sought in the claim under review based on a difference of opinion (see §3.105(b)). However, any finding favorable to the claimant is binding except as provided in §3.104(c) of this part. In addition, the higher-level adjudicator will not revise the outcome in a manner that is less advantageous to the claimant based solely on a difference of opinion. The higher-level adjudicator may reverse or revise (even if disadvantageous to the claimant) prior decisions by VA (including the decision being reviewed or any prior decision) on the grounds of clear and unmistakable error under §3.105(a)(1) or (a)(2), as applicable, depending on whether the prior decision is finally adjudicated.

(k) *Notice requirements.* Notice of a decision made under this section will include all of the elements described in §3.103(f), a general statement indicating whether evidence submitted while the record was closed was not considered, and notice of the options available to have such evidence considered.

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

[84 FR 173, Jan. 18, 2019]

PART 4—SCHEDULE FOR RATING DISABILITIES

Subpart A—General Policy in Rating

Sec.

Subpart B—Disability Ratings

THE MUSCULOSKELETAL SYSTEM

THE ORGANS OF SPECIAL SENSE

IMPAIRMENT OF AUDITORY ACUITY

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 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; 79 FR 2100, Jan. 13, 2014]

§ 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 Veterans Service Center Manager or the Pension Management Center Manager 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; 71 FR 28586, May 17, 2006; 74 FR 26959, June 5, 2009]

§ 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 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, as amended at 79 FR 2100, Jan. 13, 2014]

§ 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
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

TABLE I—COMBINED RATINGS TABLE—Continued

[10 combined with 10 is 19]

	10	20	30	40	50	60	70	80	90
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	97	98	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; 83 FR 17756, Apr. 24, 2018]

§ 4.26 Bilateral factor.

Except as provided in paragraph (d) of this section, 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 one 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 (with the two 10 percent evaluations being 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 combine to 74 percent, converted to 70 percent as the final degree of disability.

(a) *Definitions.* 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) *Procedure for four affected extremities.* 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)*Applicability.* The bilateral factor is not applicable unless there is partial disability of compensable degree in each of 2 paired extremities, or paired skeletal muscles.

(d) *Exception.* In cases where the combined evaluation is lower than what could be achieved by not including one or more bilateral disabilities in the bilateral factor calculation, those bilateral disabilities will be removed from the bilateral factor calculation and combined separately, to achieve the combined evaluation most favorable to the veteran.

[29 FR 6718, May 22, 1964, as amended at 88 FR 22917, Apr. 14, 2023]

§ 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 ''5002–5240.'' 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, as amended at 70 FR 75399, Dec. 20, 2005]

§ 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 Veterans Service Center Manager.

(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 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; 71 FR 28586, May 17, 2006; 79 FR 2100, Jan. 13, 2014]

§ 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 Veterans Service Center Manager.

[41 FR 34256, Aug. 13, 1976, as amended at 54 FR 4281, Jan. 30, 1989; 71 FR 28586, May 17, 2006]

§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.

