, not improved by orthopedic shoes or appliances.	
Bilateral	50
Unilateral	30
Severe; objective evidence of marked deformity (pronation, abduction, etc.), pain on manipulation and use accentuated, indication of swelling on use, characteristic callosities:	
Bilateral	30
Unilateral	20

THE FOOT—Continued

	Rating
Moderate; weight-bearing line over or medial to great toe, inward bowing of the tendo achillis, pain on manipulation and use of the feet, bilateral or unilateral	10
Mild; symptoms relieved by built-up shoe or arch support	0
5277 Weak foot, bilateral:	
A symptomatic condition secondary to many constitutional conditions, characterized by atrophy of the musculature, disturbed circulation, and weakness:	
Rate the underlying condition, minimum rating	10
5278 Claw foot (pes cavus), acquired:	
Marked contraction of plantar fascia with dropped forefoot, all toes hammer toes, very painful callosities, marked varus deformity:	
Bilateral	50
Unilateral	30
All toes tending to dorsiflexion, limitation of dorsiflexion at ankle to right angle, shortened plantar fascia, and marked tenderness under metatarsal heads:	
Bilateral	30
Unilateral	20
Great toe dorsiflexed, some limitation of dorsiflexion at ankle, definite tenderness under metatarsal heads:	
Bilateral	10
Unilateral	10
Slight	0
5279 Metatarsalgia, anterior (Morton's disease), unilateral, or bilateral	10
5280 Hallux valgus, unilateral:	
Operated with resection of metatarsal head	10
Severe, if equivalent to amputation of great toe	10
5281 Hallux rigidus, unilateral, severe:	
Rate as hallux valgus, severe.	
Note: Not to be combined with claw foot ratings.	
5282 Hammer toe:	
All toes, unilateral without claw foot	10
Single toes	0
5283 Tarsal, or metatarsal bones, malunion of, or nonunion of:	
Severe	30
Moderately severe	20
Moderate	10
NOTE: With actual loss of use of the foot, rate 40 percent.	
5284 Foot injuries, other:	
Severe	30
Moderately severe	20
Moderate	10
NOTE: With actual loss of use of the foot, rate 40 percent.	

THE SKULL

	Rating
5296 Skull, loss of part of, both inner and outer tables:	
With brain hernia	80
Without brain hernia:	
Area larger than size of a 50-cent piece or 1.140 in^2 (7.355 cm^2)	50
Area intermediate	30
Area smaller than the size of a 25-cent piece or 0.716 in^2 (4.619 cm^2)	10

THE SKULL—Continued

	Rating
NOTE: Rate separately for intracranial complications.	

THE RIBS

	Rating
5297 Ribs, removal of:	
More than six	50
Five or six	40
Three or four	30
Two	20
One or resection of two or more ribs without regeneration	10
NOTE (1): The rating for rib resection or removal is not to be applied with ratings for purrulent pleurisy, lobectomy, pneumonectomy or injuries of pleural cavity.	
NOTE (2): However, rib resection will be considered as rib removal in thoracoplasty performed for collapse therapy or to accomplish obliteration of space and will be combined with the rating for lung collapse, or with the rating for lobectomy, pneumonectomy or the graduated ratings for pulmonary tuberculosis.	

THE COCCYX

	Rating
5298 Coccyx, removal of:	
Partial or complete, with painful residuals	10
Without painful residuals	0

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

[29 FR 6718, May 22, 1964, as amended at 34 FR 5062, Mar. 11, 1969; 40 FR 42536, Sept. 15, 1975; 41 FR 11294, Mar. 18, 1976; 43 FR 45350, Oct. 2, 1978; 51 FR 6411, Feb. 24, 1986; 61 FR 20439, May 7, 1996; 67 FR 48785, July 26, 2002; 67 FR 54349, Aug. 22, 2002; 68 FR 51456, Aug. 27, 2003; 69 FR 32450, June 10, 2004]

§4.72 [Reserved]

§4.73 Schedule of ratings—muscle injuries.

NOTE: 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.

THE SHOULDER GIRDLE AND ARM

	Rating	
	Dominant	Nondominant
5301 Group I. *Function:* Upward rotation of scapula; elevation of arm above shoulder level. *Extrinsic muscles of shoulder girdle:* (1) Trapezius; (2) levator scapulae; (3) serratus magnus.		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0
5302 Group II. *Function:* Depression of arm from vertical overhead to hanging at side (1, 2); downward rotation of scapula (3, 4); 1 and 2 act with Group III in forward and backward swing of arm. *Extrinsic muscles of shoulder girdle: (1) Pectoralis major II (costosternal); (2) latissimus dorsi and teres major (teres major, although technically an intrinsic muscle, is included with latissimus dorsi); (3) pectoralis minor; (4) rhomboid.*		
Severe	40	30
Moderately Severe	30	20
Moderate	20	20
Slight	0	0
5303 Group III. *Function:* Elevation and abduction of arm to level of shoulder; act with 1 and 2 of Group II in forward and backward swing of arm. *Intrinsic muscles of shoulder girdle: (1) Pectoralis major I (clavicular); (2) deltoid.*		
Severe	40	30
Moderately Severe	30	20
Moderate	20	20
Slight	0	0
5304 Group IV. *Function:* Stabilization of shoulder against injury in strong movements, holding head of humerus in socket; abduction; outward rotation and inward rotation of arm. *Intrinsic muscles of shoulder girdle: (1) Supraspinatus; (2) infraspinatus and teres minor; (3) subscapularis; (4) coracobrachialis.*		
Severe	30	20
Moderately Severe	20	20
Moderate	10	10
Slight	0	0
5305 Group V. *Function:* Elbow supination (1) (long head of biceps is stabilizer of shoulder joint); flexion of elbow (1, 2, 3). *Flexor muscles of elbow: (1) Biceps; (2) brachialis; (3) brachioradialis.*		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0
5306 Group VI. *Function:* Extension of elbow (long head of triceps is stabilizer of shoulder joint). *Extensor muscles of the elbow:* (1) Triceps; (2) anconeus..		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0

THE FOREARM AND HAND

	Rating	
	Dominant	Nondominant
5307 Group VII. *Function:* Flexion of wrist and fingers. *Muscles arising from internal condyle of humerus:* Flexors of the carpus and long flexors of fingers and thumb; pronator.		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0
5308 Group VIII. *Function:* Extension of wrist, fingers, and thumb; abduction of thumb. *Muscles arising mainly from external condyle of humerus:* Extensors of carpus, fingers, and thumb; supinator.		
Severe	30	20
Moderately Severe	20	20
Moderate	10	10
Slight	0	0
5309 Group IX. *Function:* The forearm muscles act in strong grasping movements and are supplemented by the intrinsic muscles in delicate manipulative movements. *Intrinsic muscles of hand:* Thenar eminence; short flexor, opponens, abductor and adductor of thumb; hypothenar eminence; short flexor, opponens and abductor of little finger; 4 lumbricales; 4 dorsal and 3 palmar interossei.		
NOTE: The hand is so compact a structure that isolated muscle injuries are rare, being nearly always complicated with injuries of bones, joints, tendons, etc. Rate on limitation of motion, minimum 10 percent.		

THE FOOT AND LEG

	Rating
5310 Group X. *Function:* Movements of forefoot and toes; propulsion thrust in walking. *Intrinsic muscles of the foot: Plantar:* (1) Flexor digitorum brevis; (2) abductor hallucis; (3) abductor digiti minimi; (4) quadratus plantae; (5) lumbricales; (6) flexor hallucis brevis; (7) adductor hallucis; (8) flexor digiti minimi brevis; (9) dorsal and plantar interossei. Other important plantar structures: Plantar aponeurosis, long plantar and calcaneonavicular ligament, tendons of posterior tibial, peroneus longus, and long flexors of great and little toes.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
Dorsal: (1) Extensor hallucis brevis; (2) extensor digitorum brevis. Other important dorsal structures: cruciate, crural, deltoid, and other ligaments; tendons of long extensors of toes and peronei muscles.	
Severe	20
Moderately Severe	10
Moderate	10
Slight	0

THE FOOT AND LEG—Continued

	Rating
NOTE: Minimum rating for through-and-through wounds of the foot—10.	
5311 Group XI. *Function:* Propulsion, plantar flexion of foot (1); stabilization of arch (2, 3); flexion of toes (4, 5); Flexion of knee (6). *Posterior and lateral crural muscles, and muscles of the calf:* (1) Triceps surae (gastrocnemius and soleus); (2) tibialis posterior; (3) peroneus longus; (4) peroneus brevis; (5) flexor hallucis longus; (6) flexor digitorum longus; (7) popliteus; (8) plantaris.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
5312 Group XII. *Function:* Dorsiflexion (1); extension of toes (2); stabilization of arch (3). *Anterior muscles of the leg:* (1) Tibialis anterior; (2) extensor digitorum longus; (3) extensor hallucis longus; (4) peroneus tertius.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

THE PELVIC GIRDLE AND THIGH

	Rating
5313 Group XIII. *Function:* Extension of hip and flexion of knee; outward and inward rotation of flexed knee; acting with rectus femoris and sartorius (see XIV, 1, 2) synchronizing simultaneous flexion of hip and knee and extension of hip and knee by belt-over-pulley action at knee joint. *Posterior thigh group, Hamstring complex of 2-joint muscles:* (1) Biceps femoris; (2) semimembranosus; (3) semitendinosus.	
Severe	40
Moderately Severe	30
Moderate	10
Slight	0
5314 Group XIV. *Function:* Extension of knee (2, 3, 4, 5); simultaneous flexion of hip and flexion of knee (1); tension of fascia lata and iliotibial (Maissiat's) band, acting with XVII (1) in postural support of body (6); acting with hamstrings in synchronizing hip and knee (1, 2). *Anterior thigh group:* (1) Sartorius; (2) rectus femoris; (3) vastus externus; (4) vastus intermedius; (5) vastus internus; (6) tensor vaginae femoris.	
Severe	40
Moderately Severe	30
Moderate	10
Slight	0
5315 Group XV. *Function:* Adduction of hip (1, 2, 3, 4); flexion of hip (1, 2); flexion of knee (4). *Mesial thigh group:* (1) Adductor longus; (2) adductor brevis; (3) adductor magnus; (4) gracilis.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
5316 Group XVI. *Function:* Flexion of hip (1, 2, 3). *Pelvic girdle group 1:* (1) Psoas; (2) iliacus; (3) pectineus.	
Severe	40
Moderately Severe	30
Moderate	10
Slight	0

THE PELVIC GIRDLE AND THIGH—Continued

	Rating
5317 Group XVII. *Function:* Extension of hip (1); abduction of thigh; elevation of opposite side of pelvis (2, 3); tension of fascia lata and iliotibial (Maissiat's) band, acting with XIV (6) in postural support of body steadying pelvis upon head of femur and condyles of femur on tibia (1). *Pelvic girdle group 2:* (1) Gluteus maximus; (2) gluteus medius; (3) gluteus minimus.	
Severe	*50
Moderately Severe	40
Moderate	20
Slight	0
5318 Group XVIII. *Function:* Outward rotation of thigh and stabilization of hip joint. *Pelvic girdle group 3:* (1) Pyriformis; (2) gemellus (superior or inferior); (3) obturator (external or internal); (4) quadratus femoris.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

*If bilateral, see §3.350(a)(3) of this chapter to determine whether the veteran may be entitled to special monthly compensation.

THE TORSO AND NECK

	Rating
5319 Group XIX. *Function:* Support and compression of abdominal wall and lower thorax; flexion and lateral motions of spine; synergists in strong downward movements of arm (1). *Muscles of the abdominal wall:* (1) Rectus abdominis; (2) external oblique; (3) internal oblique; (4) transversalis; (5) quadratus lumborum.	
Severe	50
Moderately Severe	30
Moderate	10
Slight	0
5320 Group XX. *Function:* Postural support of body; extension and lateral movements of spine. *Spinal muscles:* Sacrospinalis (erector spinae and its prolongations in thoracic and cervical regions).	
Cervical and thoracic region:.	
Severe	40
Moderately Severe	20
Moderate	10
Slight	0
Lumbar region:.	
Severe	60
Moderately Severe	40
Moderate	20
Slight	0
5321 Group XXI. *Function:* Respiration. *Muscles of respiration:* Thoracic muscle group.	
Severe or Moderately Severe	20
Moderate	10
Slight	0
5322 Group XXII. *Function:* Rotary and forward movements of the head; respiration; deglutition. *Muscles of the front of the neck:* (Lateral, supra-, and infrahyoid group.) (1) Trapezius I (clavicular insertion); (2) sternocleidomastoid; (3) the "hyoid" muscles; (4) sternothyroid; (5) digastric.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

THE TORSO AND NECK—Continued

	Rating
5323 Group XXIII. *Function:* Movements of the head; fixation of shoulder movements. *Muscles of the side and back of the neck:* Suboccipital; lateral vertebral and anterior vertebral muscles.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

MISCELLANEOUS

	Rating
5324 Diaphragm, rupture of, with herniation. Rate under diagnostic code 7346.	
5325 Muscle injury, facial muscles. Evaluate functional impairment as seventh (facial) cranial nerve neuropathy (diagnostic code 8207), disfiguring scar (diagnostic code 7800), etc. Minimum, if interfering to any extent with mastication—10.	
5326 Muscle hernia, extensive. Without other injury to the muscle—10.	
5327 Muscle, neoplasm of, malignant (excluding soft tissue sarcoma)—100.	
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgery, radiation treatment, antineoplastic chemotherapy or other therapeutic procedures. 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 residual impairment of function.	
5328 Muscle, neoplasm of, benign, postoperative. Rate on impairment of function, i.e., limitation of motion, or scars, diagnostic code 7805, etc.	
5329 Sarcoma, soft tissue (of muscle, fat, or fibrous connective tissue)—100.	
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgery, radiation treatment, antineoplastic chemotherapy or other therapeutic procedures. 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 residual impairment of function.	

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

[62 FR 30239, June 3, 1997]

THE ORGANS OF SPECIAL SENSE

§ 4.75 Examination of visual acuity.

Ratings on account of visual impairments considered for service connection are, when practicable, to be based only on examination by specialists. Such special examinations should include uncorrected and corrected central visual acuity for distance and near, with record of the refraction. Snellen's test type or its equivalent will be used. Mydriatics should be routine, except when contraindicated. Funduscopic and ophthalmological findings must be recorded. The best distant vision obtainable after best correction by glasses will be the basis of rating, except in cases of keratoconus in which contact lenses are medically required. Also, if there exists a difference of more than 4 diopters of spherical correction between the two eyes, the best possible visual acuity of the poorer eye without glasses, or with a lens of not more than 4 diopters difference from that used with the better eye will be taken as the visual acuity of the poorer eye. When such a difference exists, close attention will be given to the likelihood of congenital origin in mere refractive error.

[40 FR 42537, Sept. 15, 1975]

§ 4.76 Examination of field vision.

Measurement of the visual field will be made when there is disease of the optic nerve or when otherwise indicated. The usual perimetric methods will be employed, using a standard perimeter and 3 mm. white test object. At least 16 meridians 22½ degrees apart will be charted for each eye. (See Figure 1. For the 8 principal meridians, see table III.) The charts will be made a part of the report of examination. Not less than 2 recordings, and when possible, 3 will be made. The minimum limit for this function is established as a concentric central contraction of the visual field to 5°. This type of contraction of the visual field reduces the visual efficiency to zero. Where available the examination for form field should be supplemented, when indicated, by the use of tangent screen or campimeter. This last test is especially valuable in detection of scotoma.

[43 FR 45352, Oct. 2, 1978]

§ 4.76a Computation of average concentric contraction of visual fields.

The extent of contraction of visual field in each eye is determined by recording the extent of the remaining visual fields in each of the eight 45 degree principal meridians. The number

of degrees lost is determined at each meridian by subtracting the remaining degrees from the normal visual fields given in table III. The degrees lost are then added together to determine total degrees lost. This is subtracted from 500. The difference represents the total remaining degrees of visual field. The difference divided by eight represents the average contraction for rating purposes.

TABLE III—NORMAL VISUAL FIELD EXTENT AT 8 PRINCIPAL MERIDIANS

Meridian	Normal degrees
Temporally	85
Down temporally	85
Down	65
Down nasally	50
Nasally	60
Up nasally	55
Up	45
Up temporally	55
Total	500

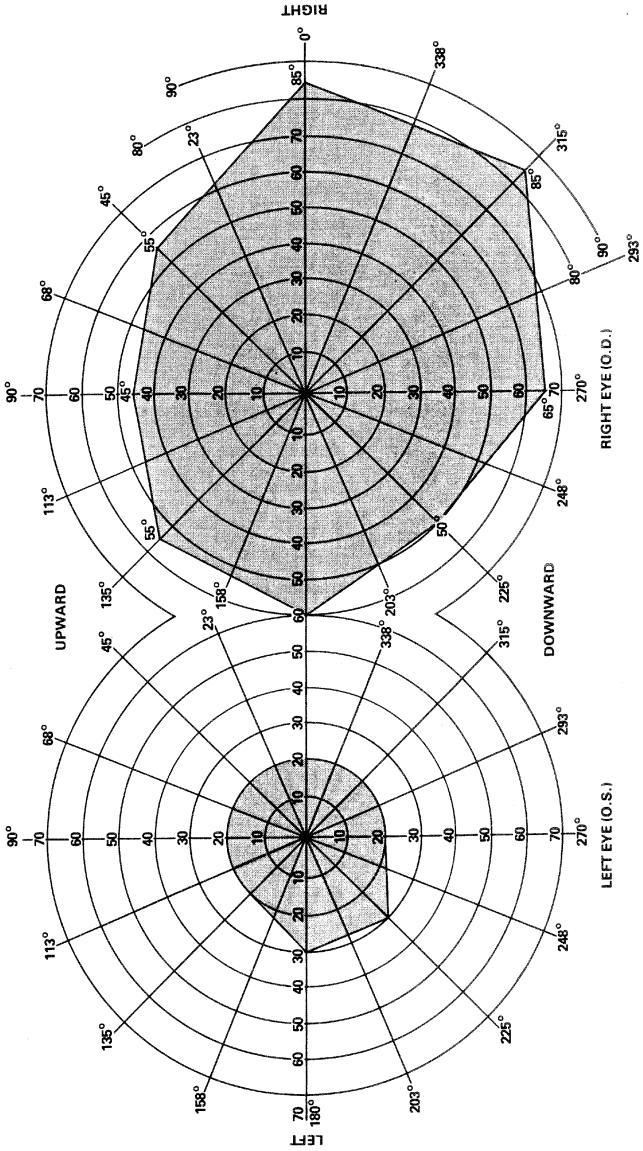


Figure 1. Chart of visual field showing normal field right eye and abnormal contraction visual field left eye.

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Example of computation of concentric contraction under the schedule with abnormal findings taken from Figure 1.

Loss	Degrees
Temporally	55
Down temporally	55
Down	45

Loss	Degrees
Down nasally	30
Nasally	40
Up nasally	35
Up	25
Up temporally	35
Total loss	320

Remaining field 500° minus 320° = 180°. 180° ÷ 8 = 22½° average concentric contraction.

[43 FR 45352, Oct. 2, 1978]

§4.77 Examination of muscle function.

The measurement of muscle function will be undertaken only when the history and findings reflect disease or injury of the extrinsic muscles of the eye, or of the motor nerves supplying these muscles. The measurement will be performed using a Goldmann Perimeter Chart as in Figure 2 below. The chart identifies four major quadrants, (upward, downward, and two lateral) plus a central field (20° or less). The examiner will chart the areas in which diplopia exists, and such plotted chart will be made a part of the examination report. Muscle function is considered normal (20/40) when diplopia does not exist within 40° in the lateral or downward quadrants, or within 30° in the upward quadrant. Impairment of muscle function is to be supported in each instance by record of actual appropriate pathology. Diplopia which is only occasional or correctable is not considered a disability.

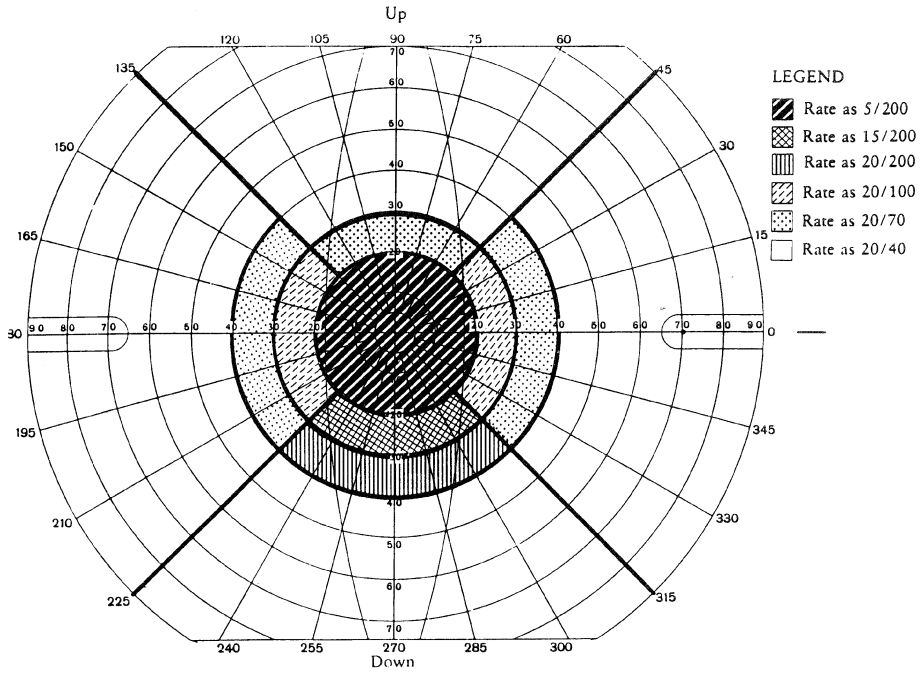

Figure 2. Goldmann Perimeter Chart

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[53 FR 30262, Aug. 11, 1988]

§ 4.78 Computing aggravation.

In determining the effect of aggravation of visual disability, even though the visual impairment of only one eye is service connected, evaluate the vision of both eyes, before and after suffering the aggravation, and subtract the former evaluation from the latter except when the bilateral vision amounts to total disability. In the event of subsequent increase in the disability of either eye, due to intercurrent disease or injury not associated with the service, the condition of the eyes before suffering the subsequent increase will be taken as the basis of compensation subject to the provisions of § 3.383(a) of this chapter.

[29 FR 6718, May 22, 1964, as amended at 43 FR 45354, Oct. 2, 1978]

§ 4.79 Loss of use of one eye, having only light perception.

Loss of use or blindness of one eye, having only light perception, will be held to exist when there is inability to recognize test letters at 1 foot (.30m.) and when further examination of the eyes reveals that perception of objects, hand movements or counting fingers cannot be accomplished at 3 feet (.91m.), lesser extents of visions, particularly perception of objects, hand movements, or counting fingers at distances less than 3 feet (.91 m.), being considered of negligible utility. With visual acuity 5/200 (1.5/60) or less or the visual field reduced to 5° concentric contraction, in either event in both eyes, the question of entitlement on account of regular aid and attendance will be determined on the facts in the individual case.

[43 FR 45354, Oct. 2, 1978]

§ 4.80 Rating of one eye.

Combined ratings for disabilities of the same eye should not exceed the amount for total loss of vision of that eye unless there is an enucleation or a serious cosmetic defect added to the total loss of vision.

§§ 4.81–4.82 [Reserved]

§ 4.83 Ratings at scheduled steps and distances.

In applying the ratings for impairment of visual acuity, a person not having the ability to read at any one of the scheduled steps or distances, but reading at the next scheduled step or distance, is to be rated as reading at this latter step or distance. That is, a person who can read at 20/100 (6/30) but who cannot at 20/70 (6/21), should be rated as seeing at 20/100 (6/30).

[41 FR 34257, Aug. 13, 1976, as amended at 43 FR 45354, Oct. 2, 1978]

§ 4.83a Impairment of central visual acuity.

The percentage evaluation will be found from table V by intersecting the horizontal row appropriate for the Snellen index for one eye and the vertical column appropriate to the Snellen index of the other eye. For example, if one eye has a Snellen index of 5/200 (1.5/60) and the other eye has a Snellen index of 20/70 (6/21), the percentage evaluation is found in the third horizontal row from the bottom and the fourth vertical column from the left. The evaluation is 50 percent and the diagnostic code 6073.

[41 FR 11297, Mar. 18, 1976, as amended at 43 FR 45354, Oct. 2, 1978]

§ 4.84 Differences between distant and near visual acuity.

Where there is a substantial difference between the near and distant corrected vision, the case should be referred to the Director, Compensation and Pension Service.

[40 FR 42537, Sept. 15, 1975]

§ 4.84a Schedule of ratings—eye.