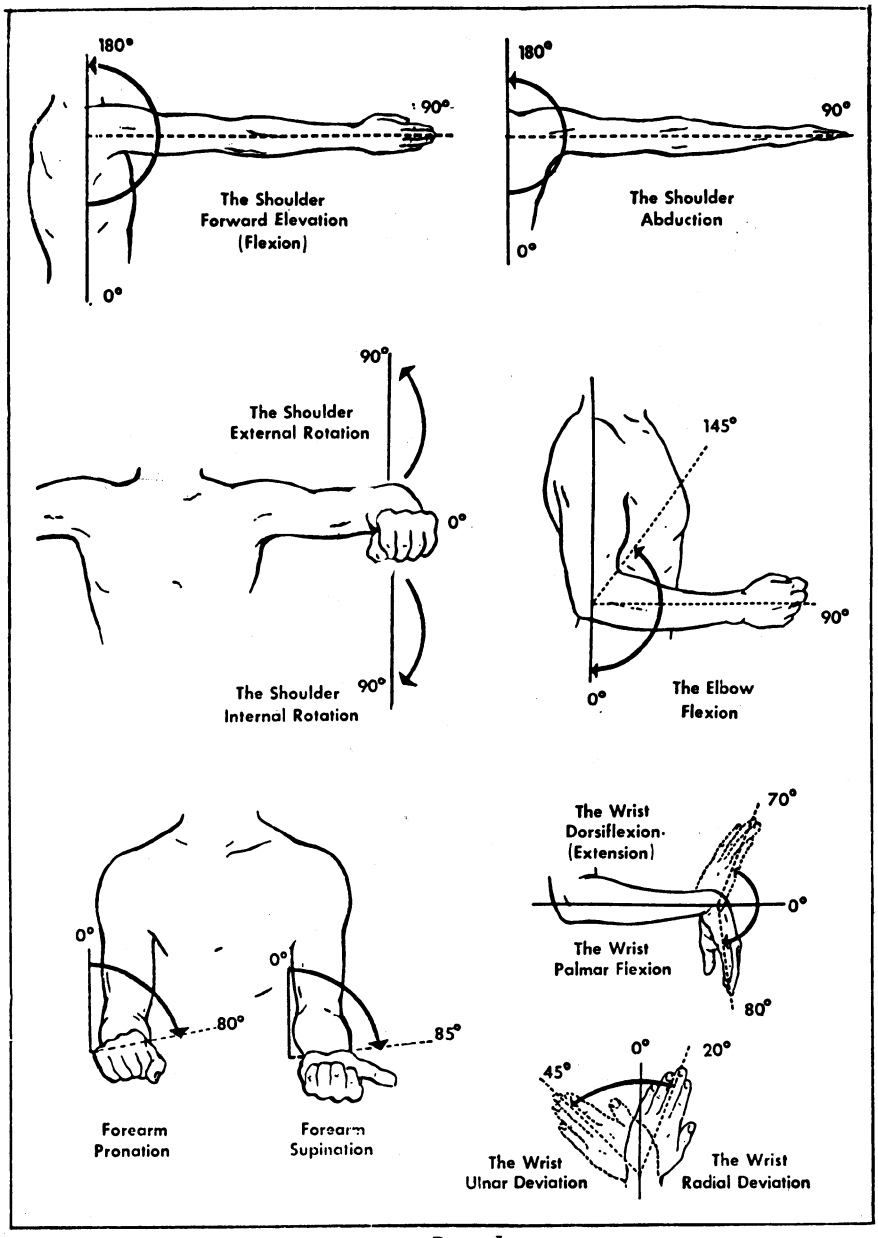

180°
90°
0°
The Shoulder
Forward Elevation
(Flexion)
180°
90°
0°
The Shoulder
Abduction
90°
0°
90°
The Shoulder
External Rotation
The Shoulder
Internal Rotation
145°
90°
0°
The Elbow
Flexion
0°
80°
0°
85°
Forearm
Pronation
Forearm
Supination
The Wrist
Dorsiflexion
(Extension)
70°
0°
The Wrist
Palmar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

PLATE I

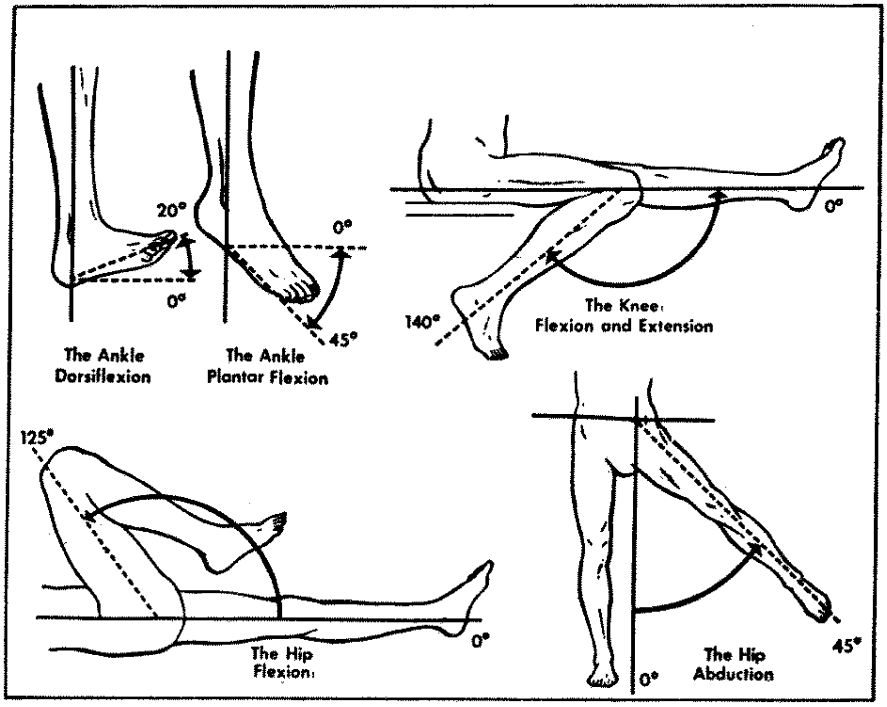


PLATE II

[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 §§ 4.88c and 4.89.	
5002 Multi-joint arthritis (except post-traumatic and gout), 2 or more joints, 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
Note (1): Examples of conditions rated using this diagnostic code include, but are not limited to, rheumatoid arthritis, psoriatic arthritis, and spondyloarthropathies.	
Note (2): For chronic residuals, rate under diagnostic code 5003.	
Note (3): The ratings for the active process will not be combined with the residual ratings for limitation of motion, ankylosis, or diagnostic code 5003. Instead, assign the higher evaluation.	
5003 Degenerative arthritis, other than post-traumatic:	
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 Other specified forms of arthropathy (excluding gout).	
Note (1): Other specified forms of arthropathy include, but are not limited to, Charcot neuropathic, hypertrophic, crystalline, and other autoimmune arthropathies.	
Note (2): With the types of arthritis, diagnostic codes 5004 through 5009, rate the acute phase under diagnostic code 5002; rate any chronic residuals under diagnostic code 5003.	
5010 Post-traumatic arthritis: Rate as limitation of motion, dislocation, or other specified instability under the affected joint. If there are 2 or more joints affected, each rating shall be combined in accordance with § 4.25.	
5011 Decompression illness: Rate manifestations under the appropriate diagnostic code within the affected body system, such as arthritis for musculoskeletal residuals; auditory system for vestibular residuals; respiratory system for pulmonary barotrauma residuals; and neurologic system for cerebrovascular accident residuals.	
5012 Bones, neoplasm, malignant, primary or secondary	100
Note: The 100 percent rating will be continued for 1 year following the cessation of surgical, X-ray, antineoplastic chemotherapy or other prescribed therapeutic procedure. If there has been no local recurrence or metastases, rate based on residuals.	
5013 Osteoporosis, residuals of.	
5014 Osteomalacia, residuals of.	
5015 Bones, neoplasm, benign.	
5016 Osteitis deformans.	
5017 Gout.	
5018 [Removed]	
5019 Bursitis.	
5020 [Removed]	
5021 Myositis.	
5022 [Removed]	
5023 Heterotopic ossification.	
5024 Tenosynovitis, tendinitis, tendinosis or tendinopathy.	