DISEASES OF THE EYE

		Rating
6000	Uveitis	
6001	Keratitis	
6002	Scleritis	
6003	Iritis	
6004	Cyclitis	
6005	Choroiditis	
6006	Retinitis	
6007	Hemorrhage, intra-ocular, recent	
6008	Retina, detachment of	
6009	Eye, injury of, unhealed:	

DISEASES OF THE EYE—Continued

	Rating
The above disabilities, in chronic form, are to be rated from 10 percent to 100 percent for impairment of visual acuity or field loss, pain, rest-requirements, or episodic incapacity, combining an additional rating of 10 percent during continuance of active pathology. Minimum rating during active pathology	10
6010 Eye, tuberculosis of, active or inactive:	
Active	100
Inactive: See §§4.88b and 4.89.	
6011 Retina, localized scars, atrophy, or irregularities of, centrally located, with irregular, duplicated enlarged or diminished image:	
Unilateral or bilateral	10
6012 Glaucoma, congestive or inflammatory:	
Frequent attacks of considerable duration; during continuance of actual total disability	100
Or, rate as iritis, diagnostic Code 6003.	
6013 Glaucoma, simple, primary, noncongestive:	
Rate on impairment of visual acuity or field loss.	
Minimum rating	10
6014 New growths, malignant (eyeball only):	
Pending completion of operation or other indicated treatment	100
Healed; rate on residuals.	
6015 New growths, benign (eyeball and adnexa, other than superficial)	
Rate on impaired vision, minimum	10
Healed; rate on residuals.	
6016 Nystagmus, central	10
6017 Conjunctivitis, trachomatous, chronic:	
Active; rate for impairment of visual acuity; minimum rating while there is active pathology	30
Healed; rate on residuals, if no residuals	0
6018 Conjunctivitis, other, chronic:	
Active, with objective symptoms	10
Healed; rate on residuals, if no residuals	0
6019 Ptosis, unilateral or bilateral:	
Pupil wholly obscured.	
Rate equivalent to 5/200 (1.5/60).	
Pupile one-half or more obscured.	
Rate equivalent to 20/100 (6/30).	
With less interference with vision.	
Rate as disfigurement.	
6020 Ectropion:	
Bilateral	20
Unilateral	10
6021 Entropion:	
Bilateral	20
Unilateral	10
6022 Lagophthalmos:	
Bilateral	20
Unilateral	10
6023 Eyebrows, loss of, complete, unilateral or bilateral	10
6024 Eyelashes, loss of, complete, unilateral or bilateral	10
6025 Epiphora (lacrymal duct, interference with, from any cause):	
Bilateral	20

DISEASES OF THE EYE—Continued

	Rating
Unilateral	10
6026 Neuritis, optic:	
Rate underlying disease, and combine impairment of visual acuity or field loss.	
6027 Cataract, traumatic:	
Preoperative.	
Rate on impairment of vision.	
Postoperative.	
Rate on impairment of vision and aphakia.	
6028 Cataract, senile, and others:	
Preoperative.	
Rate on impairment of vision.	
Postoperative.	
Rate on impairment of vision and aphakia.	
6029 Aphakia:	
Bilateral or unilateral	30
NOTE: The 30 percent rating prescribed for aphakia is a minimum rating to be applied to the unilateral or bilateral condition and is not to be combined with any other rating for impaired vision. When only one eye is aphakic, the eye having poorer corrected visual acuity will be rated on the basis of its acuity without correction. When both eyes are aphakic, both will be rated on corrected vision. The corrected vision of one or both aphakic eyes will be taken one step worse than the ascertained value, however, not better than 20/70 (6/21). Combined ratings for disabilities of the same eye should not exceed the amount for total loss of vision of that eye unless there is an enucleation or a serious cosmetic defect added to the total loss of vision.	
6030 Accommodation, paralysis of	20
6031 Dacryocystitis	
Rate as epiphora.	
6032 Eyelids, loss of portion of:	
Rate as disfigurement. (See diseases of the skin.)	
6033 Lens, crystalline, dislocation of:	
Rate as aphakia.	
6034 Pterygium:	
Rate for loss of vision, if any.	
6035 Keratoconus: To be evaluated on impairment of corrected visual acuity using contact lenses.	
NOTE: When contact lenses are medically required for keratoconus, either unilateral or bilateral, the minimum rating will be 30 percent.	

TABLE IV—TABLE FOR RATING BILATERAL BLINDNESS OR BLINDNESS COMBINED WITH HEARING LOSS WITH DICTATOR'S CODE AND 38 CFR CITATIONS

Vision one eye	Vision other eye			Plus service-connected Hearing loss				
	5/200 (1.5/60) or less	Light perception only	No light perception or anatomical loss	Total deafness one ear	10% or 20% at least one ear SC	30% at least one ear SC	40% at least one ear SC	60% or more at least one ear SC
5/200 (1.5/60) or less.	L[1] Code LB–1 38 CFR 3.350(b)(2).	L+½[1] Code LB–2 38 CFR 3.350(f)(2)(i).	M Code MB–2 a or b 38 CFR 3.350(f)(2)(ii).	Add ½ step Code PB–1 38 CFR 3.350(f)(2)(iv).	No additional SMC.	Add a full step Code PB–3 38 CFR 3.350(f)(2)(vi).	Add a full step Code PB–3 38 CFR 3.350(f)(2)(vi).	O Code OB–1 38 CFR 3.350(e)(1)(iii)
Light perception only.	.....	M Code MB–1 a 38 CFR 3.350(c)(1)((iv).	M+½ Code MB–3 a or b 38 CFR 3.350(f)(iii).	O Code OB–2 38 CFR 3.350(e)(1)(iv).	Add ½ step Code PB–2 38 CFR 3.350(f)(2)(v).	Add a full step Code PB–3 38 CFR 3.350(f)(2)(iv).	O Code OB–2 38 CFR 3.350(e)(1)(iv).	O Code OB–1 38 CFR 3.350(e)(1)(iii)
No light perception or anatomical loss.	.....	.....	N Code NB–1 a-b or c 38 CFR 3.350(d)(4).	O Code OB–2 38 CFR 3.350(e)(1)(iv).	Add ½ step Code PB–2 38 CFR 3.350(f)(2)(v).	Add full step Code PB–3 38 CFR 3.350(f)(2)(vi).	O Code OB–2 38 CFR 3.350(e)(1)(iv).	O Code OB–1 38 CFR 3.350(e)(1)(iii)

[1] With need for aid and attendance qualifies for Subpar. m. code MB–1, b; 38 CFR 3.350(c)(1)(v).

NOTE. (1) Any of the additional SMC payable under Dictator's Codes PB–1, PB–2, or PB–3 is not to exceed the rate payable under Subpar. O. (2) If in addition to any of the above the veteran has the service-connected loss or loss of use of an extremity, additional SMC is payable, not to exceed the rate payable under Subpar. O. See Dictator's Codes PB–4, PB–5, PB–6, and 38 CFR 3.350(f)(2)(vii) (A), (B), (C).

(Authority: 38 U.S.C. 1115)

IMPAIRMENT OF CENTRAL VISUAL ACUITY

	Rating
6061 Anatomical loss both eyes	[5] 100
6062 Blindness in both eyes having only light perception	[5] 100
Anatomical loss of 1 eye:	
6063 In the other eye 5/200 (1.5/60)	[5] 100
6064 In the other eye 10/200 (3/60)	[6] 90
6064 In the other eye 15/200 (4.5/60)	[6] 80
6064 In the other eye 20/200 (6/60)	[6] 70
6065 In the other eye 20/100 (6/30)	[6] 60
6065 In the other eye 20/70 (6/21)	[6] 60
6065 In the other eye 20/50 (6/15)	[6] 50
6066 In the other eye 20/40 (6/12)	[6] 40
Blindness in 1 eye, having only light perception:	
6067 In the other eye 5/200 (1.5/60)	[5] 100
6068 In the other eye 10/200 (3/60)	[5] 90
6068 In the other eye 15/200 (4.5/60)	[5] 80
6068 In the other eye 20/200 (6/60)	[5] 70
6069 In the other eye 20/100 (6/30)	[5] 60
6069 In the other eye 20/70 (6/21)	[5] 50
6069 In the other eye 20/50 (6/15)	[5] 40
6070 In the other eye 20/40 (6/12)	[5] 30
Vision in 1 eye 5/200 (1.5/60):	
6071 In the other eye 5/200 (1.5/60)	[5] 100
6072 In the other eye 10/200 (3/60)	90
6072 In the other eye 15/200 (4.5/60)	80
6072 In the other eye 20/200 (6/60)	70
6073 In the other eye 20/100 (6/30)	60
6073 In the other eye 20/70 (6/21)	50
6073 In the other eye 20/50 (6/15)	40
6074 In the other eye 20/40 (6/12)	30
Vision in 1 eye 10/200 (3/60):	
6075 In the other eye 10/200 (3/60)	90
6075 In the other eye 15/200 (4.5/60)	80
6075 In the other eye 20/200 (6/60)	70

IMPAIRMENT OF CENTRAL VISUAL ACUITY—Continued

	Rating
6076 In the other eye 20/100 (6/30)	60
6076 In the other eye 20/70 (6/21)	50
6076 In the other eye 20/50 (6/15)	40
6077 In the other eye 20/40 (6/12)	30
Vision in 1 eye 15/200 (4.5/60):	
6075 In the other eye 15/200 (4.5/60)	80
6075 In the other eye 20/200 (6/60)	70
6076 In the other eye 20/100 (6/30)	60
6076 In the other eye 20/70 (6/21)	40
6076 In the other eye 20/50 (6/15)	30
6077 In the other eye 20/40 (6/12)	20
Vision in 1 eye 20/200 (6/60):	
6075 In the other eye 20/200 (6/60)	70
6076 In the other eye 20/100 (6/30)	60
6076 In the other eye 20/70 (6/21)	40
6076 In the other eye 20/50 (6/15)	30
6077 In the other eye 20/40 (6/12)	20
Vision in 1 eye 20/100 (6/30):	
6078 In the other eye 20/100 (6/30)	50
6078 In the other eye 20/70 (6/21)	30
6078 In the other eye 20/50 (6/15)	20
6079 In the other eye 20/40 (6/12)	10
Vision in 1 eye 20/70 (6/21):	
6078 In the other eye 20/70 (6/21)	30
6078 In the other eye 20/50 (6/15)	20
6079 In the other eye 20/40 (6/12)	10
Vision in 1 eye 20/50 (6/15):	
6078 In the other eye 20/50 (6/15)	10
6079 In the other eye 20/40 (6/12)	10
Vision in 1 eye 20/40 (6/12):	
In the other eye 20/40 (6/12)	0

[5] Also entitled to special monthly compensation.
[6] Add 10% if artificial eye cannot be worn; also entitled to special monthly compensation.

TABLE V—RATINGS FOR CENTRAL VISUAL ACUITY IMPAIRMENT

[With Diagnostic Code]

Vision in one eye	Vision in other eye								
	20/40 (6/12)	20/50 (6/15)	20/70 (6/21)	20/100 (6/30)	20/200 (6/60)	15/200 (4.5/60)	10/200 (3/60)	5/200 (1.5/60)	Light perception only/anatomical loss
20/40 (6/12)	0								
20/50 (6/15)	10 (6079)	10 (6078)							
20/70 (6/21)	10 (6079)	20 (6078)	30 (6078)						
20/100 (6/30)	10 (6079)	20 (6078)	30 (6078)	50 (6078)					
20/200 (6/60)	20 (6077)	30 (6076)	40 (6076)	60 (6076)	70 (6075)				
15/200 (4.5/60)	20 (6077)	30 (6076)	40 (6076)	60 (6076)	70 (6075)	80 (6075)			
10/200 (3/60)	30 (6077)	40 (6076)	50 (6076)	60 (6076)	70 (6075)	80 (6075)	90 (6075)		
5/200 (1.5/60)	30 (6074)	40 (6073)	50 (6073)	60 (6073)	70 (6072)	80 (6072)	90 (6072)	[5] 100 (6071)	

TABLE V—RATINGS FOR CENTRAL VISUAL ACUITY IMPAIRMENT—Continued

[With Diagnostic Code]

Vision in one eye	Vision in other eye								
	20/40 (6/12)	20/50 (6/15)	20/70 (6/21)	20/100 (6/30)	20/200 (6/60)	15/200 (4.5/60)	10/200 (3/60)	5/200 (1.5/60)	Light perception only/anatomical loss
Light perception only	[5] 30 (6070)	[5] 40 (6069)	[5] 50 (6069)	[5] 60 (6069)	[5] 70 (6068)	[5] 80 (6068)	[5] 90 (6068)	[5] 100 (6067)	[5] 100 (6062)
Anatomical loss of one eye	[6] 40 (6066)	[6] 50 (6065)	[6] 60 (6065)	[6] 60 (6065)	[6] 70 (6064)	[6] 80 (6064)	[6] 90 (6064)	[5] 100 (6063)	[5] 100 (6061)

[5] Also entitled to special monthly compensation.
[6] Add 10 percent if artificial eye cannot be worn; also entitled to special monthly compensation.

RATINGS FOR IMPAIRMENT OF FIELD VISION

	Rating
6080 Field vision, impairment of:	
Homonymous hemianopsia	30
Field, visual, loss of temporal half:	
Bilateral	30
Unilateral	10
Or rate as 20/70 (6/21).	
Field, visual, loss of nasal half:	
Bilateral	20
Unilateral	10
Or rate as 20/50 (6/15).	
Field, visual, concentric contraction of:	
To 5°:	
Bilateral	100
Unilateral	30
Or rate as 5/200 (1.5/60).	
To 15° but not to 5°:	
Bilateral	70
Unilateral	20
Or rate as 20/200 (6/60).	
To 30° but not to 15°:	
Bilateral	50
Unilateral	10
Or rate as 20/100 (6/30).	
To 45° but not to 30°:	
Bilateral	30
Unilateral	10
Or rate as 20/70 (6/21):	
To 60° but not to 45°:	
Bilateral	20
Unilateral	10
Or rate as 20/50 (6/15).	
Note (1): Correct diagnosis reflecting disease or injury should be cited..	

RATINGS FOR IMPAIRMENT OF FIELD VISION—Continued

	Rating
Note (2): Demonstrable pathology commensurate with the functional loss will be required. The concentric contraction ratings require contraction within the stated degrees, temporally; the nasal contraction may be less. The alternative ratings are to be employed when there is ratable defect of visual acuity, or a different impairment of the visual field in the other eye. Concentric contraction resulting from demonstrable pathology to 5 degrees or less will be considered on a parity with reduction of central visual acuity to 5/200 (1.5/60) or less for all purposes including entitlement under § 3.350(b)(2) of this chapter; not however, for the purpose of § 3.350(a) of this chapter. Entitlement on account of blindness requiring regular aid and attendance, § 3.350(c) of this chapter, will continue to be determined on the facts in the individual case..	
6081 Scotoma, pathological, unilateral:	
Large or centrally located, minimum	10
NOTE: Rate on loss of central visual acuity or impairment of field vision. Do not combine with any other rating for visual impairment.	

RATINGS FOR IMPAIRMENT OF MUSCLE FUNCTION

[6090 Diplopia (double vision)]

Degree of diplopia	Equivalent visual acuity
(a) Central 20°	5/200
(b) 21° to 30°:	
(1) Down	15/200
(2) Lateral	20/100
(3) Up	20/70
(c) 31° to 40°:	
(1) Down	20/200
(2) Lateral	20/70
(3) Up	20/40
Note: (1) Correct diagnosis reflecting disease or injury should be cited..	

RATINGS FOR IMPAIRMENT OF MUSCLE FUNCTION—Continued

[6090 Diplopia (double vision)]

Degree of diplopia	Equivalent visual acuity
Note: (2) The above ratings will be applied to only one eye. Ratings will not be applied for both diplopia and decreased visual acuity or field of vision in the same eye. When diplopia is present and there is also ratable impairment of visual acuity or field of vision of both eyes the above diplopia ratings will be applied to the poorer eye while the better eye is rated according to the best corrected visual acuity or visual field..	
Note: (3) When the diplopia field extends beyond more than one quadrant or more than one range of degrees, the evaluation for diplopia will be based on the quadrant and degree range that provide the highest evaluation..	
Note: (4) When diplopia exists in two individual and separate areas of the same eye, the equivalent visual acuity will be taken one step worse, but no worse than 5/200..	
6091 Symblepharon..	
Rate as limited muscle function, diagnostic code 6090..	
6092 Diplopia, due to limited muscle function..	
Rate as diagnostic code 6090..	

[29 FR 6718, May 22, 1964, as amended at 34 FR 5062, Mar. 11, 1969; 40 FR 42537, Sept. 15, 1975; 41 FR 11297, Mar. 18, 1976; 43 FR 45354, Oct. 2, 1978; 51 FR 6411, Feb. 24, 1986; 53 FR 30264, Aug. 11, 1988; 53 FR 50955, Dec. 19, 1988; 57 FR 24364, June 9, 1992]

IMPAIRMENT OF AUDITORY ACUITY

§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 §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 §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 §3.383 of this chapter.

(g) When evaluating any claim for impaired hearing, refer to §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.*

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

Better Ear	XI	X	IX	VIII	VII	VI	V	IV	III	II	I
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

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

[64 FR 25206, May 11, 1999]

§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)

[64 FR 25209, May 11, 1999]

§ 4.87 Schedule of ratings—ear.

DISEASES OF THE EAR

	Rating
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 criteria or 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 § 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:	

DISEASES OF THE EAR—Continued

	Rating
Swelling, dry and scaly or serous discharge, and itching requiring frequent and prolonged treatment	10
6211 Tympanic membrane, perforation of	0
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)

[64 FR 25210, May 11, 1999, as amended at 68 FR 25823, May 14, 2003]

§ 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)

[64 FR 25210, May 11, 1999]

INFECTIOUS DISEASES, IMMUNE DISORDERS AND NUTRITIONAL DEFICIENCIES

§ 4.88 [Reserved]

§ 4.88a Chronic fatigue syndrome.

(a) For VA purposes, the diagnosis of chronic fatigue syndrome requires:

(1) new onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least six months; and

(2) the exclusion, by history, physical examination, and laboratory tests, of all other clinical conditions that may produce similar symptoms; and

(3) six or more of the following:

(i) acute onset of the condition,

(ii) low grade fever,

(iii) nonexudative pharyngitis,

(iv) palpable or tender cervical or axillary lymph nodes,

(v) generalized muscle aches or weakness,

(vi) fatigue lasting 24 hours or longer after exercise,

(vii) headaches (of a type, severity, or pattern that is different from headaches in the pre-morbid state),

(viii) migratory joint pains,

(ix) neuropsychologic symptoms,

(x) sleep disturbance.

(b) [Reserved]

[59 FR 60902, Nov. 29, 1994]

§4.88b Schedule of ratings—infectious diseases, immune disorders and nutritional deficiencies.

		Rating
6300	Cholera, Asiatic:	
	As active disease, and for 3 months convalescence	100
	Thereafter rate residuals such as renal necrosis under the appropriate system	
6301	Visceral Leishmaniasis:	
	During treatment for active disease	100
	NOTE: A 100 percent evaluation shall continue beyond the cessation of treatment for active disease. 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. Rate residuals such as liver damage or lymphadenopathy under the appropriate system.	
6302	Leprosy (Hansen's Disease):	
	As active disease	100
	NOTE: A 100 percent evaluation shall continue beyond the date that an examining physician has determined that this has become inactive. Six months after the date of inactivity, 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. Rate residuals such as skin lesions or peripheral neuropathy under the appropriate system.	
6304	Malaria:	
	As active disease	100
	NOTE: The diagnosis of malaria depends on the identification of the malarial parasites in blood smears. If the veteran served in an endemic area and presents signs and symptoms compatible with malaria, the diagnosis may be based on clinical grounds alone. Relapses must be confirmed by the presence of malarial parasites in blood smears.	
	Thereafter rate residuals such as liver or spleen damage under the appropriate system	
6305	Lymphatic Filariasis:	
	As active disease	100
	Thereafter rate residuals such as epididymitis or lymphangitis under the appropriate system	
6306	Bartonellosis:	
	As active disease, and for 3 months convalescence	100
	Thereafter rate residuals such as skin lesions under the appropriate system	
6307	Plague:	
	As active disease	100
	Thereafter rate residuals such as lymphadenopathy under the appropriate system	
6308	Relapsing Fever:	
	As active disease	100
	Thereafter rate residuals such as liver or spleen damage or central nervous system involvement under the appropriate system	
6309	Rheumatic fever:	
	As active disease	100
	Thereafter rate residuals such as heart damage under the appropriate system	
6310	Syphilis, and other treponemal infections:	
	Rate the complications of nervous system, vascular system, eyes or ears. (See DC 7004, syphilitic heart disease, DC 8013, cerebrospinal syphilis, DC 8014, meningovascular syphilis, DC 8015, tabes dorsalis, and DC 9301, dementia associated with central nervous system syphilis)	
6311	Tuberculosis, miliary:	
	As active disease	100
	Inactive: See §§4.88c and 4.89.	
6313	Avitaminosis:	
	Marked mental changes, moist dermatitis, inability to retain adequate nourishment, exhaustion, and cachexia	100
	With all of the symptoms listed below, plus mental symptoms and impaired bodily vigor	60
	With stomatitis, diarrhea, and symmetrical dermatitis	40
	With stomatitis, or achlorhydria, or diarrhea	20
	Confirmed diagnosis with nonspecific symptoms such as: decreased appetite, weight loss, abdominal discomfort, weakness, inability to concentrate and irritability	10
6314	Beriberi:	
	As active disease:	
	With congestive heart failure, anasarca, or Wernicke-Korsakoff syndrome	100

	Rating
With cardiomegaly, or; with peripheral neuropathy with footdrop or atrophy of thigh or calf muscles	60
With peripheral neuropathy with absent knee or ankle jerks and loss of sensation, or; with symptoms such as weakness, fatigue, anorexia, dizziness, heaviness and stiffness of legs, headache or sleep disturbance	30
Thereafter rate residuals under the appropriate body system.	
6315 Pellagra:	
Marked mental changes, moist dermatitis, inability to retain adequate nourishment, exhaustion, and cachexia	100
With all of the symptoms listed below, plus mental symptoms and impaired bodily vigor	60
With stomatitis, diarrhea, and symmetrical dermatitis	40
With stomatitis, or achlorhydria, or diarrhea	20
Confirmed diagnosis with nonspecific symptoms such as: decreased appetite, weight loss, abdominal discomfort, weakness, inability to concentrate and irritability	10
6316 Brucellosis:	
As active disease	100
Thereafter rate residuals such as liver or spleen damage or meningitis under the appropriate system	
6317 Typhus, scrub:	
As active disease, and for 3 months convalescence	100
Thereafter rate residuals such as spleen damage or skin conditions under the appropriate system	
6318 Melioidosis:	
As active disease	100
Thereafter rate residuals such as arthritis, lung lesions or meningitis under the appropriate system	
6319 Lyme Disease:	
As active disease	100
Thereafter rate residuals such as arthritis under the appropriate system	
6320 Parasitic diseases otherwise not specified:	
As active disease	100
Thereafter rate residuals such as spleen or liver damage under the appropriate system	
6350 Lupus erythematosus, systemic (disseminated):	
Not to be combined with ratings under DC 7809 Acute, with frequent exacerbations, producing severe impairment of health	100
Exacerbations lasting a week or more, 2 or 3 times per year	60
Exacerbations once or twice a year or symptomatic during the past 2 years	10
NOTE: Evaluate this condition either by combining the evaluations for residuals under the appropriate system, or by evaluating DC 6350, whichever method results in a higher evaluation.	
6351 HIV-Related Illness:	
AIDS with recurrent opportunistic infections or with secondary diseases afflicting multiple body systems; HIV-related illness with debility and progressive weight loss, without remission, or few or brief remissions	100
Refractory constitutional symptoms, diarrhea, and pathological weight loss, or; minimum rating following development of AIDS-related opportunistic infection or neoplasm	60
Recurrent constitutional symptoms, intermittent diarrhea, and on approved medication(s), or; minimum rating with T4 cell count less than 200, or Hairy Cell Leukoplakia, or Oral Candidiasis	30
Following development of definite medical symptoms, T4 cell of 200 or more and less than 500, and on approved medication(s), or; with evidence of depression or memory loss with employment limitations	10
Asymptomatic, following initial diagnosis of HIV infection, with or without lymphadenopathy or decreased T4 cell count	0
NOTE (1): The term "approved medication(s)" includes medications prescribed as part of a research protocol at an accredited medical institution.	
NOTE (2): Psychiatric or central nervous system manifestations, opportunistic infections, and neoplasms may be rated separately under appropriate codes if higher overall evaluation results, but not in combination with percentages otherwise assignable above.	
6354 Chronic Fatigue Syndrome (CFS):	
Debilitating fatigue, cognitive impairments (such as inability to concentrate, forgetfulness, confusion), or a combination of other signs and symptoms:	
Which are nearly constant and so severe as to restrict routine daily activities almost completely and which may occasionally preclude self-care	100
Which are nearly constant and restrict routine daily activities to less than 50 percent of the pre-illness level, or; which wax and wane, resulting in periods of incapacitation of at least six weeks total duration per year	60
Which are nearly constant and restrict routine daily activities to 50 to 75 percent of the pre-illness level, or; which wax and wane, resulting in periods of incapacitation of at least four but less than six weeks total duration per year	40
Which are nearly constant and restrict routine daily activities by less than 25 percent of the pre-illness level, or; which wax and wane, resulting in periods of incapacitation of at least two but less than four weeks total duration per year	20
Which wax and wane but result in periods of incapacitation of at least one but less than two weeks total duration per year, or; symptoms controlled by continuous medication	10
NOTE: For the purpose of evaluating this disability, the condition will be considered incapacitating only while it requires bed rest and treatment by a physician.	

[61 FR 39875, July 31, 1996]

§4.88c Ratings for inactive nonpulmonary tuberculosis initially entitled after August 19, 1968.

	Rating
For 1 year after date of inactivity, following active tuberculosis	100
Thereafter: Rate residuals under the specific body system or systems affected.	
Following the total rating for the 1 year period after date of inactivity, the schedular evaluation for residuals of nonpulmonary tuberculosis, i.e., ankylosis, surgical removal of a part, etc., will be assigned under the appropriate diagnostic code for the residual preceded by the diagnostic code for tuberculosis of the body part affected. For example, tuberculosis of the hip joint with residual ankylosis would be coded 5001–5250. Where there are existing residuals of pulmonary and nonpulmonary conditions, the evaluations for residual separate functional impairment may be combined.	
Where there are existing pulmonary and nonpulmonary conditions, the total rating for the 1 year, after attainment of inactivity, may not be applied to both conditions during the same period. However, the total rating during the 1-year period for the pulmonary or for the nonpulmonary condition will be utilized, combined with evaluation for residuals of the condition not covered by the 1-year total evaluation, so as to allow any additional benefit provided during such period.	

[34 FR 5062, Mar. 11, 1969. Redesignated at 59 FR 60902, Nov. 29, 1994]

§4.89 Ratings for inactive nonpulmonary tuberculosis in effect on August 19, 1968.