ACUTE, SUBACUTE, OR CHRONIC DISEASES—Continued

	Rating
Note to DCs 5013 through 5024: Evaluate the diseases under diagnostic codes 5013 through 5024 as degenerative arthritis, based on limitation of motion of affected parts.	
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
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 AND RESURFACING

	Rating	
	Major	Minor
Note (1): When an evaluation is assigned for joint resurfacing or the prosthetic replacement of a joint under diagnostic codes 5051–5056, an additional rating under §4.71a may not also be assigned for that joint, unless otherwise directed.		
Note (2): Only evaluate a revision procedure in the same manner as the original procedure under diagnostic codes 5051–5056 if all the original components are replaced.		
Note (3): The term ''prosthetic replacement'' in diagnostic codes 5051–5053 and 5055–5056 means a total replacement of the named joint. However, in DC 5054, ''prosthetic replacement'' means a total replacement of the head of the femur or of the acetabulum.		
Note (4): The 100 percent 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 (5): The 100 percent rating for 4 months following implantation of prosthesis or resurfacing under DCs 5054 and 5055 will commence after initial grant of the 1-month total rating assigned under §4.30 following hospital discharge.		
Note (6): Special monthly compensation is assignable during the 100 percent rating period the earliest date permanent use of crutches is established.		
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
5054 Hip, resurfacing or replacement (prosthesis):		
For 4 months following implantation of prosthesis or resurfacing	.....	100
Prosthetic replacement of the head of the femur or of the acetabulum:		
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 evaluation, total replacement only	.....	30
Note: At the conclusion of the 100 percent evaluation period, evaluate resurfacing under diagnostic codes 5250 through 5255; there is no minimum evaluation for resurfacing.		
5055 Knee, resurfacing or replacement (prosthesis):		
For 4 months following implantation of prosthesis or resurfacing	.....	100

PROSTHETIC IMPLANTS AND RESURFACING—Continued

PROSTHETIC IMPLANTS AND RESURFACING—Continued

	Rating	
	Major	Minor
Prosthetic replacement of knee joint:		
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 evaluation, total replacement only	.....	30
Note: At the conclusion of the 100 percent evaluation period, evaluate resurfacing under diagnostic codes 5256 through 5262; there is no minimum evaluation for resurfacing.		
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

PROSTHETIC IMPLANTS AND RESURFACING—Continued

	Rating	
	Major	Minor
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 Complete amputation, upper extremity:		
Forequarter amputation (involving complete removal of the humerus along with any portion of the scapula, clavicle, and/or ribs)	[1] 100	[1] 100
Disarticulation (involving complete removal of the humerus only)	[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
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..		
(c) Amputations at distal joints, or through distal phalanges, other than negligible losses, will be rated as prescribed for favorable ankylosis of the fingers..		

AMPUTATIONS: UPPER EXTREMITY—Continued

	Rating	
	Major	Minor
(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 appliance.		
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