Public Law 90–493 repealed section 356 of title 38, United States Code which provided graduated ratings for inactive tuberculosis. The repealed section, however, still applies to the case of any veteran who on August 19, 1968, was receiving or entitled to receive compensation for tuberculosis. The use of the protective provisions of Pub. L. 90–493 should be mentioned in the discussion portion of all ratings in which these provisions are applied. For use in rating cases in which the protective provisions of Pub. L. 90–493 apply, the former evaluations are retained in this section.

	Rating
For 2 years after date of inactivity, following active tuberculosis, which was clinically identified during service or subsequently	100
Thereafter, for 4 years, or in any event, to 6 years after date of inactivity	50
Thereafter, for 5 years, or to 11 years after date of inactivity	30
Thereafter, in the absence of a schedular compensable permanent residual	0
Following the total rating for the 2-year period after date of inactivity, the schedular evaluation for residuals of nonpulmonary tuberculosis, i.e., ankylosis, surgical removal of a part, etc., if in excess of 50 percent or 30 percent will be assigned under the appropriate diagnostic code for the specific residual preceded by the diagnostic code for tuberculosis of the body part affected. For example, tuberculosis of the hipjoint with residual ankylosis would be coded 5001–5250.	
The graduated ratings for nonpulmonary tuberculosis will not be combined with residuals of nonpulmonary tuberculosis unless the graduated rating and the rating for residual disability cover separate functional losses, e.g., graduated ratings for tuberculosis of the kidney and residuals of tuberculosis of the spine. Where there are existing pulmonary and nonpulmonary conditions, the graduated evaluation for the pulmonary, or for the nonpulmonary, condition will be utilized, combined with evaluations for residuals of the condition not covered by the graduated evaluation utilized, so as to provide the higher evaluation over such period.	
The ending dates of all graduated ratings of nonpulmonary tuberculosis will be controlled by the date of attainment of inactivity.	
These ratings are applicable only to veterans with nonpulmonary tuberculosis active on or after October 10, 1949.	

[29 FR 6718, May 22, 1964, as amended at 34 FR 5062, Mar. 11, 1969; 43 FR 45361, Oct. 2, 1978]

THE RESPIRATORY SYSTEM

§4.96 Special provisions regarding evaluation of respiratory conditions.

(a) *Rating coexisting respiratory conditions.* Ratings under diagnostic codes 6600 through 6817 and 6822 through 6847 will not be combined with each other. Where there is lung or pleural involvement, ratings under diagnostic codes 6819 and 6820 will not be combined with each other or with diagnostic codes 6600 through 6817 or 6822 through 6847. A single rating will be assigned under the diagnostic code which reflects the predominant disability with elevation to the next higher evaluation where the severity of the overall disability warrants such elevation. However, in cases protected by the provisions of Pub. L. 90–493, the graduated ratings of 50 and 30 percent for inactive tuberculosis will not be elevated.

(b) *Rating "protected" tuberculosis cases.* Public Law 90–493 repealed section 356 of title 38, United States Code which had provided graduated ratings for inactive tuberculosis. The repealed

section, however, still applies to the case of any veteran who on August 19, 1968, was receiving or entitled to receive compensation for tuberculosis. The use of the protective provisions of Pub. L. 90–493 should be mentioned in the discussion portion of all ratings in which these provisions are applied. For application in rating cases in which the protective provisions of Pub. L. 90–493 apply the former evaluations pertaining to pulmonary tuberculosis are retained in § 4.97.

(c) *Special monthly compensation.* When evaluating any claim involving complete organic aphonia, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, there are other conditions in this section which under certain circumstances also establish entitlement to special monthly compensation.

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

[34 FR 5062, Mar. 11, 1969, as amended at 61 FR 46727, Sept. 5, 1996]

§ 4.97 Schedule of ratings—respiratory system.

	Rating
DISEASES OF THE NOSE AND THROAT	
6502 Septum, nasal, deviation of:	
Traumatic only,	
With 50-percent obstruction of the nasal passage on both sides or complete obstruction on one side	10
6504 Nose, loss of part of, or scars:	
Exposing both nasal passages	30
Loss of part of one ala, or other obvious disfigurement	10
Note: Or evaluate as DC 7800, scars, disfiguring, head, face, or neck.	
6510 Sinusitis, pansinusitis, chronic.	
6511 Sinusitis, ethmoid, chronic.	
6512 Sinusitis, frontal, chronic.	
6513 Sinusitis, maxillary, chronic.	
6514 Sinusitis, sphenoid, chronic.	
General Rating Formula for Sinusitis (DC's 6510 through 6514):	
Following radical surgery with chronic osteomyelitis, or; near constant sinusitis characterized by headaches, pain and tenderness of affected sinus, and purulent discharge or crusting after repeated surgeries	50
Three or more incapacitating episodes per year of sinusitis requiring prolonged (lasting four to six weeks) antibiotic treatment, or; more than six non-incapacitating episodes per year of sinusitis characterized by headaches, pain, and purulent discharge or crusting	30
One or two incapacitating episodes per year of sinusitis requiring prolonged (lasting four to six weeks) antibiotic treatment, or; three to six non-incapacitating episodes per year of sinusitis characterized by headaches, pain, and purulent discharge or crusting	10
Detected by X-ray only	0
Note: An incapacitating episode of sinusitis means one that requires bed rest and treatment by a physician.	
6515 Laryngitis, tuberculous, active or inactive.	
Rate under §§ 4.88c or 4.89, whichever is appropriate.	
6516 Laryngitis, chronic:	
Hoarseness, with thickening or nodules of cords, polyps, submucous infiltration, or pre-malignant changes on biopsy	30
Hoarseness, with inflammation of cords or mucous membrane	10
6518 Laryngectomy, total.	[1] 100
Rate the residuals of partial laryngectomy as laryngitis (DC 6516), aphonia (DC 6519), or stenosis of larynx (DC 6520).	
6519 Aphonia, complete organic:	
Constant inability to communicate by speech	[1] 100
Constant inability to speak above a whisper	60
Note: Evaluate incomplete aphonia as laryngitis, chronic (DC 6516).	
6520 Larynx, stenosis of, including residuals of laryngeal trauma (unilateral or bilateral):	
Forced expiratory volume in one second (FEV–1) less than 40 percent of predicted value, with Flow-Volume Loop compatible with upper airway obstruction, or; permanent tracheostomy	100
FEV–1 of 40- to 55-percent predicted, with Flow-Volume Loop compatible with upper airway obstruction	60
FEV–1 of 56- to 70-percent predicted, with Flow-Volume Loop compatible with upper airway obstruction	30
FEV–1 of 71- to 80-percent predicted, with Flow-Volume Loop compatible with upper airway obstruction	10
Note: Or evaluate as aphonia (DC 6519).	
6521 Pharynx, injuries to:	

		Rating
	Stricture or obstruction of pharynx or nasopharynx, or; absence of soft palate secondary to trauma, chemical burn, or granulomatous disease, or; paralysis of soft palate with swallowing difficulty (nasal regurgitation) and speech impairment	50
6522	Allergic or vasomotor rhinitis:	
	With polyps	30
	Without polyps, but with greater than 50-percent obstruction of nasal passage on both sides or complete obstruction on one side	10
6523	Bacterial rhinitis:	
	Rhinoscleroma	50
	With permanent hypertrophy of turbinates and with greater than 50-percent obstruction of nasal passage on both sides or complete obstruction on one side	10
6524	Granulomatous rhinitis:	
	Wegener's granulomatosis, lethal midline granuloma	100
	Other types of granulomatous infection	20
	DISEASES OF THE TRACHEA AND BRONCHI	
6600	Bronchitis, chronic:	
	FEV–1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV–1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy	100
	FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
	FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
	FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
6601	Bronchiectasis:	
	With incapacitating episodes of infection of at least six weeks total duration per year	100
	With incapacitating episodes of infection of four to six weeks total duration per year, or; near constant findings of cough with purulent sputum associated with anorexia, weight loss, and frank hemoptysis and requiring antibiotic usage almost continuously	60
	With incapacitating episodes of infection of two to four weeks total duration per year, or; daily productive cough with sputum that is at times purulent or blood-tinged and that requires prolonged (lasting four to six weeks) antibiotic usage more than twice a year	30
	Intermittent productive cough with acute infection requiring a course of antibiotics at least twice a year	10
	Or rate according to pulmonary impairment as for chronic bronchitis (DC 6600).	
	Note: An incapacitating episode is one that requires bedrest and treatment by a physician.	
6602	Asthma, bronchial:	
	FEV–1 less than 40-percent predicted, or; FEV–1/FVC less than 40 percent, or; more than one attack per week with episodes of respiratory failure, or; requires daily use of systemic (oral or parenteral) high dose corticosteroids or immuno-suppressive medications	100
	FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; at least monthly visits to a physician for required care of exacerbations, or; intermittent (at least three per year) courses of systemic (oral or parenteral) corticosteroids	60
	FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; daily inhalational or oral bronchodilator therapy, or; inhalational anti-inflammatory medication	30
	FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; intermittent inhalational or oral bronchodilator therapy	10
	Note: In the absence of clinical findings of asthma at time of examination, a verified history of asthmatic attacks must be of record.	
6603	Emphysema, pulmonary:	
	FEV–1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV–1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy.	100
	FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
	FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
	FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
6604	Chronic obstructive pulmonary disease:	

	Rating
FEV–1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV–1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy.	100
FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
DISEASES OF THE LUNGS AND PLEURA—TUBERCULOSIS	
Ratings for Pulmonary Tuberculosis Entitled on August 19, 1968	
6701 Tuberculosis, pulmonary, chronic, far advanced, active	100
6702 Tuberculosis, pulmonary, chronic, moderately advanced, active	100
6703 Tuberculosis, pulmonary, chronic, minimal, active	100
6704 Tuberculosis, pulmonary, chronic, active, advancement unspecified	100
6721 Tuberculosis, pulmonary, chronic, far advanced, inactive.	
6722 Tuberculosis, pulmonary, chronic, moderately advanced, inactive.	
6723 Tuberculosis, pulmonary, chronic, minimal, inactive.	
6724 Tuberculosis, pulmonary, chronic, inactive, advancement unspecified.	
General Rating Formula for Inactive Pulmonary Tuberculosis: For two years after date of inactivity, following active tuberculosis, which was clinically identified during service or subsequently	100
Thereafter for four years, or in any event, to six years after date of inactivity	50
Thereafter, for five years, or to eleven years after date of inactivity	30
Following far advanced lesions diagnosed at any time while the disease process was active, minimum	30
Following moderately advanced lesions, provided there is continued disability, emphysema, dyspnea on exertion, impairment of health, etc	20
Otherwise	0
Note (1): The 100-percent rating under codes 6701 through 6724 is not subject to a requirement of precedent hospital treatment. It will be reduced to 50 percent for failure to submit to examination or to follow prescribed treatment upon report to that effect from the medical authorities. When a veteran is placed on the 100-percent rating for inactive tuberculosis, the medical authorities will be appropriately notified of the fact, and of the necessity, as given in footnote 1 to 38 U.S.C. 1156 (and formerly in 38 U.S.C. 356, which has been repealed by Public Law 90–493), to notify the Adjudication Division in the event of failure to submit to examination or to follow treatment.	
Note (2): The graduated 50-percent and 30-percent ratings and the permanent 30 percent and 20 percent ratings for inactive pulmonary tuberculosis are not to be combined with ratings for other respiratory disabilities. Following thoracoplasty the rating will be for removal of ribs combined with the rating for collapsed lung. Resection of the ribs incident to thoracoplasty will be rated as removal.	
Ratings for Pulmonary Tuberculosis Initially Evaluated After August 19, 1968	
6730 Tuberculosis, pulmonary, chronic, active	100
Note: Active pulmonary tuberculosis will be considered permanently and totally disabling for non-service-connected pension purposes in the following circumstances: (a) Associated with active tuberculosis involving other than the respiratory system. (b) With severe associated symptoms or with extensive cavity formation. (c) Reactivated cases, generally. (d) With advancement of lesions on successive examinations or while under treatment. (e) Without retrogression of lesions or other evidence of material improvement at the end of six months hospitalization or without change of diagnosis from "active" at the end of 12 months hospitalization. Material improvement means lessening or absence of clinical symptoms, and X-ray findings of a stationary or retrogressive lesion.	
6731 Tuberculosis, pulmonary, chronic, inactive: Depending on the specific findings, rate residuals as interstitial lung disease, restrictive lung disease, or, when obstructive lung disease is the major residual, as chronic bronchitis (DC 6600). Rate thoracoplasty as removal of ribs under DC 5297.	
Note: A mandatory examination will be requested immediately following notification that active tuberculosis evaluated under DC 6730 has become inactive. Any change in evaluation will be carried out under the provisions of § 3.105(e).	
6732 Pleurisy, tuberculous, active or inactive: Rate under §§ 4.88c or 4.89, whichever is appropriate.	
NONTUBERCULOUS DISEASES	
6817 Pulmonary Vascular Disease: Primary pulmonary hypertension, or; chronic pulmonary thromboembolism with evidence of pulmonary hypertension, right ventricular hypertrophy, or cor pulmonale, or; pulmonary hypertension secondary to other obstructive disease of pulmonary arteries or veins with evidence of right ventricular hypertrophy or cor pulmonale	100

	Rating
Chronic pulmonary thromboembolism requiring anticoagulant therapy, or; following inferior vena cava surgery without evidence of pulmonary hypertension or right ventricular dysfunction	60
Symptomatic, following resolution of acute pulmonary embolism	30
Asymptomatic, following resolution of pulmonary thromboembolism	0
Note: Evaluate other residuals following pulmonary embolism under the most appropriate diagnostic code, such as chronic bronchitis (DC 6600) or chronic pleural effusion or fibrosis (DC 6844), but do not combine that evaluation with any of the above evaluations.	
6819 Neoplasms, malignant, any specified part of respiratory 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 § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
6820 Neoplasms, benign, any specified part of respiratory system. Evaluate using an appropriate respiratory analogy.	
Bacterial Infections of the Lung	
6822 Actinomycosis.	
6823 Nocardiosis.	
6824 Chronic lung abscess.	
General Rating Formula for Bacterial Infections of the Lung (diagnostic codes 6822 through 6824):	
Active infection with systemic symptoms such as fever, night sweats, weight loss, or hemoptysis	100
Depending on the specific findings, rate residuals as interstitial lung disease, restrictive lung disease, or, when obstructive lung disease is the major residual, as chronic bronchitis (DC 6600).	
Interstitial Lung Disease	
6825 Diffuse interstitial fibrosis (interstitial pneumonitis, fibrosing alveolitis).	
6826 Desquamative interstitial pneumonitis.	
6827 Pulmonary alveolar proteinosis.	
6828 Eosinophilic granuloma of lung.	
6829 Drug-induced pulmonary pneumonitis and fibrosis.	
6830 Radiation-induced pulmonary pneumonitis and fibrosis.	
6831 Hypersensitivity pneumonitis (extrinsic allergic alveolitis).	
6832 Pneumoconiosis (silicosis, anthracosis, etc.).	
6833 Asbestosis.	
General Rating Formula for Interstitial Lung Disease (diagnostic codes 6825 through 6833):	
Forced Vital Capacity (FVC) less than 50-percent predicted, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption with cardiorespiratory limitation, or; cor pulmonale or pulmonary hypertension, or; requires outpatient oxygen therapy	100
FVC of 50- to 64-percent predicted, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum exercise capacity of 15 to 20 ml/kg/min oxygen consumption with cardiorespiratory limitation	60
FVC of 65- to 74-percent predicted, or; DLCO (SB) of 56- to 65-percent predicted	30
FVC of 75- to 80-percent predicted, or; DLCO (SB) of 66- to 80-percent predicted	10
Mycotic Lung Disease	
6834 Histoplasmosis of lung.	
6835 Coccidioidomycosis.	
6836 Blastomycosis.	
6837 Cryptococcosis.	
6838 Aspergillosis.	
6839 Mucormycosis.	
General Rating Formula for Mycotic Lung Disease (diagnostic codes 6834 through 6839):	
Chronic pulmonary mycosis with persistent fever, weight loss, night sweats, or massive hemoptysis	100
Chronic pulmonary mycosis requiring suppressive therapy with no more than minimal symptoms such as occasional minor hemoptysis or productive cough	50
Chronic pulmonary mycosis with minimal symptoms such as occasional minor hemoptysis or productive cough	30
Healed and inactive mycotic lesions, asymptomatic	0
Note: Coccidioidomycosis has an incubation period up to 21 days, and the disseminated phase is ordinarily manifest within six months of the primary phase. However, there are instances of dissemination delayed up to many years after the initial infection which may have been unrecognized. Accordingly, when service connection is under consideration in the absence of record or other evidence of the disease in service, service in southwestern United States where the disease is endemic and absence of prolonged residence in this locality before or after service will be the deciding factor.	
Restrictive Lung Disease	
6840 Diaphragm paralysis or paresis.	
6841 Spinal cord injury with respiratory insufficiency.	
6842 Kyphoscoliosis, pectus excavatum, pectus carinatum.	

	Rating
6843 Traumatic chest wall defect, pneumothorax, hernia, etc.	
6844 Post-surgical residual (lobectomy, pneumonectomy, etc.).	
6845 Chronic pleural effusion or fibrosis.	
General Rating Formula for Restrictive Lung Disease (diagnostic codes 6840 through 6845):	
FEV–1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV–1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy	100
FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
Or rate primary disorder.	
Note (1): A 100-percent rating shall be assigned for pleurisy with empyema, with or without pleurocutaneous fistula, until resolved.	
Note (2): Following episodes of total spontaneous pneumothorax, a rating of 100 percent shall be assigned as of the date of hospital admission and shall continue for three months from the first day of the month after hospital discharge.	
Note (3): Gunshot wounds of the pleural cavity with bullet or missile retained in lung, pain or discomfort on exertion, or with scattered rales or some limitation of excursion of diaphragm or of lower chest expansion shall be rated at least 20-percent disabling. Disabling injuries of shoulder girdle muscles (Groups I to IV) shall be separately rated and combined with ratings for respiratory involvement. Involvement of Muscle Group XXI (DC 5321), however, will not be separately rated.	
6846 Sarcoidosis:	
Cor pulmonale, or; cardiac involvement with congestive heart failure, or; progressive pulmonary disease with fever, night sweats, and weight loss despite treatment	100
Pulmonary involvement requiring systemic high dose (therapeutic) corticosteroids for control	60
Pulmonary involvement with persistent symptoms requiring chronic low dose (maintenance) or intermittent corticosteroids	30
Chronic hilar adenopathy or stable lung infiltrates without symptoms or physiologic impairment	0
Or rate active disease or residuals as chronic bronchitis (DC 6600) and extra-pulmonary involvement under specific body system involved.	
6847 Sleep Apnea Syndromes (Obstructive, Central, Mixed):	
Chronic respiratory failure with carbon dioxide retention or cor pulmonale, or; requires tracheostomy	100
Requires use of breathing assistance device such as continuous airway pressure (CPAP) machine	50
Persistent day-time hypersomnolence	30
Asymptomatic but with documented sleep disorder breathing	0

[1] Review for entitlement to special monthly compensation under § 3.350 of this chapter.

[61 FR 46728, Sept. 5, 1996]

THE CARDIOVASCULAR SYSTEM

§§ 4.100–4.103 [Reserved]

§ 4.104 Schedule of ratings—cardiovascular system.

DISEASES OF THE HEART

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

DISEASES OF THE HEART—Continued

	Rating
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.	
7000 Valvular heart disease (including rheumatic heart disease):	

DISEASES OF THE HEART—Continued

	Rating
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 electro-cardiogram, 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

DISEASES OF THE HEART—Continued

	Rating
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 electro-cardiogram, 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 electro-cardiogram, 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 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 HEART—Continued

	Rating
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

DISEASES OF THE HEART—Continued

	Rating
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 be 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

DISEASES OF THE HEART—Continued

	Rating
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 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 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

DISEASES OF THE HEART—Continued

	Rating
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

DISEASES OF THE HEART—Continued

	Rating
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

DISEASES OF THE HEART—Continued

	Rating
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 of 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

DISEASES OF THE HEART—Continued

	Rating
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

DISEASES OF THE HEART—Continued

	Rating
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

DISEASES OF THE HEART—Continued

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

DISEASES OF THE HEART—Continued

	Rating
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)

[62 FR 65219, Dec. 11, 1997, as amended at 63 FR 37779, July 14, 1998]

THE DIGESTIVE SYSTEM

§ 4.110 Ulcers.

Experience has shown that the term "peptic ulcer" is not sufficiently specific for rating purposes. Manifest differences in ulcers of the stomach or duodenum in comparison with those at an anastomotic stoma are sufficiently recognized as to warrant two separate graduated descriptions. In evaluating the ulcer, care should be taken that the findings adequately identify the particular location.

§ 4.111 Postgastrectomy syndromes.

There are various postgastrectomy symptoms which may occur following anastomotic operations of the stomach. When present, those occurring during or immediately after eating and known as the "dumping syndrome" are characterized by gastrointestinal complaints and generalized symptoms simulating hypoglycemia; those occurring from 1 to 3 hours after eating usually present definite manifestations of hypoglycemia.

§ 4.112 Weight loss.

For purposes of evaluating conditions in § 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)

[66 FR 29488, May 31, 2001]

§4.113 Coexisting abdominal conditions.

There are diseases of the digestive system, particularly within the abdomen, which, while differing in the site of pathology, produce a common disability picture characterized in the main by varying degrees of abdominal distress or pain, anemia and disturbances in nutrition. Consequently, certain coexisting diseases in this area, as indicated in the instruction under the title "Diseases of the Digestive System," do not lend themselves to distinct and separate disability evaluations without violating the fundamental principle relating to pyramiding as outlined in §4.14.

§4.114 Schedule of ratings—digestive system.

Ratings under diagnostic codes 7301 to 7329, inclusive, 7331, 7342, and 7345 to 7348 inclusive will not be combined with each other. A single evaluation will be assigned under the diagnostic code which reflects the predominant disability picture, with elevation to the next higher evaluation where the severity of the overall disability warrants such elevation.