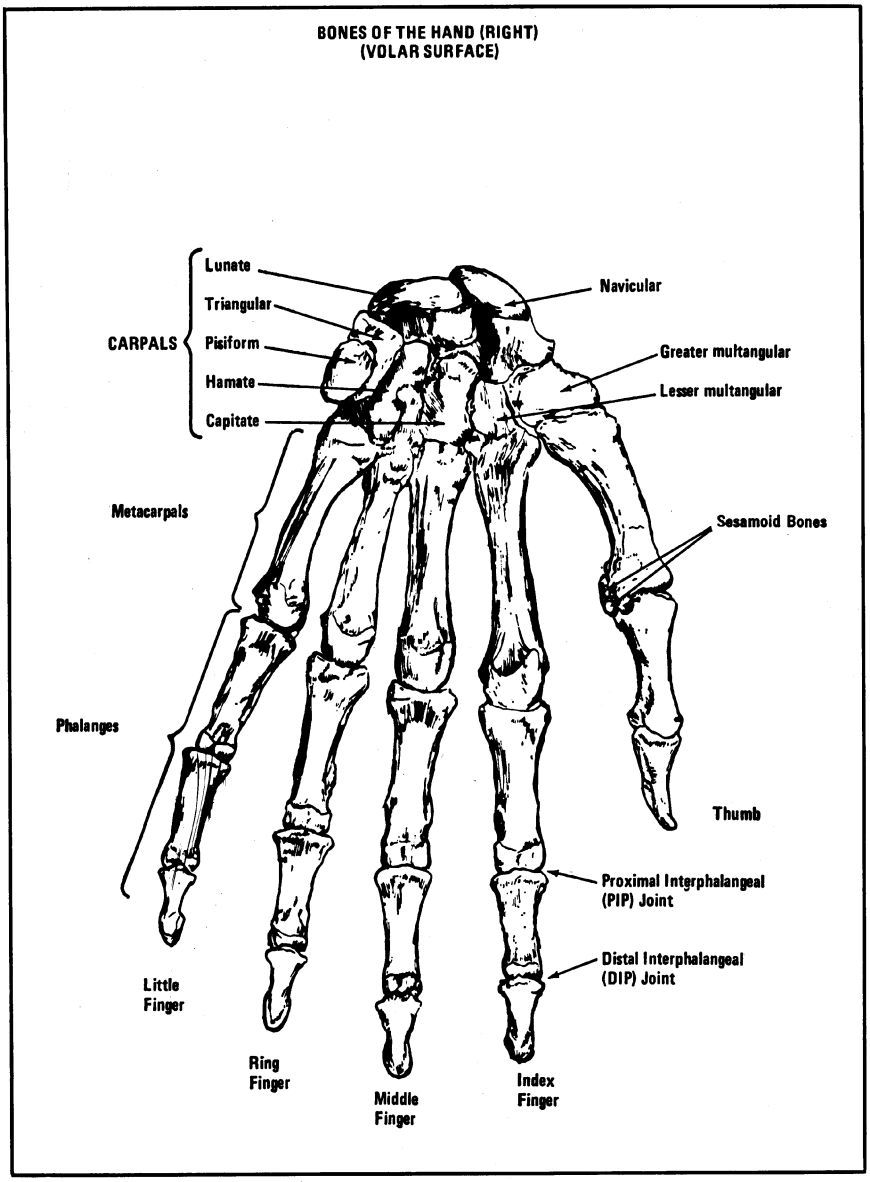


PLATE III

AMPUTATIONS: LOWER EXTREMITY

	Rating
Thigh, amputation of:	

AMPUTATIONS: LOWER EXTREMITY—Continued

	Rating
5160 Complete amputation, lower extremity:	

AMPUTATIONS: LOWER EXTREMITY—Continued

	Rating
Trans-pelvic amputation (involving complete removal of the femur and intrinsic pelvic musculature along with any portion of the pelvic bones)	[2] 100
Disarticulation (involving complete removal of the femur and intrinsic pelvic musculature only)	[2] 90
Note: Separately evaluate residuals involving other body systems (*e.g.,* bowel impairment, bladder impairment) under the appropriate diagnostic code.	
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

AMPUTATIONS: LOWER EXTREMITY—Continued

	Rating
5166 Forefoot, amputation proximal to metatarsal bones (more than one-half of metatarsal loss)	[2] 40
5167 Foot, loss of use of	[2] 40
5170 Toes, all, amputation of, without metatarsal loss or transmetatarsal, amputation of, with up to half of 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