	Rating
7200 Mouth, injuries of.	
Rate as for disfigurement and impairment of function of mastication.	
7201 Lips, injuries of.	
Rate as for disfigurement of face.	
7202 Tongue, loss of whole or part:	
With inability to communicate by speech	100
One-half or more	60
With marked speech impairment	30
7203 Esophagus, stricture of:	
Permitting passage of liquids only, with marked impairment of general health	80
Severe, permitting liquids only	50
Moderate	30
7204 Esophagus, spasm of (cardiospasm).	
If not amenable to dilation, rate as for the degree of obstruction (stricture).	
7205 Esophagus, diverticulum of, acquired.	
Rate as for obstruction (stricture).	
7301 Peritoneum, adhesions of:	
Severe; definite partial obstruction shown by X-ray, with frequent and prolonged episodes of severe colic distension, nausea or vomiting, following severe peritonitis, ruptured appendix, perforated ulcer, or operation with drainage	50
Moderately severe; partial obstruction manifested by delayed motility of barium meal and less frequent and less prolonged episodes of pain	30
Moderate; pulling pain on attempting work or aggravated by movements of the body, or occasional episodes of colic pain, nausea, constipation (perhaps alternating with diarrhea) or abdominal distension	10
Mild	0
NOTE: Ratings for adhesions will be considered when there is history of operative or other traumatic or infectious (intraabdominal) process, and at least two of the following: disturbance of motility, actual partial obstruction, reflex disturbances, presence of pain.	
7304 Ulcer, gastric.	
7305 Ulcer, duodenal:	
Severe; pain only partially relieved by standard ulcer therapy, periodic vomiting, recurrent hematemesis or melena, with manifestations of anemia and weight loss productive of definite impairment of health	60
Moderately severe; less than severe but with impairment of health manifested by anemia and weight loss; or recurrent incapacitating episodes averaging 10 days or more in duration at least four or more times a year	40
Moderate; recurring episodes of severe symptoms two or three times a year averaging 10 days in duration; or with continuous moderate manifestations	20
Mild; with recurring symptoms once or twice yearly	10
7306 Ulcer, marginal (gastrojejunal):	
Pronounced; periodic or continuous pain unrelieved by standard ulcer therapy with periodic vomiting, recurring melena or hematemesis, and weight loss. Totally incapacitating	100
Severe; same as pronounced with less pronounced and less continuous symptoms with definite impairment of health	60
Moderately severe; intercurrent episodes of abdominal pain at least once a month partially or completely relieved by ulcer therapy, mild and transient episodes of vomiting or melena	40
Moderate; with episodes of recurring symptoms several times a year	20
Mild; with brief episodes of recurring symptoms once or twice yearly	10
7307 Gastritis, hypertrophic (identified by gastroscope):	
Chronic; with severe hemorrhages, or large ulcerated or eroded areas	60
Chronic; with multiple small eroded or ulcerated areas, and symptoms	30
Chronic; with small nodular lesions, and symptoms	10
Gastritis, atrophic.	
A complication of a number of diseases, including pernicious anemia.	
Rate the underlying condition.	
7308 Postgastrectomy syndromes:	
Severe; associated with nausea, sweating, circulatory disturbance after meals, diarrhea, hypoglycemic symptoms, and weight loss with malnutrition and anemia	60

	Rating
Moderate; less frequent episodes of epigastric disorders with characteristic mild circulatory symptoms after meals but with diarrhea and weight loss	40
Mild; infrequent episodes of epigastric distress with characteristic mild circulatory symptoms or continuous mild manifestations	20
7309 Stomach, stenosis of.	
Rate as for gastric ulcer.	
7310 Stomach, injury of, residuals.	
Rate as peritoneal adhesions.	
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.	
7314 Cholecystitis, chronic:	
Severe; frequent attacks of gall bladder colic	30
Moderate; gall bladder dyspepsia, confirmed by X-ray technique, and with infrequent attacks (not over two or three a year) of gall bladder colic, with or without jaundice	10
Mild	0
7315 Cholelithiasis, chronic.	
Rate as for chronic cholecystitis.	
7316 Cholangitis, chronic.	
Rate as for chronic cholecystitis.	
7317 Gall bladder, injury of.	
Rate as for peritoneal adhesions.	
7318 Gall bladder, removal of:	
With severe symptoms	30
With mild symptoms	10
Nonsymptomatic	0
Spleen, disease or injury of.	
See Hemic and Lymphatic Systems.	
7319 Irritable colon syndrome (spastic colitis, mucous colitis, etc.):	
Severe; diarrhea, or alternating diarrhea and constipation, with more or less constant abdominal distress	30
Moderate; frequent episodes of bowel disturbance with abdominal distress	10
Mild; disturbances of bowel function with occasional episodes of abdominal distress	0
7321 Amebiasis:	
Mild gastrointestinal disturbances, lower abdominal cramps, nausea, gaseous distention, chronic constipation interrupted by diarrhea	10
Asymptomatic	0
NOTE: Amebiasis with or without liver abscess is parallel in symptomatology with ulcerative colitis and should be rated on the scale provided for the latter. Similarly, lung abscess due to amebiasis will be rated under the respiratory system schedule, diagnostic code 6809.	
7322 Dysentery, bacillary.	
Rate as for ulcerative colitis..	
7323 Colitis, ulcerative:	
Pronounced; resulting in marked malnutrition, anemia, and general debility, or with serious complication as liver abscess	100
Severe; with numerous attacks a year and malnutrition, the health only fair during remissions	60
Moderately severe; with frequent exacerbations	30
Moderate; with infrequent exacerbations	10
7324 Distomiasis, intestinal or hepatic:	
Severe symptoms	30
Moderate symptoms	10
Mild or no symptoms	0
7325 Enteritis, chronic.	
Rate as for irritable colon syndrome.	
7326 Enterocolitis, chronic.	
Rate as for irritable colon syndrome.	
7327 Diverticulitis.	
Rate as for irritable colon syndrome, peritoneal adhesions, or colitis, ulcerative, depending upon the predominant disability picture.	
7328 Intestine, small, resection of:	
With marked interference with absorption and nutrition, manifested by severe impairment of health objectively supported by examination findings including material weight loss	60
With definite interference with absorption and nutrition, manifested by impairment of health objectively supported by examination findings including definite weight loss	40
Symptomatic with diarrhea, anemia and inability to gain weight	20
NOTE: Where residual adhesions constitute the predominant disability, rate under diagnostic code 7301.	
7329 Intestine, large, resection of:	
With severe symptoms, objectively supported by examination findings	40
With moderate symptoms	20
With slight symptoms	10
NOTE: Where residual adhesions constitute the predominant disability, rate under diagnostic code 7301.	
7330 Intestine, fistula of, persistent, or after attempt at operative closure:	
Copious and frequent, fecal discharge	100
Constant or frequent, fecal discharge	60
Slight infrequent, fecal discharge	30
Healed; rate for peritoneal adhesions.	
7331 Peritonitis, tuberculous, active or inactive:	
Active	100
Inactive: See §§ 4.88b and 4.89.	
7332 Rectum and anus, impairment of sphincter control:	
Complete loss of sphincter control	100
Extensive leakage and fairly frequent involuntary bowel movements	60
Occasional involuntary bowel movements, necessitating wearing of pad	30
Constant slight, or occasional moderate leakage	10
Healed or slight, without leakage	0
7333 Rectum and anus, stricture of:	
Requiring colostomy	100
Great reduction of lumen, or extensive leakage	50
Moderate reduction of lumen, or moderate constant leakage	30

	Rating
7334 Rectum, prolapse of:	
Severe (or complete), persistent	50
Moderate, persistent or frequently recurring	30
Mild with constant slight or occasional moderate leakage	10
7335 Ano, fistula in.	
Rate as for impairment of sphincter control.	
7336 Hemorrhoids, external or internal:	
With persistent bleeding and with secondary anemia, or with fissures	20
Large or thrombotic, irreducible, with excessive redundant tissue, evidencing frequent recurrences	10
Mild or moderate	0
7337 Pruritus ani.	
Rate for the underlying condition.	
7338 Hernia, inguinal:	
Large, postoperative, recurrent, not well supported under ordinary conditions and not readily reducible, when considered inoperable	60
Small, postoperative recurrent, or unoperated irremediable, not well supported by truss, or not readily reducible	30
Postoperative recurrent, readily reducible and well supported by truss or belt	10
Not operated, but remediable	0
Small, reducible, or without true hernia protrusion	0
NOTE: Add 10 percent for bilateral involvement, provided the second hernia is compensable. This means that the more severely disabling hernia is to be evaluated, and 10 percent, only, added for the second hernia, if the latter is of compensable degree.	
7339 Hernia, ventral, postoperative:	
Massive, persistent, severe diastasis of recti muscles or extensive diffuse destruction or weakening of muscular and fascial support of abdominal wall so as to be inoperable	100
Large, not well supported by belt under ordinary conditions	40
Small, not well supported by belt under ordinary conditions, or healed ventral hernia or post-operative wounds with weakening of abdominal wall and indication for a supporting belt	20
Wounds, postoperative, healed, no disability, belt not indicated	0
7340 Hernia, femoral.	
Rate as for inguinal hernia.	
7342 Visceroptosis, symptomatic, marked	10
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 §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 §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.	
7346 Hernia hiatal:	
Symptoms of pain, vomiting, material weight loss and hematemesis or melena with moderate anemia; or other symptom combinations productive of severe impairment of health	60
Persistently recurrent epigastric distress with dysphagia, pyrosis, and regurgitation, accompanied by substernal or arm or shoulder pain, productive of considerable impairment of health	30
With two or more of the symptoms for the 30 percent evaluation of less severity	10
7347 Pancreatitis:	
With frequently recurrent disabling attacks of abdominal pain with few pain free intermissions and with steatorrhea, malabsorption, diarrhea and severe malnutrition	100
With frequent attacks of abdominal pain, loss of normal body weight and other findings showing continuing pancreatic insufficiency between acute attacks	60

	Rating
Moderately severe; with at least 4–7 typical attacks of abdominal pain per year with good remission between attacks	30
With at least one recurring attack of typical severe abdominal pain in the past year	10
NOTE 1: Abdominal pain in this condition must be confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies.	
NOTE 2: Following total or partial pancreatectomy, rate under above, symptoms, minimum rating 30 percent.	
7348 Vagotomy with pyloroplasty or gastroenterostomy:	
Followed by demonstrably confirmative postoperative complications of stricture or continuing gastric retention	40
With symptoms and confirmed diagnosis of alkaline gastritis, or of confirmed persisting diarrhea	30
Recurrent ulcer with incomplete vagotomy	20
NOTE: Rate recurrent ulcer following complete vagotomy under diagnostic code 7305, minimum rating 20 percent; and rate dumping syndrome under diagnostic code 7308.	
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 § 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 § 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)

[29 FR 6718, May 22, 1964, as amended at 34 FR 5063, Mar. 11, 1969; 40 FR 42540, Sept. 15, 1975; 41 FR 11301, Mar. 18, 1976; 66 FR 29488, May 31, 2001]

THE GENITOURINARY SYSTEM

§ 4.115 Nephritis.

Albuminuria alone is not nephritis, nor will the presence of transient albumin and casts following acute febrile illness be taken as nephritis. The glomerular type of nephritis is usually preceded by or associated with severe infectious disease; the onset is sudden, and the course marked by red blood cells, salt retention, and edema; it may clear up entirely or progress to a chronic condition. The nephrosclerotic type, originating in hypertension or arteriosclerosis, develops slowly, with minimum laboratory findings, and is associated with natural progress. Separate ratings are not to be assigned for disability from disease of the heart and any form of nephritis, on account of the close interrelationships of cardiovascular disabilities. If, however, absence of a kidney is the sole renal disability, even if removal was required because of nephritis, the absent kidney and any hypertension or heart disease will be separately rated. Also, in the event that chronic renal disease has progressed to the point where regular

dialysis is required, any coexisting hypertension or heart disease will be separately rated.

[41 FR 34258, Aug. 13, 1976, as amended at 59 FR 2527, Jan. 18, 1994]

§4.115a Ratings of the genitourinary system—dysfunctions.

Diseases of the genitourinary system generally result in disabilities related to renal or voiding dysfunctions, infections, or a combination of these. The following section provides descriptions of various levels of disability in each of these symptom areas. Where diagnostic codes refer the decisionmaker to these specific areas dysfunction, only the predominant area of dysfunction shall be considered for rating purposes. Since the areas of dysfunction described below do not cover all symptoms resulting from genitourinary diseases, specific diagnoses may include a description of symptoms assigned to that diagnosis.

	Rating
Renal dysfunction:	
Requiring regular dialysis, or precluding more than sedentary activity from one of the following: persistent edema and albuminuria; or, BUN more than 80mg%; or, creatinine more than 8mg%; or, markedly decreased function of kidney or other organ systems, estpecially cardiovascular	100
Persistent edema and albuminuria with BUN 40 to 80mg%; or, creatinine 4 to 8mg%; or, generalized poor health characterized by lethargy, weakness, anorexia, weight loss, or limitation of exertion	80
Constant albuminuria with some edema; or, definite decrease in kidney function; or, hypertension at least 40 percent disabling under diagnostic code 7101	60
Albumin constant or recurring with hyaline and granular casts or red blood cells; or, transient or slight edema or hypertension at least 10 percent disabling under diagnostic code 7101	30
Albumin and casts with history of acute nephritis; or, hypertension non-compensable under diagnostic code 7101	0
Voiding dysfunction:	
Rate particular condition as urine leakage, frequency, or obstructed voiding	
Continual Urine Leakage, Post Surgical Urinary Diversion, Urinary Incontinence, or Stress Incontinence:	
Requiring the use of an appliance or the wearing of absorbent materials which must be changed more than 4 times per day	60
Requiring the wearing of absorbent materials which must be changed 2 to 4 times per day	40
Requiring the wearing of absorbent materials which must be changed less than 2 times per day	20
Urinary frequency:	
Daytime voiding interval less than one hour, or; awakening to void five or more times per night	40
Daytime voiding interval between one and two hours, or; awakening to void three to four times per night	20
Daytime voiding interval between two and three hours, or; awakening to void two times per night	10
Obstructed voiding:	
Urinary retention requiring intermittent or continuous catheterization	30
Marked obstructive symptomatology (hesitancy, slow or weak stream, decreased force of stream) with any one or combination of the following:	
1. Post void residuals greater than 150 cc.	
2. Uroflowmetry; markedly diminished peak flow rate (less than 10 cc/sec).	
3. Recurrent urinary tract infections secondary to obstruction.	
4. Stricture disease requiring periodic dilatation every 2 to 3 months	10
Obstructive symptomatology with or without stricture disease requiring dilatation 1 to 2 times per year	0
Urninary tract infection:	
Poor renal function: Rate as renal dysfunction.	
Recurrent symptomatic infection requiring drainage/frequent hospitalization (greater than two times/year), and/or requiring continuous intensive management	30
Long-term drug therapy, 1–2 hospitalizations per year and/or requiring intermittent intensive management	10

[59 FR 2527, Jan. 18, 1994; 59 FR 10676, Mar. 7, 1994]

§4.115b Ratings of the genitourinary system—diagnoses.

	Rating
Note: When evaluating any claim involving loss or loss of use of one or more creative organs, refer to §3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, there are other conditions in this section which under certain circumstances also establish entitlement to special monthly compensation.	
7500 Kidney, removal of one:	
Minimum evaluation	30
Or rate as renal dysfunction if there is nephritis, infection, or pathology of the other.	
7501 Kidney, abscess of:	
Rate as urinary tract infection	.....

	Rating
7502 Nephritis, chronic:	
Rate as renal dysfunction.	
7504 Pyelonephritis, chronic:	
Rate as renal dysfunction or urinary tract infection, whichever is predominant.	
7505 Kidney, tuberculosis of:	
Rate in accordance with §§ 4.88b or 4.89, whichever is appropriate.	
7507 Nephrosclerosis, arteriolar:	
Rate according to predominant symptoms as renal dysfunction, hypertension or heart disease. If rated under the cardiovascular schedule, however, the percentage rating which would otherwise be assigned will be elevated to the next higher evaluation.	
7508 Nephrolithiasis:	
Rate as hydronephrosis, *except for* recurrent stone formation requiring one or more of the following:	
1. diet therapy	
2. drug therapy	
3. invasive or non-invasive procedures more than two times/year	30
7509 Hydronephrosis:	
Severe; Rate as renal dysfunction.	
Frequent attacks of colic with infection (pyonephrosis), kidney function impaired	30
Frequent attacks of colic, requiring catheter drainage	20
Only an occasional attack of colic, not infected and not requiring catheter drainage	10
7510 Ureterolithiasis:	
Rate as hydronephrosis, *except for* recurrent stone formation requiring one or more of the following:	
1. diet therapy	
2. drug therapy	
3. invasive or non-invasive procedures more than two times/year	30
7511 Ureter, stricture of:	
Rate as hydronephrosis, *except for* recurrent stone formation requiring one or more of the following:	
1. diet therapy	
2. drug therapy	
3. invasive or non-invasive procedures more than two times/year	30
7512 Cystitis, chronic, includes interstitial and all etiologies, infectious and non-infectious:	
Rate as voiding dysfunction.	
7515 Bladder, calculus in, with symptoms interfering with function:	
Rate as voiding dysfunction	
7516 Bladder, fistula of:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	
Postoperative, suprapubic cystotomy	100
7517 Bladder, injury of:	
Rate as voiding dysfunction.	
7518 Urethra, stricture of:	
Rate as voiding dysfunction.	
7519 Urethra, fistual of:	
Rate as voiding dysfunction.	
Multiple urethroperineal fistulae	100
7520 Penis, removal of half or more	30
Or rate as voiding dysfunction.	
7521 Penis removal of glans	20
Or rate as voiding dysfunction.	
7522 Penis, deformity, with loss of erectile power—20 [1].	
7523 Testis, atrophy complete:.	
Both—20 [1]	
One—0 [1]	
7524 Testis, removal:.	
Both—30 [1]	
One—0 [1]	
Note: In cases of the removal of one testis as the result of a service-incurred injury or disease, other than an undescended or congenitally undeveloped testis, with the absence or nonfunctioning of the other testis unrelated to service, an evaluation of 30 percent will be assigned for the service-connected testicular loss. Testis, underscended, or congenitally undeveloped is not a ratable disability.	
7525 Epididymo-orchitis, chronic only:	
Rate as urinary tract infection.	
For tubercular infections: Rate in accordance with §§ 4.88b or 4.89, whichever is appropriate.	
7527 Prostate gland injuries, infections, hypertrophy, postoperative residuals:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	
7528 Malignant neoplasms of the genitourinary system	100

	Rating
Note—Following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure, the rating of 100 percent shall continue with a mandatory VA examination at the expiration of six months. 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 reoccurrence or metastasis, rate on residuals as voiding dysfunction or renal dysfunction, whichever is predominant.	
7529 Benign neoplasms of the genitourinary system:	
Rate as voiding dysfunction or renal dysfunction, whichever is predominant.	
7530 Chronic renal disease requiring regular dialysis:	
Rate as renal dysfunction.	
7531 Kidney transplant:	
Following transplant surgery	100
Thereafter: Rate on residuals as renal dysfunction, minimum rating	30
Note—The 100 percent evaluation shall be assigned as of the date of hospital admission for transplant surgery and shall continue with a mandatory VA examination one year following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.	
7532 Renal tubular disorders (such as renal glycosurias, aminoacidurias, renal tubular acidosis, Fanconi's syndrome, Bartter's syndrome, related disorders of Henle's loop and proximal or distal nephron function, etc.):	
Minimum rating for symptomatic condition	20
Or rate as renal dysfunction.	
7533 Cystic diseases of the kidneys (polycystic disease, uremic medullary cystic disease, Medullary sponge kidney, and similar conditions):	
Rate as renal dysfunction.	
7534 Atherosclerotic renal disease (renal artery stenosis or atheroembolic renal disease):	
Rate as renal dysfunction.	
7535 Toxic nephropathy (antibotics, radiocontrast agents, nonsteroidal anti-inflammatory agents, heavy metals, and similar agents):	
Rate as renal dysfunction.	
7536 Glomerulonephritis:	
Rate as renal dysfunction.	
7537 Interstitial nephritis:	
Rate as renal dysfunction.	
7538 Papillary necrosis:	
Rate as renal dysfunction.	
7539 Renal amyloid disease:	
Rate as renal dysfunction.	
7540 Disseminated intravascular coagulation with renal cortical necrosis:	
Rate as renal dysfunction.	
7541 Renal involvement in diabetes mellitus, sickle cell anemia, systemic lupus erythematosus, vasculitis, or other systemic disease processes.	
Rate as renal dysfunction.	
7542 Neurogenic bladder:	
Rate as voiding dysfunction.	

[1] Review for entitlement to special monthly compensation under §3.350 of this chapter.

[59 FR 2527, Jan. 18, 1994; 59 FR 14567, Mar. 29, 1994, as amended at 59 FR 46339, Sept. 8, 1994]

GYNECOLOGICAL CONDITIONS AND DISORDERS OF THE BREAST

§ 4.116 Schedule of ratings—gynecological conditions and disorders of the breast.

	Rating
Note 1: Natural menopause, primary amenorrhea, and pregnancy and childbirth are not disabilities for rating purposes. Chronic residuals of medical or surgical complications of pregnancy may be disabilities for rating purposes.	
Note 2: When evaluating any claim involving loss or loss of use of one or more creative organs or anatomical loss of one or both breasts, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, almost any condition in this section might, under certain circumstances, establish entitlement to special monthly compensation.	
7610 Vulva, disease or injury of (including vulvovaginitis).	
7611 Vagina, disease or injury of.	
7612 Cervix, disease or injury of.	
7613 Uterus, disease, injury, or adhesions of.	
7614 Fallopian tube, disease, injury, or adhesions of (including pelvic inflammatory disease (PID)).	
7615 Ovary, disease, injury, or adhesions of.	
General Rating Formula for Disease, Injury, or Adhesions of Female Reproductive Organs (diagnostic codes 7610 through 7615):	
Symptoms not controlled by continuous treatment	30
Symptoms that require continuous treatment	10
Symptoms that do not require continuous treatment	0
7617 Uterus and both ovaries, removal of, complete:	
For three months after removal	[1] 100
Thereafter	[1] 50
7618 Uterus, removal of, including corpus:	
For three months after removal	[1] 100
Thereafter	[1] 30
7619 Ovary, removal of:	
For three months after removal	[1] 100
Thereafter:	
Complete removal of both ovaries	[1] 30
Removal of one with or without partial removal of the other	[1] 0
7620 Ovaries, atrophy of both, complete	[1] 20
7621 Uterus, prolapse:	
Complete, through vagina and introitus	50
Incomplete	30
7622 Uterus, displacement of:	
With marked displacement and frequent or continuous menstrual disturbances	30
With adhesions and irregular menstruation	10
7623 Pregnancy, surgical complications of:	
With rectocele or cystocele	50
With relaxation of perineum	10
7624 Fistula, rectovaginal:	
Vaginal fecal leakage at least once a day requiring wearing of pad	100
Vaginal fecal leakage four or more times per week, but less than daily, requiring wearing of pad	60
Vaginal fecal leakage one to three times per week requiring wearing of pad	30
Vaginal fecal leakage less than once a week	10
Without leakage	0
7625 Fistula, urethrovaginal:	
Multiple urethrovaginal fistulae	100
Requiring the use of an appliance or the wearing of absorbent materials which must be changed more than four times per day	60
Requiring the wearing of absorbent materials which must be changed two to four times per day	40
Requiring the wearing of absorbent materials which must be changed less than two times per day	20
7626 Breast, surgery of:	
Following radical mastectomy:	
Both	[1] 80
One	[1] 50
Following modified radical mastectomy:	
Both	[1] 60
One	[1] 40
Following simple mastectomy or wide local excision with significant alteration of size or form:	
Both	[1] 50
One	[1] 30
Following wide local excision without significant alteration of size or form:	
Both or one	0
Note: For VA purposes:	
(1) *Radical mastectomy* means removal of the entire breast, underlying pectoral muscles, and regional lymph nodes up to the coracoclavicular ligament..	
(2) *Modified radical mastectomy* means removal of the entire breast and axillary lymph nodes (in continuity with the breast). Pectoral muscles are left intact..	
(3) *Simple (or total) mastectomy* means removal of all of the breast tissue, nipple, and a small portion of the overlying skin, but lymph nodes and muscles are left intact..	
(4) *Wide local excision* (including partial mastectomy, lumpectomy, tylectomy, segmentectomy, and quadrantectomy) means removal of a portion of the breast tissue..	
7627 Malignant neoplasms of gynecological system or breast	100

	Rating
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.	
7628 Benign neoplasms of the gynecological system or breast. Rate according to impairment in function of the urinary or gynecological systems, or skin.	
7629 Endometriosis:	
Lesions involving bowel or bladder confirmed by laparoscopy, pelvic pain or heavy or irregular bleeding not controlled by treatment, and bowel or bladder symptoms	50
Pelvic pain or heavy or irregular bleeding not controlled by treatment	30
Pelvic pain or heavy or irregular bleeding requiring continuous treatment for control	10
Note: Diagnosis of endometriosis must be substantiated by laparoscopy.	

[1] Review for entitlement to special monthly compensation under §3.350 of this chapter.

[60 FR 19855, Apr. 21, 1995, as amended at 67 FR 6874, Feb. 14, 2002; 67 FR 37695, May 30, 2002]

THE HEMIC AND LYMPHATIC SYSTEMS

§4.117 Schedule of ratings—hemic and lymphatic systems.

	Rating
7700 Anemia, hypochromic-microcytic and megaloblastic, such as iron-deficiency and pernicious anemia:	
Hemoglobin 5gm/100ml or less, with findings such as high output congestive heart failure or dyspnea at rest	100
Hemoglobin 7gm/100ml or less, with findings such as dyspnea on mild exertion, cardiomegaly, tachycardia (100 to 120 beats per minute) or syncope (three episodes in the last six months)	70
Hemoglobin 8gm/100ml or less, with findings such as weakness, easy fatigability, headaches, lightheadedness, or shortness of breath	30
Hemoglobin 10gm/100ml or less with findings such as weakness, easy fatigability or headaches	10
Hemoglobin 10gm/100ml or less, asymptomatic	0

NOTE: Evaluate complications of pernicious anemia, such as dementia or peripheral neuropathy, separately.

7702 Agranulocytosis, acute:	
Requiring bone marrow transplant, or; requiring transfusion of platelets or red cells at least once every six weeks, or; infections recurring at least once every six weeks	100
Requiring transfusion of platelets or red cells at least once every three months, or; infections recurring at least once every three months	60
Requiring transfusion of platelets or red cells at least once per year but less than once every three months, or; infections recurring at least once per year but less than once every three months	30
Requiring continuous medication for control	10

NOTE: The 100 percent rating for bone marrow transplant shall be assigned as of the date of hospital admission and shall continue with a mandatory VA examination six months following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.

7703 Leukemia:	
With active disease or during a treatment phase	100
Otherwise rate as anemia (code 7700) or aplastic anemia (code 7716), whichever would result in the greater benefit.	

NOTE: The 100 percent rating shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. 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 recurrence, rate on residuals.

7704 Polycythemia vera:	
During periods of treatment with myelosuppressants and for three months following cessation of myelosuppressant therapy	100
Requiring phlebotomy	40
Stable, with or without continuous medication	10

NOTE: Rate complications such as hypertension, gout, stroke or thrombotic disease separately.

7705 Thrombocytopenia, primary, idiopathic or immune:	
Platelet count of less than 20,000, with active bleeding, requiring treatment with medication and transfusions	100
Platelet count between 20,000 and 70,000, not requiring treatment, without bleeding	70
Stable platelet count between 70,000 and 100,000, without bleeding	30
Stable platelet count of 100,000 or more, without bleeding	0
7706 Splenectomy	20

NOTE: Rate complications such as systemic infections with encapsulated bacteria separately.

7707 Spleen, injury of, healed.	
Rate for any residuals.	
7709 Hodgkin's disease:	
With active disease or during a treatment phase	100

NOTE: The 100 percent rating shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. 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.

	Rating
7710 Adenitis, tuberculous, active or inactive.	
Rate under §§ 4.88c or 4.89 of this part, whichever is appropriate.	
7714 Sickle cell anemia:	
With repeated painful crises, occurring in skin, joints, bones or any major organs caused by hemolysis and sickling of red blood cells, with anemia, thrombosis and infarction, with symptoms precluding even light manual labor	100
With painful crises several times a year or with symptoms precluding other than light manual labor	60
Following repeated hemolytic sickling crises with continuing impairment of health	30
Asymptomatic, established case in remission, but with identifiable organ impairment	10

NOTE: Sickle cell trait alone, without a history of directly attributable pathological findings, is not a ratable disability. Cases of symptomatic sickle cell trait will be forwarded to the Director, Compensation and Pension Service, for consideration under § 3.321(b)(1) of this chapter.

7715 Non-Hodgkin's lymphoma:	
With active disease or during a treatment phase	100

NOTE: The 100 percent rating shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be dtermined 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.