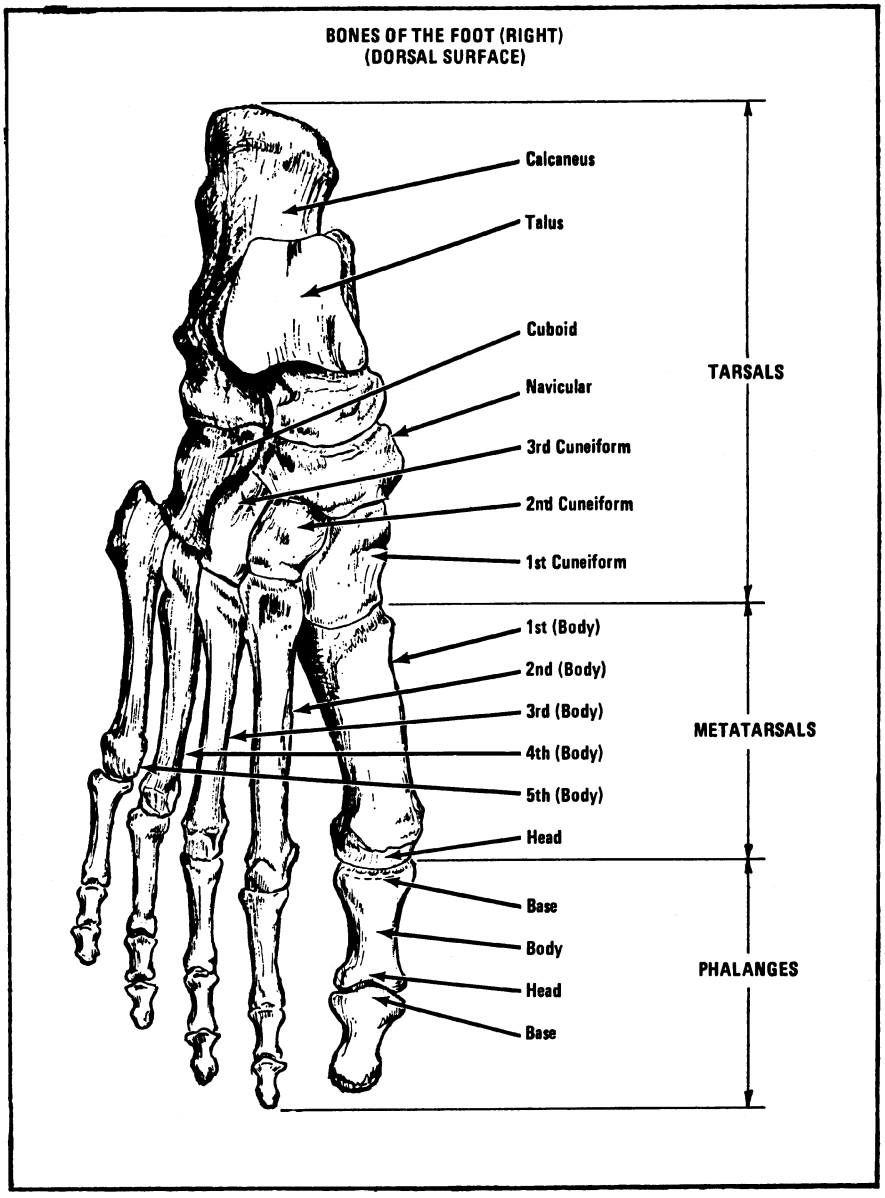


PLATE IV

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:		
Flexion and/or abduction limited to 25° from side	40	30
Midway between side and shoulder level (flexion and/or abduction limited to 45°)	30	20
At shoulder level (flexion and/or abduction limited to 90°)	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 (flexion and/or abduction at 90 °)	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

THE ELBOW AND FOREARM—Continued

	Rating	
	Major	Minor
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
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:		

THE WRIST—Continued

	Rating	
	Major	Minor
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.		

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

	Rating	
	Major	Minor
(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	.....	.....
(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

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.		
5218 Three digits of one hand, unfavorable ankylosis of:		
Thumb and any two fingers	50	40
Index, long, and ring; index, long, and little; or index, ring, and little fingers	40	30
Long, ring, and little fingers	30	20
Note: Also consider whether evaluation as amputation is warranted.		
5219 Two digits of one hand, unfavorable ankylosis of:		
Thumb and any finger	40	30
Index and long; index and ring; or index and little fingers	30	20
Long and ring; long and little; or ring and little fingers	20	20
Note: Also consider whether evaluation as amputation is warranted.		
II. Multiple Digits: Favorable Ankylosis		
5220 Five digits of one hand, favorable ankylosis of	50	40
5221 Four digits of one hand, favorable ankylosis of:		
Thumb and any three fingers	50	40
Index, long, ring, and little fingers	40	30
5222 Three digits of one hand, favorable ankylosis of:		
Thumb and any two fingers	40	30
Index, long, and ring; index, long, and little; or index, ring, and little 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