7716 Aplastic anemia:	
Requiring bone marrow transplant, or; requiring transfusion of platelets or red cells at least once every six weeks, or; infections recurring at least once every six weeks	100
Requiring transfusion of platelets or red cells at least once every three months, or; infections recurring at least once every three months	60
Requiring transfusion of platelets or red cells at least once per year but less than once every three months, or; infections recurring at least once per year but less than once every three months	30
Requiring continuous medication for control	10

NOTE: The 100 percent rating for bone marrow transplant shall be assigned as of the date of hospital admission and shall continue with a mandatory VA examination six months following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

[60 FR 49227, Sept. 22, 1995]

THE SKIN

§ 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 § 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 § 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 cause limited motion:.	
Area or areas of 144 square inches (929 sq. cm.) or greater	10

	Rating
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 §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 §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 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 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), depending 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 disabililty.	
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 §§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 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.	
7816 Psoriasis:	
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 more, but not constantly, during the past 12-month period	30

	Rating
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.	
7817 Exfoliative dermatitis (erythroderma):	
Generalized involvement of the skin, plus systemic manifestations (such as fever, weight loss, and hypoproteinemia), 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 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 (ultraviolet-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 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 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 § 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 (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 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 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)):	

	Rating
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 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 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-month 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

	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 § 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)

[67 FR 49596, July 31, 2002; 67 FR 58448, 58449, Sept. 16, 2002]

THE ENDOCRINE SYSTEM

§ 4.119 Schedule of ratings—endocrine system.

	Rating
7900 Hyperthyroidism	
Thyroid enlargement, tachycardia (more than 100 beats per minute), eye involvement, muscular weakness, loss of weight, and sympathetic nervous system, cardiovascular, or astrointestinal symptoms	100
Emotional instability, tachycardia, fatigability, and increased pulse pressure or blood pressure	60
Tachycardia, tremor, and increased pulse pressure or blood pressure	30
Tachycardia, which may be intermittent, and tremor, or; continuous medication required for control	10
NOTE (1): If disease of the heart is the predominant finding, evaluate as hyperthyroid heart disease (DC 7008) if doing so would result in a higher evaluation than using the criteria above.	
NOTE (2): If ophthalmopathy is the sole finding, evaluate as field vision, impairment of (DC 6080); diplopia (DC 6090); or impairment of central visual acuity (DC 6061–6079).	
7901 Thyroid gland, toxic adenoma of	
Thyroid enlargement, tachycardia (more than 100 beats per minute), eye involvement, muscular weakness, loss of weight, and sympathetic nervous system, cardiovascular, or gastrointestinal symptoms	100
Emotional instability, tachycardia, fatigability, and increased pulse pressure or blood pressure	60
Tachycardia, tremor, and increased pulse pressure or blood pressure	30
Tachycardia, which may be intermittent, and tremor, or; continuous medication required for control	10
NOTE (1): If disease of the heart is the predominant finding, evaluate as hyperthyroid heart disease (DC 7008) if doing so would result in a higher evaluation than using the criteria above.	
NOTE (2): If ophthalmopathy is the sole finding, evaluate as field vision, impairment of (DC 6080); diplopia (DC 6090); or impairment of central visual acuity (DC 6061–6079).	
7902 Thyroid gland, nontoxic adenoma of	
With disfigurement of the head or neck	20
Without disfigurement of the head or neck	0
NOTE: If there are symptoms due to pressure on adjacent organs such as the trachea, larynx, or esophagus, evaluate under the diagnostic code for disability of that organ, if doing so would result in a higher evaluation than using this diagnostic code.	
7903 Hypothyroidism	
Cold intolerance, muscular weakness, cardiovascular involvement, mental disturbance (dementia, slowing of thought, depression), bradycardia (less than 60 beats per minute), and sleepiness	100
Muscular weakness, mental disturbance, and weight gain	60
Fatigability, constipation, and mental sluggishness	30
Fatigability, or; continuous medication required for control	10
7904 Hyperparathyroidism	
Generalized decalcification of bones, kidney stones, gastrointestinal symptoms (nausea, vomiting, anorexia, constipation, weight loss, or peptic ulcer), and weakness	100
Gastrointestinal symptoms and weakness	60
Continuous medication required for control	10
NOTE: Following surgery or treatment, evaluate as digestive, skeletal, renal, or cardiovascular residuals or as endocrine dysfunction.	
7905 Hypoparathyroidism	
Marked neuromuscular excitability (such as convulsions, muscular spasms (tetany), or laryngeal stridor) plus either cataract or evidence of increased intracranial pressure (such as papilledema)	100
Marked neuromuscular excitability, or; paresthesias (of arms, legs, or circumoral area) plus either cataract or evidence of increased intracranial pressure	60
Continuous medication required for control	10
7907 Cushing's syndrome	
As active, progressive disease including loss of muscle strength, areas of osteoporosis, hypertension, weakness, and enlargement of pituitary or adrenal gland	100
Loss of muscle strength and enlargement of pituitary or adrenal gland	60
With striae, obesity, moon face, glucose intolerance, and vascular fragility	30
NOTE: With recovery or control, evaluate as residuals of adrenal insufficiency or cardiovascular, psychiatric, skin, or skeletal complications under appropriate diagnostic code.	
7908 Acromegaly	
Evidence of increased intracranial pressure (such as visual field defect), arthropathy, glucose intolerance, and either hypertension or cardiomegaly	100
Arthropathy, glucose intolerance, and hypertension	60

	Rating
Enlargement of acral parts or overgrowth of long bones, and enlarged sella turcica	30
7909 Diabetes insipidus	
Polyuria with near-continuous thirst, and more than two documented episodes of dehydration requiring parenteral hydration in the past year	100
Polyuria with near-continuous thirst, and one or two documented episodes of dehydration requiring parenteral hydration in the past year	60
Polyuria with near-continuous thirst, and one or more episodes of dehydration in the past year not requiring parenteral hydration	40
Polyuria with near-continuous thirst	20
7911 Addison's disease (Adrenal Cortical Hypofunction)	
Four or more crises during the past year	60
Three crises during the past year, or; five or more episodes during the past year	40
One or two crises during the past year, or; two to four episodes during the past year, or; weakness and fatigability, or; corticosteroid therapy required for control	20
NOTE (1): An Addisonian "crisis" consists of the rapid onset of peripheral vascular collapse (with acute hypotension and shock), with findings that may include: anorexia; nausea; vomiting; dehydration; profound weakness; pain in abdomen, legs, and back; fever; apathy, and depressed mentation with possible progression to coma, renal shutdown, and death.	
NOTE (2): An Addisonian "episode," for VA purposes, is a less acute and less severe event than an Addisonian crisis and may consist of anorexia, nausea, vomiting, diarrhea, dehydration, weakness, malaise, orthostatic hypotension, or hypoglycemia, but no peripheral vascular collapse.	
NOTE (3): Tuberculous Addison's disease will be evaluated as active or inactive tuberculosis. If inactive, these evaluations are not to be combined with the graduated ratings of 50 percent or 30 percent for non-pulmonary tuberculosis specified under §4.88b. Assign the higher rating.	
7912 Pluriglandular syndrome	
Evaluate according to major manifestations.	
7913 Diabetes mellitus	
Requiring more than one daily injection of insulin, restricted diet, and regulation of activities (avoidance of strenuous occupational and recreational activities) with episodes of ketoacidosis or hypoglycemic reactions requiring at least three hospitalizations per year or weekly visits to a diabetic care provider, plus either progressive loss of weight and strength or complications that would be compensable if separately evaluated	100
Requiring insulin, restricted diet, and regulation of activities with episodes of ketoacidosis or hypoglycemic reactions requiring one or two hospitalizations per year or twice a month visits to a diabetic care provider, plus complications that would not be compensable if separately evaluated	60
Requiring insulin, restricted diet, and regulation of activities	40
Requiring insulin and restricted diet, or; oral hypoglycemic agent and restricted diet	20
Manageable by restricted diet only	10
NOTE (1): Evaluate compensable complications of diabetes separately unless they are part of the criteria used to support a 100 percent evaluation. Noncompensable complications are considered part of the diabetic process under diagnostic code 7913.	
NOTE (2): When diabetes mellitus has been conclusively diagnosed, do not request a glucose tolerance test solely for rating purposes.	
7914 Neoplasm, malignant, any specified part of the endocrine system	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.	
7915 Neoplasm, benign, any specified part of the endocrine system rate as residuals of endocrine dysfunction.	
7916 Hyperpituitarism (prolactin secreting pituitary dysfunction)	
7917 Hyperaldosteronism (benign or malignant)	
7918 Pheochromocytoma (benign or malignant)	
NOTE: Evaluate diagnostic codes 7916, 7917, and 7918 as malignant or benign neoplasm as appropriate.	
7919 C-cell hyperplasia of the thyroid	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.	

[61 FR 20446, May 7, 1996]

NEUROLOGICAL CONDITIONS AND CONVULSIVE DISORDERS

§4.120 Evaluations by comparison.

Disability in this field is ordinarily to be rated in proportion to the impairment of motor, sensory or mental function. Consider especially psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, injury to the skull, etc. In rating disability from the conditions in the preceding sentence refer to the appropriate schedule. In rating peripheral nerve injuries and their residuals, attention should be

given to the site and character of the injury, the relative impairment in motor function, trophic changes, or sensory disturbances.

§ 4.121 Identification of epilepsy.

When there is doubt as to the true nature of epileptiform attacks, neurological observation in a hospital adequate to make such a study is necessary. To warrant a rating for epilepsy, the seizures must be witnessed or verified at some time by a physician. As to frequency, competent, consistent lay testimony emphasizing convulsive and immediate post-convulsive characteristics may be accepted. The frequency of seizures should be ascertained under the ordinary conditions of life (while not hospitalized).

§ 4.122 Psychomotor epilepsy.

The term psychomotor epilepsy refers to a condition that is characterized by seizures and not uncommonly by a chronic psychiatric disturbance as well.

(a) Psychomotor seizures consist of episodic alterations in conscious control that may be associated with automatic states, generalized convulsions, random motor movements (chewing, lip smacking, fumbling), hallucinatory phenomena (involving taste, smell, sound, vision), perceptual illusions (deja vu, feelings of loneliness, strangeness, macropsia, micropsia, dreamy states), alterations in thinking (not open to reason), alterations in memory, abnormalities of mood or affect (fear, alarm, terror, anger, dread, well-being), and autonomic disturbances (sweating, pallor, flushing of the face, visceral phenomena such as nausea, vomiting, defecation, a rising feeling of warmth in the abdomen). Automatic states or automatisms are characterized by episodes of irrational, irrelevant, disjointed, unconventional, asocial, purposeless though seemingly coordinated and purposeful, confused or inappropriate activity of one to several minutes (or, infrequently, hours) duration with subsequent amnesia for the seizure. Examples: A person of high social standing remained seated, muttered angrily, and rubbed the arms of his chair while the National Anthem was being played; an apparently normal person suddenly disrobed in public; a man traded an expensive automobile for an antiquated automobile in poor mechanical condition and after regaining conscious control, discovered that he had signed an agreement to pay an additional sum of money in the trade. The seizure manifestations of psychomotor epilepsy vary from patient to patient and in the same patient from seizure to seizure.

(b) A chronic mental disorder is not uncommon as an interseizure manifestation of psychomotor epilepsy and may include psychiatric disturbances extending from minimal anxiety to severe personality disorder (as distinguished from developmental) or almost complete personality disintegration (psychosis). The manifestations of a chronic mental disorder associated with psychomotor epilepsy, like those of the seizures, are protean in character.

§ 4.123 Neuritis, cranial or peripheral.

Neuritis, cranial or peripheral, characterized by loss of reflexes, muscle atrophy, sensory disturbances, and constant pain, at times excruciating, is to be rated on the scale provided for injury of the nerve involved, with a maximum equal to severe, incomplete, paralysis. See nerve involved for diagnostic code number and rating. The maximum rating which may be assigned for neuritis not characterized by organic changes referred to in this section will be that for moderate, or with sciatic nerve involvement, for moderately severe, incomplete paralysis.

§ 4.124 Neuralgia, cranial or peripheral.

Neuralgia, cranial or peripheral, characterized usually by a dull and intermittent pain, of typical distribution so as to identify the nerve, is to be rated on the same scale, with a maximum equal to moderate incomplete paralysis. See nerve involved for diagnostic code number and rating. Tic douloureux, or trifacial neuralgia, may be rated up to complete paralysis of the affected nerve.

§4.124a Schedule of ratings—neurological conditions and convulsive disorders.

[With the exceptions noted, disability from the following diseases and their residuals may be rated from 10 percent to 100 percent in proportion to the impairment of motor, sensory, or mental function. Consider especially psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, etc., referring to the appropriate bodily system of the schedule. With partial loss of use of one or more extremities from neurological lesions, rate by comparison with the mild, moderate, severe, or complete paralysis of peripheral nerves]

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM

	Rating
8000 Encephalitis, epidemic, chronic:	
As active febrile disease	100
Rate residuals, minimum	10
Brain, new growth of:	
8002 Malignant	100
NOTE: The rating in code 8002 will be continued for 2 years following cessation of surgical, chemotherapeutic or other treatment modality. At this point, if the residuals have stabilized, the rating will be made on neurological residuals according to symptomatology.	
Minimum rating	30
8003 Benign, minimum	60
Rate residuals, minimum	10
8004 Paralysis agitans:	
Minimum rating	30
8005 Bulbar palsy	100
8007 Brain, vessels, embolism of.	
8008 Brain, vessels, thrombosis of.	
8009 Brain, vessels, hemorrhage from:	
Rate the vascular conditions under Codes 8007 through 8009, for 6 months	100
Rate residuals, thereafter, minimum	10
8010 Myelitis:	
Minimum rating	10
8011 Poliomyelitis, anterior:	
As active febrile disease	100
Rate residuals, minimum	10
8012 Hematomyelia:	
For 6 months	100
Rate residuals, minimum	10
8013 Syphilis, cerebrospinal.	
8014 Syphilis, meningovascular.	
8015 Tabes dorsalis.	
NOTE: Rate upon the severity of convulsions, paralysis, visual impairment or psychotic involvement, etc.	
8017 Amyotrophic lateral sclerosis:	
Minimum rating	30
8018 Multiple sclerosis:	
Minimum rating	30
8019 Meningitis, cerebrospinal, epidemic:	
As active febrile disease	100
Rate residuals, minimum	10
8020 Brain, abscess of:	
As active disease	100

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
Rate residuals, minimum	10
Spinal cord, new growths of:.	
8021 Malignant	100
NOTE: The rating in code 8021 will be continued for 2 years following cessation of surgical, chemotherapeutic or other treatment modality. At this point, if the residuals have stabilized, the rating will be made on neurological residuals according to symptomatology.	
Minimum rating	30
8022 Benign, minimum rating	60
Rate residuals, minimum	10
8023 Progressive muscular atrophy:	
Minimum rating	30
8024 Syringomyelia:	
Minimum rating	30
8025 Myasthenia gravis:	
Minimum rating	30
NOTE: It is required for the minimum ratings for residuals under diagnostic codes 8000–8025, that there be ascertainable residuals. Determinations as to the presence of residuals not capable of objective verification, i.e., headaches, dizziness, fatigability, must be approached on the basis of the diagnosis recorded; subjective residuals will be accepted when consistent with the disease and not more likely attributable to other disease or no disease. It is of exceptional importance that when ratings in excess of the prescribed minimum ratings are assigned, the diagnostic codes utilized as bases of evaluation be cited, in addition to the codes identifying the diagnoses.	
8045 Brain disease due to trauma:	
Purely neurological disabilities, such as hemiplegia, epileptiform seizures, facial nerve paralysis, etc., following trauma to the brain, will be rated under the diagnostic codes specifically dealing with such disabilities, with citation of a hyphenated diagnostic code (e.g., 8045–8207).	
Purely subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma, will be rated 10 percent and no more under diagnostic code 9304. This 10 percent rating will not be combined with any other rating for a disability due to brain trauma. Ratings in excess of 10 percent for brain disease due to trauma under diagnostic code 9304 are not assignable in the absence of a diagnosis of multi-infarct dementia associated with brain trauma.	
8046 Cerebral arteriosclerosis:	

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
Purely neurological disabilities, such as hemiplegia, cranial nerve paralysis, etc., due to cerebral arteriosclerosis will be rated under the diagnostic codes dealing with such specific disabilities, with citation of a hyphenated diagnostic code (e.g., 8046–8207).	
Purely subjective complaints such as headache, dizziness, tinnitus, insomnia and irritability, recognized as symptomatic of a properly diagnosed cerebral arteriosclerosis, will be rated 10 percent and no more under diagnostic code 9305. This 10 percent rating will not be combined with any other rating for a disability due to cerebral or generalized arteriosclerosis. Ratings in excess of 10 percent for cerebral arteriosclerosis under diagnostic code 9305 are not assignable in the absence of a diagnosis of multi-infarct dementia with cerebral arteriosclerosis.	
NOTE: The ratings under code 8046 apply only when the diagnosis of cerebral arteriosclerosis is substantiated by the entire clinical picture and not solely on findings of retinal arteriosclerosis.	

MISCELLANEOUS DISEASES

	Rating
8100 Migraine:	
With very frequent completely prostrating and prolonged attacks productive of severe economic inadaptability	50
With characteristic prostrating attacks occurring on an average once a month over last several months	30
With characteristic prostrating attacks averaging one in 2 months over last several months	10
With less frequent attacks	0
8103 Tic, convulsive:	
Severe	30
Moderate	10
Mild	0
NOTE: Depending upon frequency, severity, muscle groups involved.	
8104 Paramyoclonus multiplex (convulsive state, myoclonic type):	
Rate as tic; convulsive; severe cases	60
8105 Chorea, Sydenham's:	
Pronounced, progressive grave types	100
Severe	80
Moderately severe	50
Moderate	30
Mild	10
NOTE: Consider rheumatic etiology and complications.	
8106 Chorea, Huntington's.	
Rate as Sydenham's chorea. This, though a familial disease, has its onset in late adult life, and is considered a ratable disability.	
8107 Athetosis, acquired.	
Rate as chorea.	
8108 Narcolepsy.	
Rate as for epilepsy, petit mal.	

DISEASES OF THE CRANIAL NERVES

	Rating
Disability from lesions of peripheral portions of first, second, third, fourth, sixth, and eighth nerves will be rated under the Organs of Special Sense. The ratings for the cranial nerves are for unilateral involvement; when bilateral, combine but without the bilateral factor.	
Fifth (trigeminal) cranial nerve	
8205 Paralysis of:	
Complete	50
Incomplete, severe	30
Incomplete, moderate	10
NOTE: Dependent upon relative degree of sensory manifestation or motor loss.	
8305 Neuritis.	
8405 Neuralgia.	
NOTE: Tic douloureux may be rated in accordance with severity, up to complete paralysis.	
Seventh (facial) cranial nerve	
8207 Paralysis of:	
Complete	30
Incomplete, severe	20
Incomplete, moderate	10
NOTE: Dependent upon relative loss of innervation of facial muscles.	
8307 Neuritis.	
8407 Neuralgia.	
Ninth (glossopharyngeal) cranial nerve.	
8209 Paralysis of:	
Complete	30
Incomplete, severe	20
Incomplete, moderate	10
NOTE: Dependent upon relative loss of ordinary sensation in mucous membrane of the pharynx, fauces, and tonsils.	
8309 Neuritis.	
8409 Neuralgia.	
Tenth (pneumogastric, vagus) cranial nerve.	
8210 Paralysis of:	
Complete	50
Incomplete, severe	30
Incomplete, moderate	10
NOTE : Dependent upon extent of sensory and motor loss to organs of voice, respiration, pharynx, stomach and heart.	
8310 Neuritis.	
8410 Neuralgia.	
Eleventh (spinal accessory, external branch) cranial nerve.	
8211 Paralysis of:	
Complete	30
Incomplete, severe	20
Incomplete, moderate	10
NOTE: Dependent upon loss of motor function of sternomastoid and trapezius muscles.	
8311 Neuritis.	
8411 Neuralgia.	
Twelfth (hypoglossal) cranial nerve.	
8212 Paralysis of:	
Complete	50
Incomplete, severe	30
Incomplete, moderate	10
NOTE: Dependent upon loss of motor function of tongue.	
8312 Neuritis.	
8412 Neuralgia.	

DISEASES OF THE PERIPHERAL NERVES

Schedule of ratings	Rating	
	Major	Minor
The term "incomplete paralysis," with this and other peripheral nerve injuries, indicates a degree of lost or impaired function substantially less than the type picture for complete paralysis given with each nerve, whether due to varied level of the nerve lesion or to partial regeneration. When the involvement is wholly sensory, the rating should be for the mild, or at most, the moderate degree. The ratings for the peripheral nerves are for unilateral involvement; when bilateral, combine with application of the bilateral factor.		
Upper radicular group (fifth and sixth cervicals)		
8510 Paralysis of:		
Complete; all shoulder and elbow movements lost or severely affected, hand and wrist movements not affected	70	60
Incomplete:		
Severe	50	40
Moderate	40	30
Mild	20	20
8610 Neuritis.		
8710 Neuralgia.		
Middle radicular group		
8511 Paralysis of:		
Complete; adduction, abduction and rotation of arm, flexion of elbow, and extension of wrist lost or severely affected	70	60
Incomplete:		
Severe	50	40
Moderate	40	30
Mild	20	20
8611 Neuritis.		
8711 Neuralgia.		
Lower radicular group		
8512 Paralysis of:		
Complete; all intrinsic muscles of hand, and some or all of flexors of wrist and fingers, paralyzed (substantial loss of use of hand)	70	60
Incomplete:		
Severe	50	40
Moderate	40	30
Mild	20	20
8612 Neuritis.		
8712 Neuralgia.		
All radicular groups		
8513 Paralysis of:		
Complete	90	80
Incomplete:		
Severe	70	60
Moderate	40	30
Mild	20	20

DISEASES OF THE PERIPHERAL NERVES—Continued

Schedule of ratings	Rating	
	Major	Minor
8613 Neuritis.		
8713 Neuralgia.		
The musculospiral nerve (radial nerve)		
8514 Paralysis of:		
Complete; drop of hand and fingers, wrist and fingers perpetually flexed, the thumb adducted falling within the line of the outer border of the index finger; can not extend hand at wrist, extend proximal phalanges of fingers, extend thumb, or make lateral movement of wrist; supination of hand, extension and flexion of elbow weakened, the loss of synergic motion of extensors impairs the hand grip seriously; total paralysis of the triceps occurs only as the greatest rarity	70	60
Incomplete:		
Severe	50	40
Moderate	30	20
Mild	20	20
8614 Neuritis.		
8714 Neuralgia.		
NOTE: Lesions involving only "dissociation of extensor communis digitorum" and "paralysis below the extensor communis digitorum," will not exceed the moderate rating under code 8514.		
The median nerve		
8515 Paralysis of:		
Complete; the hand inclined to the ulnar side, the index and middle fingers more extended than normally, considerable atrophy of the muscles of the thenar eminence, the thumb in the plane of the hand (ape hand); pronation incomplete and defective, absence of flexion of index finger and feeble flexion of middle finger, cannot make a fist, index and middle fingers remain extended; cannot flex distal phalanx of thumb, defective opposition and abduction of the thumb, at right angles to palm; flexion of wrist weakened; pain with trophic disturbances	70	60
Incomplete:		
Severe	50	40
Moderate	30	20
Mild	10	10
8615 Neuritis.		
8715 Neuralgia.		
The ulnar nerve		
8516 Paralysis of:		
Complete; the "griffin claw" deformity, due to flexor contraction of ring and little fingers, atrophy very marked in dorsal interspace and thenar and hypothenar eminences; loss of extension of ring and little fingers cannot spread the fingers (or reverse), cannot adduct the thumb; flexion of wrist weakened	60	50
Incomplete:		
Severe	40	30
Moderate	30	20
Mild	10	10

DISEASES OF THE PERIPHERAL NERVES—Continued

Schedule of ratings	Rating	
	Major	Minor
8616 Neuritis.		
8716 Neuralgia.		
Musculocutaneous nerve		
8517 Paralysis of:		
Complete; weakness but not loss of flexion of elbow and supination of forearm	30	20
Incomplete:		
Severe	20	20
Moderate	10	10
Mild	0	0
8617 Neuritis.		
8717 Neuralgia.		
Circumflex nerve		
8518 Paralysis of:		
Complete; abduction of arm is impossible, outward rotation is weakened; muscles supplied are deltoid and teres minor	50	40
Incomplete:		
Severe	30	20
Moderate	10	10
Mild	0	0
8618 Neuritis.		
8718 Neuralgia.		
Long thoracic nerve		
8519 Paralysis of:		
Complete; inability to raise arm above shoulder level, winged scapula deformity	30	20
Incomplete:		
Severe	20	20
Moderate	10	10
Mild	0	0
NOTE: Not to be combined with lost motion above shoulder level.		
8619 Neuritis.		
8719 Neuralgia.		
NOTE: Combined nerve injuries should be rated by reference to the major involvement, or if sufficient in extent, consider radicular group ratings.		

	Rating
Sciatic nerve	
8520 Paralysis of:	
Complete; the foot dangles and drops, no active movement possible of muscles below the knee, flexion of knee weakened or (very rarely) lost	80
Incomplete:	
Severe, with marked muscular atrophy	60
Moderately severe	40
Moderate	20
Mild	10
8620 Neuritis.	
8720 Neuralgia.	
External popliteal nerve (common peroneal)	
8521 Paralysis of:	
Complete; foot drop and slight droop of first phalanges of all toes, cannot dorsiflex the foot, extension (dorsal flexion) of proximal phalanges of toes lost; abduction of foot lost, adduction weakened; anesthesia covers entire dorsum of foot and toes	40
Incomplete:	
Severe	30
Moderate	20
Mild	10
8621 Neuritis.	
8721 Neuralgia.	
Musculocutaneous nerve (superficial peroneal)	
8522 Paralysis of:	
Complete; eversion of foot weakened	30
Incomplete:	
Severe	20
Moderate	10
Mild	0
8622 Neuritis.	
8722 Neuralgia.	
Anterior tibial nerve (deep peroneal)	
8523 Paralysis of:	
Complete; dorsal flexion of foot lost	30
Incomplete:	
Severe	20
Moderate	10
Mild	0
8623 Neuritis.	
8723 Neuralgia.	
Internal popliteal nerve (tibial)	
8524 Paralysis of:	
Complete; plantar flexion lost, frank adduction of foot impossible, flexion and separation of toes abolished; no muscle in sole can move; in lesions of the nerve high in popliteal fossa, plantar flexion of foot is lost	40
Incomplete:	
Severe	30
Moderate	20
Mild	10
8624 Neuritis.	
8724 Neuralgia.	
Posterior tibial nerve	
8525 Paralysis of:	
Complete; paralysis of all muscles of sole of foot, frequently with painful paralysis of a causalgic nature; toes cannot be flexed; adduction is weakened; plantar flexion is impaired	30
Incomplete:	
Severe	20

	Rating
Moderate	10
Mild	10
8625 Neuritis.	
8725 Neuralgia.	
Anterior crural nerve (femoral)	
8526 Paralysis of:	
Complete; paralysis of quadriceps extensor muscles	40
Incomplete:	
Severe	30
Moderate	20
Mild	10
8626 Neuritis.	
8726 Neuralgia.	
Internal saphenous nerve	
8527 Paralysis of:	
Severe to complete	10
Mild to moderate	0
8627 Neuritis.	
8727 Neuralgia.	
Obturator nerve	
8528 Paralysis of:	
Severe to complete	10
Mild or moderate	0
8628 Neuritis.	
8728 Neuralgia.	
External cutaneous nerve of thigh	
8529 Paralysis of:	
Severe to complete	10
Mild or moderate	0
8629 Neuritis.	
8729 Neuralgia.	
Ilio-inguinal nerve	
8530 Paralysis of:	
Severe to complete	10
Mild or moderate	0
8630 Neuritis.	
8730 Neuralgia.	
8540 Soft-tissue sarcoma (of neurogenic origin)	100

NOTE: The 100 percent rating will be continued for 6 months following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. At this point, if there has been no local recurrence or metastases, the rating will be made on residuals.