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.		
5227 Ring or little finger, ankylosis of:		
Unfavorable or favorable	0	0
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
IV. Limitation of Motion of Individual Digits		
5228 Thumb, limitation of motion:		
With a gap of more than two inches (5.1 cm.) between the thumb pad and the fingers, with the 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

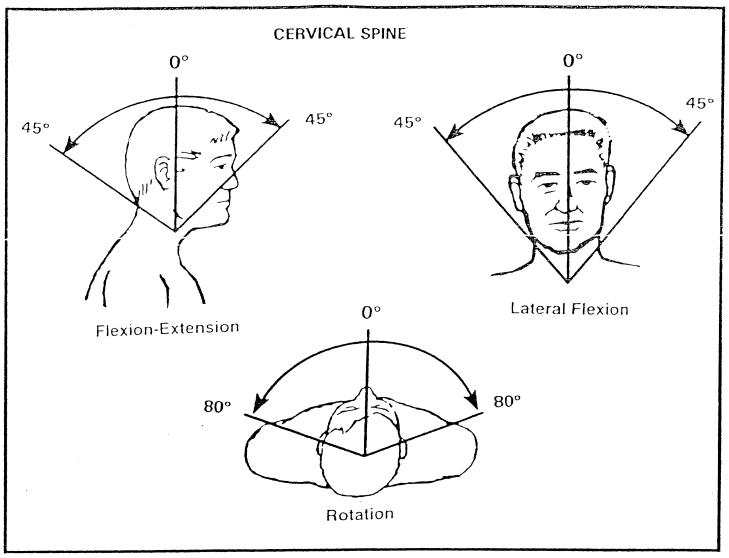
	Rating
General Rating Formula for Diseases and Injuries of the Spine	
(For diagnostic codes 5235 to 5243 unless 5243 is evaluated under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes):	
With or without symptoms such as pain (whther or not it radiates), stiffness, 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
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

	Rating
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, degenerative disc disease other than intervertebral disc syndrome (also, see either DC 5003 or 5010)	
5243 Intervertebral disc syndrome: Assign this diagnostic code only when there is disc herniation with compression and/or irritation of the adjacent nerve root; assign diagnostic code 5242 for all other disc diagnoses.	

THE SPINE—Continued

	Rating
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.	
5244 Traumatic paralysis, complete: Paraplegia: Rate under diagnostic code 5110. Quadriplegia: Rate separately under diagnostic codes 5109 and 5110 and combine evaluations in accordance with §4.25. **Note:** If traumatic paralysis does not cause loss of use of both hands or both feet, it is incomplete paralysis. Evaluate residuals of incomplete traumatic paralysis under the appropriate diagnostic code (*e.g.,* §4.124a, Diseases of the Peripheral Nerves).	
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.	