THE EPILEPSIES

	Rating
A thorough study of all material in §§4.121 and 4.122 of the preface and under the ratings for epilepsy is necessary prior to any rating action.	
8910 Epilepsy, grand mal.	
Rate under the general rating formula for major seizures.	
8911 Epilepsy, petit mal.	

THE EPILEPSIES—Continued

	Rating
Rate under the general rating formula for minor seizures.	
NOTE (1): A major seizure is characterized by the generalized tonic-clonic convulsion with unconsciousness.	
NOTE (2): A minor seizure consists of a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head ("pure" petit mal), or sudden jerking movements of the arms, trunk, or head (myoclonic type) or sudden loss of postural control (akinetic type).	
General Rating Formula for Major and Minor Epileptic Seizures:	
Averaging at least 1 major seizure per month over the last year	100
Averaging at least 1 major seizure in 3 months over the last year; or more than 10 minor seizures weekly	80
Averaging at least 1 major seizure in 4 months over the last year; or 9–10 minor seizures per week	60
At least 1 major seizure in the last 6 months or 2 in the last year; or averaging at least 5 to 8 minor seizures weekly	40
At least 1 major seizure in the last 2 years; or at least 2 minor seizures in the last 6 months	20
A confirmed diagnosis of epilepsy with a history of seizures	10
NOTE (1): When continuous medication is shown necessary for the control of epilepsy, the minimum evaluation will be 10 percent. This rating will not be combined with any other rating for epilepsy.	
NOTE (2): In the presence of major and minor seizures, rate the predominating type.	
NOTE (3): There will be no distinction between diurnal and nocturnal major seizures.	
8912 Epilepsy, Jacksonian and focal motor or sensory.	
8913 Epilepsy, diencephalic.	
Rate as minor seizures, except in the presence of major and minor seizures, rate the predominating type.	
8914 Epilepsy, psychomotor.	
Major seizures:	
Psychomotor seizures will be rated as major seizures under the general rating formula when characterized by automatic states and/or generalized convulsions with unconsciousness.	
Minor seizures:	
Psychomotor seizures will be rated as minor seizures under the general rating formula when characterized by brief transient episodes of random motor movements, hallucinations, perceptual illusions, abnormalities of thinking, memory or mood, or autonomic disturbances.	

Mental Disorders in Epilepsies: A nonpsychotic organic brain syndrome will be rated separately under the appropriate diagnostic code (e.g., 9304 or 9307). In the absence of a diagnosis of non-psychotic organic psychiatric disturbance (psychotic, psychoneurotic or personality disorder) if diagnosed and shown to be secondary to or directly associated with epilepsy will be rated separately. The psychotic or psychroneurotic disorder will be rated under the appropriate diagnostic code. The personality disorder will be rated as a dementia (e.g., diagnostic code 9304 or 9307).

Epilepsy and Unemployability: (1) Rating specialists must bear in mind that the epileptic, although his or her seizures are controlled, may find employment and rehabilitation difficult of attainment due to employer reluctance to the hiring of the epileptic.

(2) Where a case is encountered with a definite history of unemployment, full and complete development should be undertaken to ascertain whether the epilepsy is the determining factor in his or her inability to obtain employment.

(3) The assent of the claimant should first be obtained for permission to conduct this economic and social survey. The purpose of this survey is to secure all the relevant facts and data necessary to permit of a true judgment as to the reason for his or her unemployment and should include information as to:

(a) Education;
(b) Occupations prior and subsequent to service;
(c) Places of employment and reasons for termination;
(d) Wages received;
(e) Number of seizures.

(4) Upon completion of this survey and current examination, the case should have rating board consideration. Where in the judgment of the rating board the veteran's unemployability is due to epilepsy and jurisdiction is not vested in that body by reason of schedular evaluations, the case should be submitted to the Director, Compensation and Pension Service.

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

[29 FR 6718, May 22, 1964, as amended at 40 FR 42540, Sept. 15, 1975; 41 FR 11302, Mar. 18, 1976; 43 FR 45362, Oct. 2, 1978; 54 FR 4282, Jan. 30, 1989; 54 FR 49755, Dec. 1, 1989; 55 FR 154, Jan. 3, 1990; 56 FR 51653, Oct. 15, 1991; 57 FR 24364, June 9, 1992]

MENTAL DISORDERS

§ 4.125 Diagnosis of mental disorders.

(a) If the diagnosis of a mental disorder does not conform to DSM–IV or is not supported by the findings on the examination report, the rating agency shall return the report to the examiner to substantiate the diagnosis.

(b) If the diagnosis of a mental disorder is changed, the rating agency shall determine whether the new diagnosis represents progression of the prior diagnosis, correction of an error in the prior diagnosis, or development of a new and separate condition. If it is not clear from the available records what the change of diagnosis represents, the rating agency shall return the report to the examiner for a determination.

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

[61 FR 52700, Oct. 8, 1996]

§ 4.126 Evaluation of disability from mental disorders.

(a) When evaluating a mental disorder, the rating agency shall consider the frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the veteran's capacity for adjustment during periods of remission. The rating agency shall assign an evaluation based on all the evidence of record that bears on occupational and social impairment rather than solely on the examiner's assessment of the level of disability at the moment of the examination.

(b) When evaluating the level of disability from a mental disorder, the rating agency will consider the extent of social impairment, but shall not assign an evaluation solely on the basis of social impairment.

(c) Delirium, dementia, and amnestic and other cognitive disorders shall be evaluated under the general rating formula for mental disorders; neurologic deficits or other impairments stemming from the same etiology (e.g., a head injury) shall be evaluated separately and combined with the evaluation for delirium, dementia, or amnestic or other cognitive disorder (see § 4.25).

(d) When a single disability has been diagnosed both as a physical condition and as a mental disorder, the rating agency shall evaluate it using a diagnostic code which represents the dominant (more disabling) aspect of the condition (see § 4.14).

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

[61 FR 52700, Oct. 8, 1996]

§ 4.127 Mental retardation and personality disorders.

Mental retardation and personality disorders are not diseases or injuries for compensation purposes, and, except as provided in § 3.310(a) of this chapter, disability resulting from them may not be service-connected. However, disability resulting from a mental disorder that is superimposed upon mental retardation or a personality disorder may be service-connected.

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

[61 FR 52700, Oct. 8, 1996]

§ 4.128 Convalescence ratings following extended hospitalization.

If a mental disorder has been assigned a total evaluation due to a continuous period of hospitalization lasting six months or more, the rating agency shall continue the total evaluation indefinitely and schedule a mandatory examination six months after the veteran is discharged or released to

nonbed care. A change in evaluation based on that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.

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

[61 FR 52700, Oct. 8, 1996]

§4.129 Mental disorders due to traumatic stress.

When a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veteran's release from active military service, the rating agency shall assign an evaluation of not less than 50 percent and schedule an examination within the six month period following the veteran's discharge to determine whether a change in evaluation is warranted.

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

[61 FR 52700, Oct. 8, 1996]

§4.130 Schedule of ratings—mental disorders.

The nomenclature employed in this portion of the rating schedule is based upon the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, of the American Psychiatric Association (DSM–IV). Rating agencies must be thoroughly familiar with this manual to properly implement the directives in §4.125 through §4.129 and to apply the general rating formula for mental disorders in §4.130. The schedule for rating for mental disorders is set forth as follows:

	Rating
Schizophrenia and Other Psychotic Disorders	
9201 Schizophrenia, disorganized type 9202 Schizophrenia, catatonic type 9203 Schizophrenia, paranoid type 9204 Schizophrenia, undifferentiated type 9205 Schizophrenia, residual type; other and unspecified types 9208 Delusional disorder 9210 Psychotic disorder, not otherwise specified (atypical psychosis) 9211 Schizoaffective disorder	
Delirium, Dementia, and Amnestic and Other Cognitive Disorders	
9300 Delirium 9301 Dementia due to infection (HIV infection, syphilis, or other systemic or intracranial infections) 9304 Dementia due to head trauma 9305 Vascular dementia 9310 Dementia of unknown etiology 9312 Dementia of the Alzheimer's type 9326 Dementia due to other neurologic or general medical conditions (endocrine disorders, metabolic disorders, Pick's disease, brain tumors, etc.) or that are substance-induced (drugs, alcohol, poisons) 9327 Organic mental disorder, other (including personality change due to a general medical condition)	
Anxiety Disorders	
9400 Generalized anxiety disorder 9403 Specific (simple) phobia; social phobia 9404 Obsessive compulsive disorder 9410 Other and unspecified neurosis 9411 Post-traumatic stress disorder 9412 Panic disorder and/or agoraphobia 9413 Anxiety disorder, not otherwise specified	
Dissociative Disorders	
9416 Dissociative amnesia; dissociative fugue; dissociative identity disorder (multiple personality disorder) 9417 Depersonalization disorder	
Somatoform Disorders	
9421 Somatization disorder 9422 Pain disorder 9423 Undifferentiated somatoform disorder 9424 Conversion disorder 9425 Hypochondriasis	

	Rating
Mood Disorders	
9431 Cyclothymic disorder	
9432 Bipolar disorder	
9433 Dysthymic disorder	
9434 Major depressive disorder	
9435 Mood disorder, not otherwise specified	
Chronic Adjustment Disorder	
9440 Chronic adjustment disorder	
General Rating Formula for Mental Disorders:	
Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name	100
Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships	70
Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships	50
Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events)	30
Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by continuous medication	10
A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication	0
Eating Disorders	
9520 Anorexia nervosa	
9521 Bulimia nervosa	
Rating Formula for Eating Disorders:	
Self-induced weight loss to less than 80 percent of expected minimum weight, with incapacitating episodes of at least six weeks total duration per year, and requiring hospitalization more than twice a year for parenteral nutrition or tube feeding	100
Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of six or more weeks total duration per year	60
Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of more than two but less than six weeks total duration per year	30
Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder and incapacitating episodes of up to two weeks total duration per year	10
Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder but without incapacitating episodes	0

NOTE: An incapacitating episode is a period during which bed rest and treatment by a physician are required.

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

[61 FR 52700, Oct. 8, 1996]

DENTAL AND ORAL CONDITIONS

§ 4.149 [Reserved]

§ 4.150 Schedule of ratings—dental and oral conditions.

	Rating
9900 Maxilla or mandible, chronic osteomyelitis or osteoradionecrosis of:	
Rate as osteomyelitis, chronic under diagnostic code 5000.	
9901 Mandible, loss of, complete, between angles	100
9902 Mandible, loss of approximately one-half:	
Involving temporomandibular articulation	50
Not involving temporomandibular articulation	30
9903 Mandible, nonunion of:	
Severe	30
Moderate	10
NOTE—Dependent upon degree of motion and relative loss of masticatory function.	
9904 Mandible, malunion of:	
Severe displacement	20
Moderate displacement	10
Slight displacement	0
NOTE—Dependent upon degree of motion and relative loss of masticatory function.	
9905 Temporomandibular articulation, limited motion of:	
Inter-incisal range:	
0 to 10 mm	40
11 to 20 mm	30
21 to 30 mm	20
31 to 40 mm	10
Range of lateral excursion:	
0 to 4 mm	10
NOTE—Ratings for limited inter-incisal movement shall not be combined with ratings for limited lateral excursion.	
9906 Ramus, loss of whole or part of:	
Involving loss of temporomandibular articulation	
Bilateral	50
Unilateral	30
Not involving loss of temporomandibular articulation	
Bilateral	30
Unilateral	20
9907 Ramus, loss of less than one-half the substance of, not involving loss of continuity:	
Bilateral	20
Unilateral	10
9908 Condyloid process, loss of, one or both sides	30
9909 Coronoid process, loss of:	
Bilateral	20
Unilateral	10
9911 Hard palate, loss of half or more:	
Not replaceable by prosthesis	30
Replaceable by prosthesis	10
9912 Hard palate, loss of less than half of:	
Not replaceable by prosthesis	20
Replaceable by prosthesis	0
9913 Teeth, loss of, due to loss of substance of body of maxilla or mandible without loss of continuity:	
Where the lost masticatory surface cannot be restored by suitable prosthesis:	
Loss of all teeth	40
Loss of all upper teeth	30
Loss of all lower teeth	30
All upper and lower posterior teeth missing	20
All upper and lower anterior teeth missing	20
All upper anterior teeth missing	10
All lower anterior teeth missing	10
All upper and lower teeth on one side missing	10
Where the loss of masticatory surface can be restored by suitable prosthesis	0
NOTE—These ratings apply only to bone loss through trauma or disease such as osteomyelitis, and not to the loss of the alveolar process as a result of periodontal disease, since such loss is not considered disabling.	
9914 Maxilla, loss of more than half:	
Not replaceable by prosthesis	100
Replaceable by prosthesis	50
9915 Maxilla, loss of half or less:	
Loss of 25 to 50 percent:	
Not replaceable by prosthesis	40
Replaceable by prosthesis	30
Loss of less than 25 percent:	
Not replaceable by prosthesis	20
Replaceable by prosthesis	0
9916 Maxilla, malunion or nonunion of:	
Severe displacement	30
Moderate displacement	10
Slight displacement	0

[59 FR 2530, Jan. 18, 1994]

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

Sec.	
4.16	Last sentence; March 1, 1963.
4.17	October 7, 1948.
4.17a	March 1, 1963.
4.29	Introductory portion preceding paragraph (a); March 1, 1963.
	Paragraph (a) "first day of continuous hospitalization"; April 8, 1959.
	Paragraph (a) "terminated last day of month"; December 1, 1962.
	Paragraph (a) penultimate sentence; November 13, 1970.
	Paragraph (b); April 8, 1959.
	Paragraph (c); August 16, 1948.
	Paragraph (d); August 16, 1948.
	Paragraph (e); March 1, 1963.
	Paragraph (f); August 9, 1976.
	NOTE: Application of this section to psychoneurotic and psychophysiologic disorders effective October 1, 1961.
4.30	Introductory portion of paragraph (a) preceding subparagraph (1); July 6, 1950.
	Paragraph (a)(1); June 9, 1952.
	Paragraph (a)(2); June 9, 1952.
	Paragraph (a)(3); June 9, 1952. Effective as to outpatient treatment March 10, 1976.
	Paragraph (b)(1); March 1, 1963.
	Paragraph (b)(2); August 9, 1976.
4.55	Paragraph (b) first sentence; March 1, 1963.
4.63	June 17, 1948.
4.64	October 1, 1956.
4.71a	Diagnostic Code 5000—60 percent; February 1, 1962.
	Diagnostic Code 5000 NOTE (2):
	First three sentences; July 10, 1956.
	Last sentence; July 6, 1950.
	Diagnostic Code 5002—100 percent, 60 percent, 40 percent, 20 percent; March 1, 1963.

Sec.	
	Diagnostic Code 5003; July 6, 1950.
	Diagnostic Code 5012—NOTE; March 10, 1976.
	In sentence following DC 5024: "except gout which will be rated under 5002"; March 1, 1963.
	Diagnostic Code 5051;
	Diagnostic Code 5052;
	Diagnostic Code 5053;
	Diagnostic Code 5054; September 9, 1975.
	Diagnostic Code 5055; September 9, 1975.
	Diagnostic Code 5056;
	Diagnostic Code 5164—60 percent; June 9, 1952.
	Diagnostic Code 5172; July 6, 1950.
	Diagnostic Code 5173; June 9, 1952.
	Diagnostic Code 5255 "or hip"; July 6, 1950.
	Diagnostic Code 5257—Evaluation; July 6, 1950.
	Diagnostic Code 5297—(Removal of one rib) "or resection of 2 or more"; August 23, 1948.
	Diagnostic Code 5297—NOTE (2): Reference to lobectomy; pneumonectomy and graduated ratings; February 1, 1962.
	Diagnostic Code 5298; August 23, 1948.
4.73	Diagnostic Code 5324; February 1, 1962.
	Diagnostic Code 5327; March 10, 1976.
	Diagnostic Code 5328; March 10, 1976.
4.78	Last sentence; December 1, 1963.
4.84a	Diagnostic Code 6029—Note; August 23, 1948.
	Diagnostic Code 6035; September 9, 1975.
	Diagnostic Code 6076—60%: Vision 1 eye 15/200 and other eye 20/100; August 23, 1948.
	Diagnostic Code 6080—Note—"as to 38 U.S.C. 1114(L)"; July 6, 1950.
	Diagnostic Code 6081—Words "unilateral", "minimal" and all of Note; March 10, 1976.
4.84b	Removed-December 18, 1987 (text redesignated § 4.871, December 18, 1987)
4.85	March 23, 1956. December 18, 1987.
4.86	March 23, 1956. December 18, 1987.
4.86a	March 23, 1956. December 18, 1987.
4.87	Tables VI and VII replaced by new Tables VI VIa and VII December 18, 1987.
4.87a	Diagnostic Codes 6277 through 6297; March 23, 1956; removed December 18, 1987. (Text from § 4.84b redesignated § 4.87a, December 18, 1987).
4.88a	Diagnostic Code 6304—Notes (1) and (2); August 23, 1948.
	Diagnostic Code 6309; March 1, 1963.
	Diagnostic Code 6350; 80% Evaluation and Criterion for 60% and 30% Evaluations; March 10, 1976. Other Evaluations and Note; March 1, 1963.
4.89	Ratings for nonpulmonary TB; December 1, 1949.
4.97	Diagnostic Code 6600—100% Evaluations and Criteria for 60%; September 9, 1975.
	Diagnostic Code 6602—Criteria for all Evaluations and Note; September 9, 1975.
	Diagnostic Code 6603; September 9, 1975.
	Second note following Diagnostic Code 6724; December 1, 1949.
	Diagnostic Code 6802—Criteria for all Evaluations; September 9, 1975.
	Diagnostic Code 6819—Note; March 10, 1976.
	Diagnostic Code 6821—Evaluations and Note; August 23, 1948.
4.104	Diagnostic Code 7000—30 percent; July 6, 1950.
	Diagnostic Code 7000—100 percent inactive "with signs of congestive failure upon any exertion beyond rest in bed" revoked;
	Diagnostic Code 7005—80 percent revoked;
	Diagnostic Code 7007—80 percent revoked;
	Diagnostic Code 7015—100 percent Evaluation. Criteria for All Evaluations and NOTES (1) and (2); September 9, 1975.
	Diagnostic Code 7016; September 9, 1975.
	Diagnostic Code 7017;
	Diagnostic Code 7100—20 percent; July 6, 1950.
	Diagnostic Code 7101 "or more"; September 1, 1960.
	Diagnostic Code 7101—NOTE (2); September 9, 1975.
	Diagnostic Code 7110—Criteria for 100 percent, NOTE and 60 percent and 20 percent Evaluations; September 9, 1975.
	Diagnostic Code 7111—NOTE; September 9, 1975.
	Diagnostic Codes 7114, 7115, 7116, and NOTE; June 9, 1952.
	Diagnostic Code 7117 and NOTE; June 9, 1952.
	NOTE following Diagnostic Code 7120; July 6, 1950.
	Diagnostic Code 7121—100 percent Criterion and Evaluation and 60 percent Criterion; March 10, 1976. Criteria for 30 percent and 10 percent and NOTE; July 6, 1950.
	Last sentence of NOTE following Diagnostic Code 7122; July 6, 1950.
4.114	Diagnostic Codes 7304 and 7305—Evaluations; November 1, 1962.
	Diagnostic Code 7308—Evaluations; April 8, 1959.
	Diagnostic Code 7312—70% Evaluation and 50% Evaluation and Criterion; March 10, 1976.
	Diagnostic Code 7313—20% Evaluation; March 10, 1976.
	Diagnostic Code 7319—Evaluations; November 1, 1962.
	Diagnostic Code 7321—Evaluations and Note; July 6, 1950.
	Diagnostic Code 7328—Evaluations and Note; November 1, 1962.
	Diagnostic Code 7329—Evaluations and Note; November 1, 1962.
	Diagnostic Code 7330—60% Evaluation; November 1, 1962.
	Diagnostic Code 7332—60% Evaluation; November 1, 1962.
	Diagnostic Code 7334—50% and 30% Evaluations; July 6, 1950.
	Diagnostic Code 7334—10% Evaluation; November 1, 1962.
	Diagnostic Code 7339—Criterion for 20% Evaluation; March 10, 1976.
	Diagnostic Code 7343—Note; March 10, 1976.
	Diagnostic Code 7345—100%, 60% and 30% Evaluations; August 23, 1948.
	Diagnostic Code 7345—10% Evaluation; February 17, 1955.
	Diagnostic Code 7345—10% Evaluation; February 17, 1955.
	Diagnostic Code 7346—Evaluations; February 1, 1962.
	Diagnostic Code 7347; September 9, 1975.
	Diagnostic Code 7348; March 10, 1976.
4.115a	Diagnostic Code 7500—Note; July 6, 1950.
	Diagnostic Code 7519—20%, 40% and 60% Evaluations; March 10, 1976.
	Diagnostic Code 7524—Note; July 6, 1950.
	Diagnostic Code 7528—Note; March 10, 1976.
	Diagnostic Code 7530; September 9, 1975.
	Diagnostic Code 7531; September 9, 1975.
4.116a	Diagnostic Code 7627—Note; March 10, 1976.

Sec.	
4.117	Diagnostic Code 7703—Evaluations; August 23, 1948.
	Diagnostic Code 7709—Note; March 10, 1976. Evaluations; June 9, 1952.
	Diagnostic Code 7714; September 9, 1975.
4.118	Diagnostic Code 7801—Note (2); July 6, 1950.
	Diagnostic Code 7804—Note; July 6, 1950.
4.119	Diagnostic Code 7900—10% Evaluation; and Notes (2) and (3); August 13, 1981.
	Diagnostic Code 7902—20% Evaluation; August 13, 1981.
	Diagnostic Code 7903—10% Evaluation; August 13, 1981.
	Diagnostic Code 7905—10% Evaluation; August 13, 1981.
	Diagnostic Code 7907—60% Evaluation; August 13, 1981.
	Diagnostic Code 7909—40% and 20% Evaluation; August 13, 1981.
	Diagnostic Code 7911—Evaluations and Note; March 1, 1963; 40% and 20% Evaluations; August 13, 1981.
	Diagnostic Code 7913—Note; September 9, 1975.
	Diagnostic Code 7914—Note; March 10, 1976.
4.122	October 1, 1961.
4.124a	Diagnostic Code 8002, NOTE;
	Diagnostic Code 8021, NOTE;
	Diagnostic Code 8045; October 1, 1961.
	Diagnostic Code 8046; October 1, 1961.
	Diagnostic Code 8100—Evaluations; June 9, 1953.
	Diagnostic Codes 8910 through 8914; October 1, 1961.
	Diagnostic Codes 8910 through 8914 General Rating Formula—Criteria and Evaluations; September 9, 1975.
4.125–4.132	All Diagnostic Codes under Mental Disorders; October 1, 1961, except as to evaluation for Diagnostic Codes 9500 through 9511; September 9, 1975.

[29 FR 6718, May 22, 1964, as amended at 34 FR 5064, Mar. 11, 1969; 40 FR 42541, Sept. 15, 1975; 41 FR 11291, Mar. 18, 1976; 41 FR 34258, Aug. 13, 1976; 43 FR 45362, Oct. 2, 1978; 46 FR 43666, Aug. 31, 1981; 52 FR 44122, Nov. 18, 1987; 52 FR 46439, Dec. 7, 1987]

APPENDIX B TO PART 4—NUMERICAL INDEX OF DISABILITIES

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
5000	Osteomyelitis, acute, subacute, or chronic.
5001	Bones and Joints, tuberculosis of.
5002	Arthritis, rheumatoid (atrophic).
5003	Arthritis, degenerative, hypertrophic, or osteoarthritis.
5004	Arthritis, gonorrheal.
5005	Arthritis, pneumococcic.
5006	Arthritis, typhoid.
5007	Arthritis, syphilitic.
5008	Arthritis, streptococcic.
5009	Arthritis, other types.
5010	Arthritis, due to trauma.
5011	Bones, caisson disease of.
5012	Bones, new growths of, malignant.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
5013	Osteoporosis, with joint manifestations.
5014	Osteomalacia.
5015	Bones, new growths of, benign.
5016	Osteitis deformans.
5017	Gout.
5018	Hydrarthrosis, intermittent.
5019	Bursitis.
5020	Synovitis.
5021	Myositis.
5022	Periostitis.
5023	Myositis ossificans.
5024	Tenosynovitis.

COMBINATIONS OF DISABILITIES

5100	Anatomical loss of both hands and both feet.
5101	Loss of use of both hands and both feet.
5102	Anatomical loss of both hands and one foot.
5103	Anatomical loss of both feet and one hand.
5104	Loss of use of both hands and one foot.
5105	Loss of use of both feet and one hand.
5106	Anatomical loss of both hands.
5107	Anatomical loss of both feet.
5108	Anatomical loss of one hand and one foot.
5109	Loss of use of both hands.
5110	Loss of use of both feet.
5111	Loss of use of one hand and one foot.

AMPUTATIONS: UPPER EXTREMITY

	Arm, amputation of:
5120	Disarticulation.
5121	Above insertion of deltoid.
5122	Below insertion of deltoid.
	Forearm, amputation of:
5123	Above insertion of pronator teres.
5124	Below insertion of pronator teres.
5125	Hand, loss of use of.
5126	Five digits of one hand, amputation of:
	Four digits of one hand, amputation of:
5127	Thumb, index, middle and ring.
5128	Thumb, index, middle and little.
5129	Thumb, index, ring and little.
5130	Thumb, middle, ring and little.
5131	Index, middle, ring and little.
	Three digits of one hand, amputation of:
5132	Thumb, index and middle.
5133	Thumb, index and ring.
5134	Thumb, index and little.
5135	Thumb, middle and ring.
5136	Thumb, middle and little.
5137	Thumb, ring and little.
5138	Index, middle and ring.
5139	Index, middle and little.
5140	Index, ring and little.
5141	Middle, ring and little.
	Two digits of one hand, amputation of:
5142	Thumb and index.
5143	Thumb and middle.
5144	Thumb and ring.
5145	Thumb and little.
5146	Index and middle.
5147	Index and ring.
5148	Index and little.
5149	Middle and ring.
5150	Middle and little.
5151	Ring and little.
5152	Thumb, amputation of.
5153	Index finger, amputation of.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
5154	Middle finger, amputation of.
5155	Ring finger, amputation of.
5156	Little finger, amputation of.

AMPUTATIONS: LOWER EXTREMITY

	Thigh, amputation of:
5160	Disarticulation.
5161	Upper third.
5162	Middle or lower thirds.
	Leg, amputation of:
5163	With defective stump.
5164	With loss of natural knee action.
5165	At a lower level.
5166	Forefoot, amputation proximal to metatarsal bones.
5167	Foot, loss of use of.
5170	Toes, all, amputation of, without metatarsal loss.
5171	Toe, great, amputation of.
5172	Toe, other, amputation of.
5173	Toes, three or more, amputation of, not including great toe.

THE SHOULDER AND ARM

5200	Scapulohumeral articulation, ankylosis of.
5201	Arm, limitation of motion of.
5202	Humerus, other impairment of.
5203	Clavicle or scapula, impairment of.

THE ELBOW AND FOREARM

5205	Elbow, ankylosis of.
5206	Forearm, limitation of flexion of.
5207	Forearm, limitation of extension of
5208	Forearm, flexion limited to 100° and extension to 45°.
5209	Elbow, other impairment of.
5210	Radius and ulna, nonunion of, with flail false joint.
5211	Ulna, impairment of.
5212	Radius, impairment of.
5213	Supination and pronation, impairment of.

THE WRIST AND HAND

5214	Wrist, ankylosis.
5215	Wrist, limitation of motion of.
5216	Five digits of one hand, unfavorable ankylosis of.
5217	Four digits of one hand, unfavorable ankylosis of.
5218	Three digits of one hand, unfavorable ankylosis of.
5219	Two digits of one hand, unfavorable ankylosis of.
5220	Five digits of one hand, favorable ankylosis of.
5221	Four digits of one hand, favorable ankylosis of.
5222	Three digits of one hand, favorable ankylosis of.
5223	Two digits of one hand, favorable ankylosis of.
5224	Thumb, ankylosis of.
5225	Index finger, ankylosis of.
5226	Middle finger, ankylosis of.
5227	Finger, any other, ankylosis of.

THE HIP AND THIGH

5250	Hip, ankylosis of.
5251	Thigh, limitation of extension of.
5252	Thigh, limitation of flexion of.
5253	Thigh, impairment of.
5254	Hip, flail joint.
5255	Femur, impairment of.

THE KNEE AND LEG

5256	Knee, ankylosis of.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
5257	Knee, other impairment of.
5258	Cartilage, semilunar, dislocated.
5259	Cartilage, semilunar, removal of.
5260	Leg, limitation of flexion of.
5261	Leg, limitation of extension of.
5262	Tibia and fibula, impairment of.
5263	Genu recurvatum.

THE ANKLE

5270	Ankle, ankylosis of.
5271	Ankle, limited motion of.
5272	Subastragalar or tarsal joint, ankylosis of.
5273	Os calcis or astragalus, malunion of.
5274	Astragalectomy.

SHORTENING OF THE LOWER EXTREMITY

5275	Bones, of the lower extremity, shortening of.

THE FOOT

5276	Flatfoot, acquired.
5277	Weak foot, bilateral.
5278	Claw foot (pes cavus), acquired.
5279	Metatarsalgia, anterior (Morton's disease).
5280	Hallux valgus.
5281	Hallux rigidus.
5282	Hammer toe.
5283	Tarsal, or metatarsal bones, malunion of, or nonunion of.
5284	Foot injuries, other.

THE SPINE

5285	Vertebra, fracture of, residuals.
5286	Spine, complete bony fixation (ankylosis) of.
5287	Spine, ankylosis of, cervical.
5288	Spine, ankylosis of, dorsal.
5289	Spine, ankylosis of, lumbar.
5290	Spine, limitation of motion of, cervical.
5291	Spine, limitation of motion of, dorsal.
5292	Spine, limitation of motion of, lumbar.
5293	Intervertebral disc syndrome.
5294	Sacroiliac injury and weakness.
5295	Lumbosacral strain.

THE SKULL

5296	Skull, loss of part of, both inner and outer tables.

THE RIBS

5297	Ribs, removal of.

THE COCCYX

5298	Coccyx, removal of.

MUSCLE INJURIES

5301	Group I—Extrinsic muscles of shoulder girdle.
5302	Group II—Extrinsic muscles of shoulder girdle.
5303	Group III—Intrinsic muscles of shoulder girdle.
5304	Group IV—Intrinsic muscles of shoulder girdle.
5305	Group V—Flexor muscles of the elbow.
5306	Group VI—Extensor muscles of the elbow.
5307	Group VII—Muscles arising from internal condyle of humerus.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
5308	Group VIII—Muscles arising mainly from external condyle of humerus.
5309	Group IX—Intrinsic muscles of the hand.
5310	Group X—Intrinsic muscles of the foot.
5311	Group XI—Posterior and lateral muscles of the leg.
5312	Group XII—Anterior muscles of the leg.
5313	Group XIII—Posterior thigh group.
5314	Group XIV—Anterior thigh group.
5315	Group XV—Mesial thigh group.
5316	Group XVI—Pelvic girdle group 1.
5317	Group XVII—Pelvic girdle group 2.
5318	Group XVIII—Pelvic girdle group 3.
5319	Group XIX—Muscles of the abdominal wall.
5320	Group XX—Spinal muscles.
5321	Group XXI—Muscles of respiration.
5322	Group XXII—Lateral, supra and infrahyoid group.
5323	Group XXIII—Lateral and posterior muscles of the neck.
5324	Diaphragm, rupture of.
5325	Muscle injury, facial muscles.
5326	Muscle hernia.

DISEASES OF THE EYE

6000	Uveitis.
6001	Keratitis.
6002	Scleritis.
6003	Iritis.
6004	Cyclitis.
6005	Choroiditis.
6006	Retinitis.
6007	Hemorrhage, intra-ocular, recent.
6008	Retina, detachment of.
6009	Eye, injury of, unhealed.
6010	Eye, tuberculosis of.
6011	Retina, localized scars.
6012	Glaucoma, congestive or inflammatory.
6013	Glaucoma, simple, primary, noncongestive.
6014	New growths, malignant, eyeball.
6015	New growths, benign, eyeball and adnexa.
6016	Nystagmus, central.
6017	Conjunctivitis, trachomatous, chronic.
6018	Conjunctivitis, other, chronic.
6019	Ptosis, eyelids.
6020	Ectropion.
6021	Entropion.
6022	Lagophthalmos.
6023	Eyebrows, loss of.
6024	Eyelashes, loss of.
6025	Epiphora.
6026	Neuritis, optic.
6027	Cataract, traumatic.
6028	Cataract, senile, and others.
6029	Aphakia.
6030	Accommodation, paralysis of.
6031	Dacryocystitis.
6032	Eyelids, loss of portion of.
6033	Lens, crystalline, dislocation of.
6034	Pterygium.

COMBINATIONS OF DISABILITIES

6050	Blindness in both eyes having only light perception and anatomical loss of both hands and both feet.
6051	Blindness in both eyes having only light perception and loss of use of both hands and both feet.
6052	Blindness in both eyes having only light perception and anatomical loss of both hands.
6053	Blindness in both eyes having only light perception and anatomical loss of both feet.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
6054	Blindness in both eyes having only light perception and anatomical loss of one hand and one foot.
6055	Blindness in both eyes having only light perception and loss of use of both hands.
6056	Blindness in both eyes having only light perception and loss of use of both feet.
6057	Blindness in both eyes having only light perception and loss of use of one hand and one foot.
6058	Blindness in both eyes having only light perception and anatomical loss of one hand.
6059	Blindness in both eyes having only light perception and anatomical loss of one foot.
6060	Blindness in both eyes having only light perception and loss of use of one hand.
6061	Blindness in both eyes having only light perception and loss of use of one foot.
6062	Blindness in both eyes having only light perception.

IMPAIRMENT OF CENTRAL VISUAL ACUITY

	Blindness, anatomical loss, one eye:
6063	Other blind (5/200 or less).
6064	Other impaired (20/200 or less).
6065	Other impaired.
6066	Other normal.
	Blindness, light perception only one eye:
6067	Other blind (5/200 or less).
6068	Other impaired (20/200 or less).
6069	Other impaired.
6070	Other normal.
	Blindness, total (5/200 or less):
6071	Both eyes.
	Blindness, total one eye (5/200 or less):
6072	Other impaired (20/200 or less).
6073	Other impaired.
6074	Other normal.
	Blindness, partial (20/200 or less):
6075	Both eyes.
....	One eye:
6076	Other impaired.
6077	Other normal.
	Blindness, partial:
6078	Both eyes.
6079	One eye only.
6080	Field vision, impairment of.
6081	Scotoma, pathological.
6090	Muscle function, ocular, impairment of.
6091	Symblepharon.
6092	Diplopia, due to limited muscle function.

IMPAIRMENT OF AUDITORY ACUITY

6100	0% evaluation based on Table VII
6101	10% evaluation based on Table VII
6102	20% evaluation based on Table VII
6103	30% evaluation based on Table VII
6104	40% evaluation based on Table VII
6105	50% evaluation based on Table VII
6106	60% evaluation based on Table VII
6107	70% evaluation based on Table VII
6108	80% evaluation based on Table VII
6109	90% evaluation based on Table VII
6110	100% evaluation based on Table VII.

DISEASES OF THE EAR

6200	Otitis media, suppurative, chronic.
6201	Otitis media, catarrhal, chronic.
6202	Otosclerosis.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
6203	Otitis interna.
6204	Labyrinthitis.
6205	Meniere's syndrome.
6206	Mastoiditis.
6207	Auricle, loss or deformity.
6208	New growths, malignant, ear.
6209	New growths, benign, ear.
6210	Auditory canal, disease of.
6211	Tympanic membrane, perforation of.
6260	Tinnitus.
	OTHER SENSE ORGANS
6275	Smell, loss of sense of.
6276	Taste, loss of sense of.
	SYSTEMIC DISEASES
6300	Cholera, Asiatic.
6301	Kala-azar (visceral leishmaniasis).
6302	Leprosy.
6304	Malaria.
6305	Filariasis.
6306	Oroya fever.
6307	Plague.
6308	Relapsing fever.
6309	Rheumatic fever.
6310	Syphilis, unspecified.
6311	Tuberculosis, military.
6313	Avitaminosis.
6314	Beriberi.
6315	Pellagra.
6316	Brucellosis (Malta or undulant fever).
6317	Typhus, scrub.
6350	Lupus erythematosus, systemic.
	RESPIRATORY SYSTEM
	THE NOSE AND THROAT
6501	Rhinitis, atrophic, chronic.
6502	Septum, nasal, deflection of.
6504	Nose, loss of part of, or scars.
6510	Sinusitis, pansinusitis, chronic.
6511	Sinusitis, ethmoid, chronic.
6512	Sinusitis, frontal, chronic.
6513	Sinusitis, maxillary, chronic.
6514	Sinusitis, sphenoid, chronic.
6515	Laryngitis, tuberculous.
6516	Laryngitis, chronic.
6517	Larynx, injuries of, healed.
6518	Laryngectomy.
6519	Aphonia, organic.
6520	Larynx, stenosis of.
	THE TRACHEA AND BRONCHI
6600	Bronchitis, chronic.
6601	Bronchiectasis.
6602	Asthma, bronchial.
	THE LUNGS AND PLEURA
6701	Tuberculosis, pulmonary, chronic, far advanced, active.
6702	Tuberculosis, pulmonary, chronic, moderately advanced, active.
6703	Tuberculosis, pulmonary, chronic, minimal, active.
6704	Tuberculosis, pulmonary, chronic, active, advancement unspecified.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
6707	Tuberculosis, pulmonary, chronic, far advanced, active.
6708	Tuberculosis, pulmonary, chronic, moderately advanced, active.
6709	Tuberculosis, pulmonary, chronic, minimal, active.
6710	Tuberculosis, pulmonary, chronic, active, advancement unspecified.
6721	Tuberculosis, pulmonary, chronic, far advanced, inactive.
6722	Tuberculosis, pulmonary, chronic, moderately advanced, inactive.
6723	Tuberculosis, pulmonary, chronic, minimal, inactive.
6724	Tuberculosis, pulmonary, chronic, inactive, advancement unspecified.
6725	Tuberculosis, pulmonary, chronic, far advanced, inactive.
6726	Tuberculosis, pulmonary, chronic, moderately advanced, inactive.
6727	Tuberculosis, pulmonary, chronic, minimal, inactive.
6728	Tuberculosis, pulmonary, chronic, inactive, advancement unspecified.
6732	Pleurisy, tuberculous.
6800	Anthracosis.
6801	Silicosis.
6802	Pneumoconiosis, unspecified.
6803	Actinomycosis of lung.
6804	Streptotrichosis of lung.
6805	Blastomycosis of lung.
6806	Sporotrichosis of lung.
6807	Aspergillosis of lung.
6808	Mycosis of lung, unspecified.
6809	Lung, abscess of.
6810	Pleurisy, serofibrinous.
6811	Pleurisy, purulent (empyema).
6812	Fistula, bronchocutaneous, or bronchopleural.
6813	Lung, permanent collapse of.
6814	Pneumothorax, spontaneous.
6815	Pneumonectomy.
6816	Lobectomy.
6817	Lung, chronic passive congestion of.
6818	Pleural cavity, injuries, residuals of, including gunshot wounds.
6819	New growths, malignant, any specified part of respiratory system.
6820	New growths, benign, any specified part of respiratory system.
6821	Coccidioidomycosis.
	THE CARDIOVASCULAR SYSTEM
	THE HEART
7000	Rheumatic heart disease.
7001	Endocarditis, bacterial, subacute.
7002	Pericarditis, bacterial or rheumatic, acute.
7003	Adhesions, pericardial.
7004	Syphilitic heart disease.
7005	Arteriosclerotic heart disease.
7006	Myocardium, infarction of, due to thrombosis or embolism.
7007	Hypertensive heart disease.
7008	Hyperthyroid heart disease.
7010	Auricular flutter, paroxysmal.
7011	Auricular fibrillation, paroxysmal.
7012	Auricular fibrillation, permanent.
7013	Tachycardia, paroxysmal.
7014	Sinus tachycardia.
7015	Auriculoventricular block.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
	THE ARTERIES AND VEINS
7100	Arteriosclerosis, general.
7101	Hypertensive vascular disease (essential arterial hypertension).
7110	Aorta or branches, aneurysm of.
7111	Artery, any large artery, aneurysm of.
7112	Artery, small aneurysmal dilatation.
7113	Arteriovenous aneurysm, traumatic.
7114	Arteriosclerosis obliterans.
7115	Thrombo-angiitis obliterans (Buerger's disease).
7116	Claudication, intermittent.
7117	Raynaud's disease.
7118	Angioneurotic edema.
7119	Erythromelalgia.
7120	Varicose veins.
7121	Phlebitis.
7122	Frozen feet, residuals of (Immersion foot).
	THE DIGESTIVE SYSTEM
7200	Mouth, injuries of.
7201	Lips, injuries of.
7202	Tongue, loss of, whole or part.
7203	Esophagus, stricture of.
7204	Esophagus, spasm of (cardiospasm).
7205	Esophagus, diverticulum of, acquired.
7301	Peritoneum, adhesions of.
7304	Ulcer, gastric.
7305	Ulcer, duodenal.
7306	Ulcer, marginal (gastrojejunal).
7307	Gastritis, hypertrophic.
7308	Postgastrectomy syndromes.
7309	Stomach, stenosis of.
7310	Stomach, injury of, residuals.
7311	Liver, injury of.
7312	Liver, cirrhosis of.
7313	Liver, abscess of, residuals.
7314	Cholecystitis, chronic.
7315	Cholelithiasis, chronic.
7316	Cholangitis, chronic.
7317	Gall bladder, injury of.
7318	Gall bladder, removal of.
7319	Irritable colon syndrome (spastic colitis, mucous colitis, etc.).
7321	Amebiasis.
7322	Dysentery, bacillary.
7323	Colitis, ulcerative.
7324	Distomiasis, intestinal or hepatic.
7325	Enteritis, chronic.
7326	Enterocolitis, chronic.
7327	Diverticulitis.
7328	Intestine, small, resection of.
7329	Intestine, large, resection of.
7330	Intestine, fistula of.
7331	Peritonitis, tuberculous, active.
7332	Rectum and anus, impairment of sphincter control.
7333	Rectum and anus, stricture of.
7334	Rectum, persistent prolapse of.
7335	Ano, fistula in.
7336	Hemorrhoids, external or internal.
7337	Pruritus ani.
7338	Hernia, inguinal.
7339	Hernia, ventral.
7340	Hernia, femoral.
7341	Wounds, incised, healed, abdominal wall.
7342	Visceroptosis.
7343	New growths, malignant, any specified part of digestive system.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
7344	New growths, benign, any specified part of digestive system.
7345	Hepatitis, infectious.
7346	Hernia, hiatal.
	THE GENITOURINARY SYSTEM
7500	Kidney, removal of.
7501	Kidney, abscess of.
7502	Nephritis, chronic.
7503	Pyelitis.
7504	Pyelonephritis, chronic.
7505	Kidney, tuberculosis of, active.
7507	Nephrosclerosis, arteriolar.
7508	Nephrolithiasis.
7509	Hydronephrosis.
7510	Ureterolithiasis.
7511	Ureter, stricture of.
7512	Cystitis, chronic.
7513	Cystitis, interstitial (Hunner), submucous or elusive ulcer.
7514	Bladder, tuberculosis of.
7515	Bladder, calculus in.
7516	Bladder, fistula of.
7517	Bladder, injury of.
7518	Urethra, stricture of.
7519	Urethra, fistula of.
7520	Penis, removal of half or more.
7521	Penis, removal of glans.
7522	Penis, deformity, with loss of erectile power.
7523	Testis, atrophy, complete.
7524	Testis, removal of.
7525	Epididymo-orchitis (tuberculous).
7526	Prostate gland, resection or removal.
7527	Prostate gland injuries, infectious hypertrophy, postoperative residuals.
7528	New growths, malignant, any specified part of genitourinary system.
7529	New growths, benign, any specified part of genitourinary system.
	GYNECOLOGICAL CONDITIONS
7610	Vulvovaginitis.
7611	Vaginitis.
7612	Cervicitis.
7613	Metritis.
7614	Salpingitis.
7615	Oophoritis.
7617	Uterus and ovaries, removal of, complete.
7618	Uterus, removal of, including corpus.
7619	Ovaries, removal of.
7620	Ovaries, atrophy of both.
7621	Uterus, prolapse.
7622	Uterus, displacement of.
7623	Pregnancy, surgical complications of.
7624	Fistula, rectovaginal.
7625	Fistula, urethrovaginal.
7626	Mammary glands, removal of.
7627	New growth, malignant, gynecological system, or mammary glands.
	THE HEMIC AND LYMPHATIC SYSTEMS
7700	Anemia, pernicious.
7701	Anemia, secondary.
7702	Agranulocytosis, acute.
7703	Leukemia.
7704	Polycythemia, primary.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
7705	Purpura hemorrhagica.
7706	Splenectomy.
7707	Spleen, injury of, healed.
7709	Lymphogranulomatosis (Hodgkin's disease).
7710	Adenitis, cervical, tuberculous.
7711	Adenitis, axillary, tuberculous.
7712	Adenitis, inguinal, tuberculous.
7713	Adenitis, secondary.

THE SKIN

7800	Scars, disfiguring, head, face or neck.
7801	Scars, burns, third degree.
7802	Scars, burns, second degree.
7803	Scars, superficial, poorly nourished.
7804	Scars, superficial, tender and painful.
7805	Scars, others.
7806	Eczema.
7807	Leishmaniasis, americana (mucocutaneous, espundia).
7808	Leishmaniasis, old world (cutaneous, oriental sore).
7809	Lupus erythematosus, discoid.
7810	Pinta.
7811	Tuberculosis luposa (lupus vulgaris).
7812	Verruga peruana.
7813	Dermatophytosis.
7814	Tinea barbae.
7815	Pemphigus.
7816	Psoriasis.
7817	Dermatitis exfoliativa.
7818	New growths, malignant, skin.
7819	New growths, benign, skin.

THE ENDOCRINE SYSTEM

7900	Hyperthyroidism.
7901	Thyroid gland, toxic adenoma of.
7902	Thyroid gland, non-toxic adenoma of.
7903	Hypothyroidism.
7904	Hyperparathyroidism (osteitis fibrosa cystica).
7905	Hypoparathyroidism.
7907	Hyperpituitarism (pituitary basophilism, Cushing's syndrome).
7908	Hyperpituitarism (acromegaly or gigantism).
7909	Hypopituitarism (diabetes inspidus).
7910	Hyperadrenia (adrenogenital syndrome).
7911	Addison's disease.
7912	Pluriglandular syndromes.
7913	Diabetes mellitus.
7914	New growths, malignant, endocrine system.
7915	New growths, benign, endocrine system.

NEUROLOGICAL CONDITIONS AND CONVULSIVE DISORDERS

8000	Encephalitis, epidemic, chronic.
	Brain, new growth of:
8002	Malignant.
8003	Benign.
8004	Paralysis agitans.
8005	Bulbar palsy.
8007	Brain, vessels, embolism of.
8008	Brain, vessels, thrombosis of.
8009	Brain, vessels, hemorrhage from.
8010	Myelitis.
8011	Poliomyelitis, anterior.
8012	Hematomyelia.
8013	Syphilis, cerebrospinal.
8014	Syphilis, meningovascular.
8015	Tabes dorsalis.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
8017	Amyotrophic lateral sclerosis.
8018	Multiple sclerosis.
8019	Meningitis, cerebrospinal, epidemic.
8020	Brain, abscess of. Spinal cord, new growths:
8021	Malignant.
8022	Benign.
8023	Progressive muscular atrophy.
8024	Syringomyelia.
8025	Myasthenia gravis.
8045	Brain disease due to trauma.
8046	Cerebral arteriosclerosis.
8100	Migraine.
8103	Tic, convulsive.
8104	Paramyoclonus multiplex (convulsive state, myoclonic type).
8105	Chorea, Sydenham's.
8106	Chorea, Huntington's.
8107	Athetosis, acquired.
8108	Narcolepsy.

THE CRANIAL NERVES

8205	Fifth (trigeminal) cranial nerve, paralysis of.
8207	Seventh (facial) cranial nerve, paralysis of.
8209	Ninth (glossopharyngeal) cranial nerve, paralysis of.
8210	Tenth (pneumogastric, vagus) cranial nerve, paralysis of.
8211	Eleventh (spinal accessory, external branch) cranial nerve, paralysis of.
8212	Twelfth (hypoglossal) cranial nerve, paralysis of.
8305	Fifth (trigeminal) cranial nerve, neuritis.
8307	Seventh (facial) cranial nerve, neuritis.
8309	Ninth (glossopharyngeal) cranial nerve, neuritis.
8310	Tenth (pneumogastric, vagus) cranial nerve, neuritis.
8311	Eleventh (spinal accessory, external branch) cranial nerve, neuritis.
8312	Twelfth (hypoglossal) cranial nerve, neuritis.
8407	Seventh (facial) cranial nerve, neuralgia.
8409	Ninth (glossopharyngeal) cranial nerve, neuralgia.
8410	Tenth (pneumogastric, vagus) cranial nerve, neuralgia.
8411	Eleventh (spinal accessory, external branch) cranial nerve, neuralgia.
8412	Twelfth (hypoglossal) cranial nerve, neuralgia.

PERIPHERAL NERVES: PARALYSIS

8510	Upper radicular group (fifth and sixth cervicals), paralysis of.
8511	Middle radicular group, paralysis of.
8512	Lower radicular group, paralysis of.
8513	All radicular groups, paralysis of.
8514	The musculospiral nerve (radial nerve), paralysis of.
8515	The median nerve, paralysis of.
8516	The ulnar nerve, paralysis of.
8517	Musculocutaneous nerve, paralysis of.
8518	Circumflex nerve, paralysis of.
8519	Long thoracic nerve, paralysis of.
8520	The sciatic nerve, paralysis of.
8521	External popliteal nerve (common peroneal), paralysis of.
8522	Musculocutaneous nerve (superficial peroneal), paralysis of.
8523	Anterior tibial nerve (deep peroneal), paralysis of.
8524	Internal popliteal nerve (tibial), paralysis of.
8525	Posterior tibial nerve, paralysis of.
8526	Anterior crural nerve (femoral), paralysis of.
8527	Internal saphenous nerve, paralysis of.
8528	Obturator nerve, paralysis of.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
8529	External cutaneous nerve of thigh, paralysis of.
8530	Ilio-inguinal nerve, paralysis of.
	PERIPHERAL NERVES: NEURITIS
8610	Upper radicular group (fifth and sixth cervicals), neuritis.
8611	Middle radicular group, neuritis.
8612	Lower radicular group, neuritis.
8613	All radicular groups, neuritis.
8614	The musculospiral nerve (radial nerve), neuritis.
8615	The median nerve, neuritis.
8616	The ulnar nerve, neuritis.
8617	Musculocutaneous nerve, neuritis.
8618	Circumflex nerve, neuritis.
8619	Long thoracic nerve, neuritis.
8620	The sciatic nerve, neuritis.
8621	External popliteal nerve (common peroneal), neuritis.
8622	Musculocutaneous nerve (superficial peroneal), neuritis.
8623	Anterior tibial nerve (deep peroneal), neuritis.
8624	Internal popliteal nerve (tibial) neuritis.
8625	Posterior tibial nerve, neuritis.
8626	Anterior crural nerve (femoral), neuritis.
8627	Internal saphenous nerve, neuritis.
8628	Obturator nerve, neuritis.
8629	External cutaneous nerve of thigh, neuritis.
8630	Ilio-inguinal nerve, neuritis.
	PERIPHERAL NERVES: NEURALGIA
8710	Upper radicular group (fifth and sixth cervicals), neuralgia.
8711	Middle radicular group, neuralgia.
8712	Lower radicular group, neuralgia.
8713	All radicular groups, neuralgia.
8714	The musculospiral nerve (radial nerve), neuralgia.
8715	The median nerve, neuralgia.
8716	The ulnar nerve, neuralgia.
8717	Musculocutaneous nerve, neuralgia.
8718	Circumflex nerve, neuralgia.
8719	Long thoracic nerve, neuralgia.
8720	The sciatic nerve, neuralgia.
8721	External popliteal nerve (common peroneal), neuralgia.
8722	Musculocutaneous nerve (superficial peroneal), neuralgia.
8723	Anterior tibial nerve (deep peroneal), neuralgia.
8724	Internal popliteal nerve (tibial), neuralgia.
8725	Posterior tibial nerve, neuralgia.
8726	Anterior crural nerve (femoral), neuralgia.
8727	Internal saphenous nerve, neuralgia.
8728	Obturator nerve, neuralgia.
8729	External cutaneous nerve of thigh neuralgia.
8730	Ilio-inguinal nerve, neuralgia.
	THE EPILEPSIES
8910	Epilepsy, grand mal.
8911	Epilepsy, petit mal.
8912	Jacksonian type.
8913	Epilepsy, diencephalic.
8914	Epilepsy, psychomotor.
	PSYCHOTIC DISORDERS
9200	Schizophrenic reaction, simple type.
9201	Schizophrenic reaction, hebephrenic type.
9202	Schizophrenic reaction, catatonic type.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
9203	Schizophrenic reaction, paranoid type.
9204	Schizophrenic reaction, chronic undifferentiated type.
9205	Schizophrenic reaction, other.
9206	Manic depressive reaction.
9207	Psychotic depressive reaction.
9208	Paranoid reaction (specify).
9209	Involutional psychotic reaction.
9210	Psychotic reaction, other.
	ORGANIC BRAIN DISORDERS
9300	Acute brain syndrome (associated with infection, trauma, circulatory disturbance, etc.).
9301	Chronic brain syndrome associated with central nervous system syphilis (all forms).
9302	Chronic brain syndrome associated with intracranial infections other than syphilis.
9303	Chronic brain syndrome associated with intoxication.
9304	Chronic brain syndrome associated with brain trauma.
9305	Chronic brain syndrome associated with cerebral arteriosclerosis.
9306	Chronic brain syndrome associated with circulatory disturbance other than cerebral arteriosclerosis.
9307	Chronic brain syndrome associated with convulsive disorder (idiopathic epilepsy).
9308	Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition.
9309	Chronic brain syndrome associated with intracranial neoplasm.
9310	Chronic brain syndrome associated with diseases of unknown or uncertain cause.
9311	Chronic brain syndrome of unknown cause.
	PSYCHONEUROTIC DISORDERS
9400	Anxiety reaction.
9401	Dissociative reaction.
9402	Conversion reaction.
9403	Phobic reaction.
9404	Obsessive compulsive reaction.
9405	Depressive reaction.
9406	Psychoneurotic reaction, other.
	PSYCHOPHYSIOLOGIC DISORDERS
9500	Psychophysiologic skin reaction.
9501	Psychophysiologic cardiovascular reaction.
9502	Psychophysiologic gastrointestinal reaction.
9503	Psychophysiologic nervous system reaction.
9504	Psychophysiologic reaction, other.
	DENTAL AND ORAL CONDITIONS
9900	Maxilla or mandible, osteomyelitis of.
9901	Mandible, loss of, complete, between angles.
9902	Mandible, loss of approximately one-half.
9903	Mandible, nonunion of.
9904	Mandible, malunion of.
9905	Temporomandibular articulation, limited motion of.
9906	Ramus, loss of whole or part of.
9907	Ramus, loss of less than one-half the substance of, not involving loss of continuity.
9908	Condyloid process, loss of, one or both sides.
9909	Coronoid process, loss of.
9910	Maxilla, loss of whole or part of substance of, nonunion of, or malunion of.
9911	Hard palate, loss of half or more.
9912	Hard palate, loss of less than half of.

[ACUTE, SUBACUTE, OR CHRONIC DISEASES]

Diagnostic Code No.	
9913	Teeth, loss of, due to loss of substance of body of maxilla or mandible.

[29 FR 6718, May 22, 1964, as amended at 34 FR 5064, Mar. 11, 1969, 52 FR 44122, Nov. 18, 1987; 53 FR 24938, July 1, 1988]

APPENDIX C TO PART 4—ALPHABETICAL INDEX OF DISABILITIES

	Diagnostic Code No.
Abscess:	
Brain	8020
Kidney	7501
Liver	7313
Lung	6809
Actinomycosis, lung	6803
Addison's disease	7911
Adenitis, secondary	7713
Adenoma, thyroid:	
Nontoxic	7902
Toxic	7901
Adhesions:	
Pericardial	7003
Peritoneum	7301
Agranulocytosis	7702
Amebiasis	7321
Amputation:	
Arm:	
Disarticulation	5120
Above deltoid	5121
Below deltoid	5122
Feet, both, and hand, one	5103
Feet, both	5107
Finger (digit) individual:	
Thumb	5152
Index	5153
Middle	5154
Ring	5155
Little	5156
Fingers (digits) of one hand:	
Five	5126
Four, thumb, index, middle, ring	5127
Four, thumb, index, middle, little	5128
Four, thumb, index, ring, little	5129
Four, thumb, middle, ring, little	5130
Four, index, middle, ring, little	5131
Three, thumb, index, middle	5132
Three, thumb, index, ring	5133
Three, thumb, index, little	5134
Three, thumb, middle, ring	5135
Three, thumb, middle, little	5136
Three, thumb, ring, little	5137
Three, index, middle, ring	5138
Three, index, middle, little	5139
Three, index, ring, little	5140
Three, middle, ring, little	5141
Two, thumb, index	5142
Two, thumb, middle	5143
Two, thumb, ring	5144
Two, thumb, little	5145
Two, index, middle	5146
Two, index, ring	5147
Two, index, little	5148
Two, middle, ring	5149
Two, middle, little	5150
Two, ring, little	5151
Forearm:	
Above pronator teres	5123
Below pronator teres	5124
Forefoot	5166
Hand, one, and foot, one	5108
Hands, both, and feet, both	5100
Hands, both, and foot, one	5102
Hands, both	5106
Leg:	
With defective stump	5163
With loss of natural knee action	5164
At lower level	5165
Thigh:	
Disarticulation	5160
Upper third	5161
Middle or lower thirds	5162
Toe, great	5171
Toe, other, with removal metatarsal head	5172
Toes, all	5170
Toes, three or more	5173
Anemia:	
Pernicious	7700
Secondary	7701
Aneurysm:	
Aorta or branches	7110
Arteriovenous, traumatic	7113
Artery	7111
Angioneurotic edema	7118
Ankylosis:	
Ankle	5270
Elbow	5205
Finger (digit) individual:	
Thumb	5224
Index	5225
Middle	5226
Other	5227
Fingers (digits) of one hand, unfavorable:	
Five	5216
Four	5217
Three	5218
Two	5219
Hip	5250
Knee	5256
Scapulohumeral	5200
Spine:	
Complete	5286
Cervical	5287
Dorsal	5288
Lumbar	5289
Subastragular or Tarsal	5272
Wrist	5214
Anthracosis	6800
Aphakia	6029
Aphonia, organic	6519
Arteriosclerosis:	
Cerebral	8046
General	7100
Obliterans	7114
Arteriosclerotic heart disease	7005
Arthritis:	
Atrophic (rheumatoid)	5002
Gonorrheal	5004
Hypertrophic (degenerative)	5003
Other types	5009
Pneumococcic	5005
Streptococcic	5008
Syphilitic	5007
Traumatic	5010
Typhoid	5006

	Diagnostic Code No.
Aspergillosis, lung	6807
Asthma, bronchial	6602
Astragalectomy	5274
Athetosis	8107
Atrophy:	
Muscular, progressive	8023
Ovaries, both	7620
Testis, both	7523
Auditory canal, disease	6210
Avitaminosis	6313
Beriberi	6314
Blastomycosis, lung	6805
Blindness, anatomical loss, one eye:	
Other blind (5/200 or less)	6063
Other impaired (20/200 or less)	6064
Other impaired	6065
Other normal	6066
Blindness, light perception only:	
Both eyes	6062
One eye:	
Other blind, 5/200 or less	6067
Other impaired, 20/200 or less	6068
Other impaired	6069
Other normal	6070
Blindness, light perception only and loss or loss of use of hands and/or feet	6050–6061
Blindness, total (5/200 or less):	
Both eyes	6071
One eye:	
Other impaired, (20/200 or less)	6072
Other impaired	6073
Other normal	6074
Blindness, partial (20/200 or less):	
Both eyes	6075
One eye:	
Other impaired	6076
Other normal	6077
Blindness, partial:	
Both eyes	6078
One eye only	6079
Block, auricular ventricular	7015
Bones, Caisson disease of	5011
Bones and joints, tuberculosis of	5001
Bronchiectasis	6601
Bronchitis	6600
Buerger's disease	7115
Brucellosis	6316
Bursitis	5019
Caisson disease	5011
Calculus, bladder	7515
Cataract:	
Senile and others	6028
Traumatic	6027
Cervicitis	7612
Cholangitis	7316
Cholecystitis	7314
Cholelithiasis	7315
Cholera, Asiatic	6300
Chorea:	
Huntington's	8106
Sydenham's	8105
Choroiditis	6005
Claw-foot (pes cavus) acquired	5278
Cirrhosis of liver	7312
Claudication, intermittent	7116
Coccidioidomycosis	6821
Colitis:	
Mucous (See Colon syndrome, irritable)	7319
Spastic (See Colon syndrome, irritable)	7319
Ulcerative	7323
Collapse, lung, permanent	6813
Colon syndrome, irritable	7319
Congestion, lung, passive	6817
Conjunctivitis:	
Trachomatous	6017
Other	6018
Coccyx	5298
Cushing's syndrome	7907
Cyclitis	6004
Cystitis:	
Chronic	7512
Interstitial (Hunner)	7513
Dacryocystitis	6031
Deafness	
0% evaluation based on Table VII	6100
10% evaluation based on Table VII	6101
20% evaluation based on Table VII	6102
30% evaluation based on Table VII	6103
40% evaluation based on Table VII	6104
50% evaluation based on Table VII	6105
60% evaluation based on Table VII	6106
70% evaluation based on Table VII	6107
80% evaluation based on Table VII	6108
90% evaluation based on Table VII	6109
100% evaluation based on Table VII	6110
Deflection, nasal septum	6502
Dermatitis, exfoliativa	7817
Dermatophytosis	7813
Diabetes mellitus	7913
Diabetes insipidus	7909
Diaphragm, rupture	5324
Dilation, aneurysmal artery	7112
Diplopia	6090
Disease:	
Addison's	7911
Hodgkin's	7709
Morton's	5279
Raynaud's	7117
Dislocation:	
Cartilage, semilunar	5258
Lens, crystalline	6033
Disorders, mental:	
Organic brain disorders:	
Acute brain syndrome	9300
Chronic brain syndrome associated with:	
Central nervous system syphilis	9301
Intracranial infections other than syphilis	9302
Intoxication	9303
Brain trauma	9304
Cerebral arteriosclerosis	9305
Circulatory disturbance other than cerebral arteriosclerosis	9306
Convulsive disorder (idiopathic epilepsy)	9307
Disturbance of metabolism, growth or nutrition	9308
Intracranial neoplasm	9309
Diseases of unknown or uncertain cause	9310
Unknown cause	9311
Psychoneurotic disorders:	
Anxiety reaction	9400
Dissociative reaction	9401
Conversion reaction	9402
Phobic reaction	9403
Obsessive compulsive reaction	9404
Depressive reaction	9405
Psychoneurotic reaction, other	9406
Psychophysiologic disorders:	
Psychophysiologic skin reaction	9500
Psychophysiologic cardiovascular reaction	9501

	Diagnostic Code No.
Psychophysiologic gastrointestinal reaction	9502
Psychophysiologic nervous system reaction	9503
Psychophysiologic reaction, other	9504
Psychotic disorders:	
Schizophrenic reaction:	
Simple type	9200
Hebephrenic type	9201
Catatonic type	9202
Paranoid type	9203
Chronic undifferentiated type	9204
Other	9205
Manic depressive reaction	9206
Psychotic depressive reaction	9207
Paranoid reaction	9208
Involutional psychotic reaction	9209
Psychotic reaction, other	9210
Distomiasis, intestinal	7324
Diverticulitis, intestinal	7327
Diverticulum of esophagus	7205
Dupuytren's contracture—*see* Ankylosis, fingers.	
Dysentery, bacillary	7322
Ectropion	6020
Eczema	7806
Edema, angioneurotic	7118
Embolism, brain	8007
Emphysema (No DC; follows DC 6602).	
Encephalitis	8000
Endocarditis, bacterial, subacute	7001
Enteritis	7325
Enterocolitis	7326
Entropion	6021
Enucleation, eye, *see* Blindness.	
Epilepsy:	
Grand mal	8910
Petit mal	8911
Jacksonian	8912
Diencephalic	8913
Psychomotor	8914
Epiphora (lacrymal duct)	6025
Erythromelalgia	7119
Eyelids, loss of portion of	6032
Fever:	
Hemoglobinuric, *see* Malaria.	
Malta	6316
Oroya	6306
Relapsing	6308
Rheumatic	6309
Undulant	6316
Fibrillation, auricular:	
Paroxysmal	7011
Permanent	7012
Filariasis	6305
Fistula:	
Ano	7335
Bladder	7516
Bronchocutaneous or bronchopleural	6812
Intestine	7330
Rectovaginal	7624
Urethra	7625
Flail hip	5254
Flatfoot (pes planus) acquired	5276
Flutter, auricular	7010
Fracture, vertebra, residuals of	5285
Frozen feet	7122
Gastritis, atrophic (*see* DC 7307).	
Gastritis, hypertrophic	7307
Genu, recurvatum	5263
Glaucoma:	
Congestive	6012
Noncongestive	6013

	Diagnostic Code No.
Gout	5017
Growths, new benign:	
Bones, joints and muscles	5015
Brain	8003
Digestive system	7344
Ear	6209
Endocrine system	7915
Eyeball and adnexa	6015
Genitourinary system	7529
Respiratory	6820
Skin	7819
Spinal cord	8022
Growths, new, malignant:	
Bones	5012
Brain	8002
Digestive system	7343
Ear	6208
Endocrine system	7914
Eyeball only	6014
Genitourinary system	7528
Gynecological system or mammary glands	7627
Respiratory	6819
Skin	7818
Spinal cord	8021
Hallux rigidus	5281
Hallux valgus	5280
Hammer toe	5282
Hematomyelia	8012
Hemorrhage:	
Brain	8009
Intraocular	6007
Hemorrhoids	7336
Hepatitis, infectious	7345
Hernia:	
Femoral	7340
Hiatal	7346
Inguinal	7338
Muscle	5326
Ventral	7339
Hodgkin's disease	7709
Hydrarthrosis, intermittent	5018
Hydronephrosis	7509
Hyperadrenia	7910
Hyperparathyroidism	7904
Hyperpituitarism:	
Acromegaly or gigantism	7908
Cushing's syndrome	7907
Hypertensive heart disease	7007
Hypertensive vascular disease	7101
Hyperthyroid heart disease	7008
Hyperthyroidism	7900
Hypoadrenia	7911
Hypoparathyroidism	7905
Hypopituitarism	7909
Hypothyroidism	7903
Immersion foot	7122
Impairment:	
Auditory acuity, *see* Deafness.	
Clavicle	5203
Elbow	5209
Eye (field vision)	6080
Eye (muscle function)	6090
Femur	5255
Humerus	5202
Knee	5257
Radius	5212
Sphincter control	7332
Supination and pronation	5213
Thigh, motion	5253
Tibia and fibula	5262
Ulna	5211
Visual acuity, *see* Blindness.	
Infarction of myocardium	7006

	Diagnostic Code No.
Injury:	
Bladder	7517
Gall bladder	7317
Eye, unhealed	6009
Foot	5284
Larynx	6517
Lips	7201
Liver	7311
Mouth	7200
Muscle:	
Facial	5325
Group I	5301
Group II	5302
Group III	5303
Group IV	5304
Group V	5305
Group VI	5306
Group VII	5307
Group VIII	5308
Group IX	5309
Group X	5310
Group XI	5311
Group XII	5312
Group XIII	5313
Group XIV	5314
Group XV	5315
Group XVI	5316
Group XVII	5317
Group XVIII	5318
Group XIX	5319
Group XX	5320
Group XXI	5321
Group XXII	5322
Group XXIII	5323
Pleural cavity	6818
Prostate	7527
Sacroiliac	5294
Spleen	7707
Stomach, residuals	7310
Tongue, whole or part	7202
Intervertebral disc	5293
Iritis	6003
Kala-azar	6301
Keratitis	6001
Labyrinthitis	6204
Lagophthalmos	6022
Laryngectomy	6518
Laryngitis	6516
Leishmaniasis:	
Americana	7807
Old World	7808
Lens, crystalline, dislocation of	6033
Leprosy	6302
Leukemia	7703
Limitation of extension:	
Forearm	5207
Leg	5261
Thigh	5251
Limitation of field vision	6080
Limitation of flexion:	
Forearm	5206
Leg	5260
Thigh	5252
Limitation of flexion and extension:	
Forearm	5208
Limitation of motion:	
Ankle	5271
Arm	5201
Cervical	5290
Dorsal	5291
Lumbar	5292
Temporomandibular articulation	9905
Wrist	5215
Limitation, pronation	5213
Limitation, supination	5213
Limitation of muscle function, eye	6090
Lobectomy	6816
Loss:	
Auricle or deformity	6207
Condyloid process	9908
Coronoid process	9909
Eyebrows	6023
Eyelashes	6024
Mandible:	
Complete	9901
One-half	9902
Maxilla	9910
Teeth	9913
Nose, loss of part, or scars	6504
Palate, hard:	
Half or more	9911
Less than half	9912
Ramus:	
Less than one-half substance	9907
Whole or part	9906
Skull, part	5296
Smell, sense of	6275
Taste, sense of	6276
Tongue or part	7202
Others, *see* Amputation, removal, etc.	
Loss of use:	
Feet, both	5110
Feet, both, and hand, one	5105
Foot, one	5167
Hand, one	5125
Hand, one, and foot, one	5111
Hands, both, and feet, both	5101
Hands, both, and foot, one	5104
Hands, both	5109
Lupus, erythematosus, discoid	7809
Lupus, erythematosus systemic (disseminated)	6350
Lupus, vulgaris	7811
Lymphogranulomatosis	7709
Malaria	6304
Malunion:	
Clavicle	5203
Os calcis (or astragalus)	5273
Mandible	9904
Maxilla (or nonunion)	9910
Scapula	5203
Tarsal or metatarsal (or nonunion)	5283
Others, *see* Impairment.	
Mastoiditis	6206
Meniere's disease	6205
Meningitis, cerebrospinal	8019
Mental disorders—*see* Disorders, mental.	
Metatarsalgia	5279
Metritis	7613
Migraine	8100
Muscle injury, *see* Injury, muscle.	
Myasthenia gravis	8025
Mycosis, lung, unspecified	6808
Myelitis	8010
Myositis	5021
Myositis ossificans	5023
Narcolepsy	8108
Nephritis, chronic	7502
Nephrolithiasis	7508
Nephrosclerosis, arteriolar	7507
Neuralgia:	
Cranial nerves:	
Fifth (trigeminal)	8405
Seventh (facial)	8407
Ninth (glossopharyngeal)	8409

	Diagnostic Code No.
Tenth (pneumogastric, vagus)	8410
Eleventh (spinal accessory, external branch)	8411
Twelfth (hypoglossal)	8412
Peripheral nerves:	
Upper radicular group	8710
Middle radicular group	8711
Lower radicular group	8712
All radicular groups	8713
Musculospiral	8714
Median	8715
Ulnar	8716
Musculocutaneous	8717
Circumflex	8718
Long thoracic	8719
Sciatic	8720
External popliteal	8721
Musculocutaneous (superficial peroneal)	8722
Anterior tibial	8723
Internal popliteal	8724
Posterior tibial	8725
Anterior crural	8726
Internal saphenous	8727
Obturator	8728
External cutaneous, thigh	8729
Ilio-inguinal	8730
Neuritis, optic	6026
Neuritis:	
Cranial nerves:	
Fifth (trigeminal)	8305
Seventh (facial)	8307
Ninth (glossopharyngeal)	8309
Tenth (pneumogastric, vagus)	8310
Eleventh (spinal accessory, external branch)	8311
Twelfth (hypoglossal)	8312
Peripheral:	
Upper radicular group	8610
Middle radicular group	8611
Lower radicular group	8612
All radicular groups	8613
Musculospiral	8614
Median	8615
Ulnar	8616
Musculocutaneous	8617
Circumflex	8618
Long thoracic	8619
Sciatic	8620
External popliteal	8621
Musculocutaneous (superficial peroneal)	8622
Anterior tibial	8623
Internal popliteal	8624
Posterior tibial	8625
Anterior crural	8626
Internal saphenous	8627
Obturator	8628
External cutaneous, thigh	8629
Ilio-inguinal	8630
Non-union of bones:	
Mandible	9903
Radius and Ulna	5210
Tibia and fibula	5262
Others, *see* Impairment.	
Nystagmus, central	6016
Oophoritis	7615
Oroya fever	6306
Osteitis deformans	5016
Osteomalacia	5014
Osteomyelitis, jaw	9900
Osteomyelitis	5000
Osteoporosis	5013
Otitis externa	6210
Otitis interna	6203
Otitis media:	
Catarrhal	6201
Suppurative	6200
Otosclerosis	6202
Palsy, bulbar	8005
Paralysis:	
Accommodation	6030
Agitans	8004
Paralysis, nerve:	
Cranial:	
Fifth (trigeminal)	8205
Seventh (facial)	8207
Ninth (glossopharyngeal)	8209
Tenth (pneumogastric, vagus)	8210
Eleventh (spiral accessory, external branch)	8211
Twelfth (hypoglossal)	8212
Peripheral:	
Upper radicular group	8510
Middle radicular group	8511
Lower radicular group	8512
All radicular groups	8513
Musculospiral	8514
Median	8515
Ulnar	8516
Musculocutaneous	8517
Circumflex	8518
Long thoracic	8519
Sciatic	8520
External popliteal	8521
Musculocutaneous (superficial peroneal)	8522
Anterior tibial	8523
Internal popliteal	8524
Posterior tibial	8525
Anterior crural	8526
Internal saphenous	8527
Obturator	8528
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Testis	7524
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Active:	
Far advanced	6701 & 6707
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Advancement unspecified	6704 & 6710
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	Diagnostic Code No.
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[29 FR 6718, May 22, 1964, as amended at 34 FR 5064, Mar. 11, 1969; 52 FR 44122, Nov. 18, 1987; 53 FR 24938, July 1, 1988]

PART 5 [RESERVED]

PART 6—UNITED STATES GOVERNMENT LIFE INSURANCE

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AUTHORITY: 38 U.S.C. 501, 1940–1963, 1981–1988, unless otherwise noted.

AGE

§ 6.1 Misstatement of age.

If the age of the insured under a United States Government life insurance policy has been understated, the amount of the insurance payable under the policy shall be such exact amount as the premium paid would have purchased at the correct age; if overstated, the excess of premiums paid shall be refunded without interest. Guaranteed surrender and loan values will be modified accordingly. The age of the insured will be admitted by the Department of Veterans Affairs at any time upon satisfactory proof.

[13 FR 7089, Nov. 27, 1948. Redesignated at 61 FR 29024, June 7, 1996]

PREMIUMS

§ 6.2 Premium rate.

Effective January 1, 1983, United States Government Life Insurance policies, and total disability income provisions, on a premium paying status are paid-up and no premiums are required to maintain such policies and provisions in force.

[48 FR 1960, Jan. 17, 1983. Redesignated and amended at 61 FR 29024, 29025, June 7, 1996]

POLICIES

§ 6.3 Incontestability of United States Government life insurance.

Discharge or release of an insured from military or naval service for the reason of fraudulent enlistment shall not invalidate United States Government life insurance issued on the basis