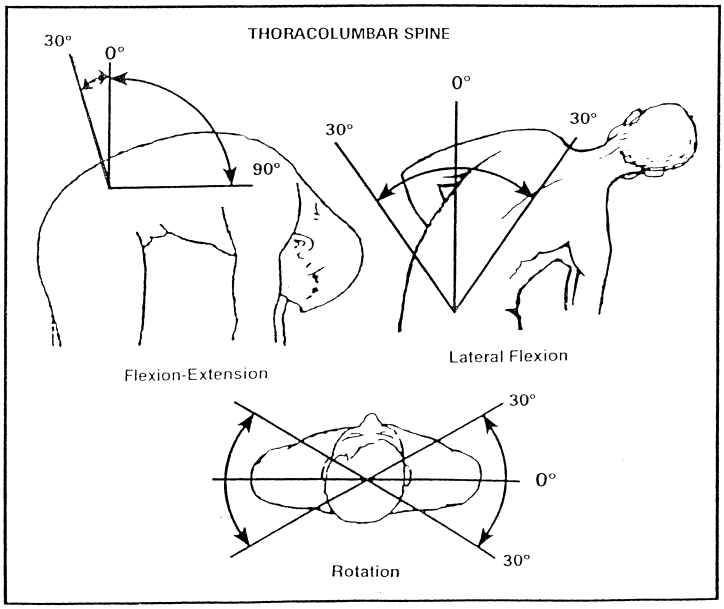


PLATE V
RANGE OF MOTION OF CERVICAL AND THORACOLUMBAR SPINE

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, weight bearing preserved with aid of brace	60
Fracture of surgical neck of, with false joint	60
Malunion of:	
Evaluate under diagnostic codes 5256, 5257, 5260, or 5261 for the knee, or 5250–5254 for the hip, whichever results in the highest evaluation.	

[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 instability:	
Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes both an assistive device (*e.g.,* cane(s), crutch(es), walker) and bracing for ambulation	30
One of the following:	
(a) Sprain, incomplete ligament tear, or repaired complete ligament tear causing persistent instability, and a medical provider prescribes a brace and/or assistive device (*e.g.,* cane(s), crutch(es), walker) for ambulation.	

THE KNEE AND LEG—Continued

	Rating
(b) Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes either an assistive device (*e.g.,* cane(s), crutch(es), walker) or bracing for ambulation	20
Sprain, incomplete ligament tear, or complete ligament tear (repaired, unrepaired, or failed repair) causing persistent instability, without a prescription from a medical provider for an assistive device (*e.g.,* cane(s), crutch(es), walker) or bracing for ambulation	10
Patellar instability:	
A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription by a medical provider for a brace and either a cane or a walker	30
A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription by a medical provider for one of the following: A brace, cane, or walker	20
A diagnosed condition involving the patellofemoral complex with recurrent instability (with or without history of surgical repair) that does not require a prescription from a medical provider for a brace, cane, or walker	10
Note (1): For patellar instability, the patellofemoral complex consists of the quadriceps tendon, the patella, and the patellar tendon.	
Note (2): A surgical procedure that does not involve repair of one or more patellofemoral components that contribute to the underlying instability shall not qualify as surgical repair for patellar instability (including, but not limited to, arthroscopy to remove loose bodies and joint aspiration).	
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:	

THE KNEE AND LEG—Continued

	Rating
Evaluate under diagnostic codes 5256, 5257, 5260, or 5261 for the knee, or 5270 or 5271 for the ankle, whichever results in the highest evaluation.	
Medial tibial stress syndrome (MTSS), or shin splints:	
Requiring treatment for no less than 12 consecutive months, and unresponsive to surgery and either shoe orthotics or other conservative treatment, both lower extremities	30
Requiring treatment for no less than 12 consecutive months, and unresponsive to surgery and either shoe orthotics or other conservative treatment, one lower extremity	20
Requiring treatment for no less than 12 consecutive months, and unresponsive to either shoe orthotics or other conservative treatment, one or both lower extremities	10
Treatment less than 12 consecutive months, one or both lower extremities	0
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 (less than 5 degrees dorsiflexion or less than 10 degrees plantar flexion)	20
Moderate (less than 15 degrees dorsiflexion or less than 30 degrees plantar flexion)	10
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

SHORTENING OF THE LOWER EXTREMITY—Continued

	Rating
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
5269 Plantar fasciitis:	
No relief from both non-surgical and surgical treatment, bilateral	30
No relief from both non-surgical and surgical treatment, unilateral	20
Otherwise, unilateral or bilateral	10
Note (1): With actual loss of use of the foot, rate 40 percent.	
Note (2): If a veteran has been recommended for surgical intervention, but is not a surgical candidate, evaluate under the 20 percent or 30 percent criteria, whichever is applicable.	
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
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

THE FOOT—Continued

	Rating
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
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; 80 FR 42041, July 16, 2015; 85 FR 76460, Nov. 30, 2020, 85 FR 85523, Dec. 29, 2020, 86 FR 8142, Feb. 4, 2021]

§ 4.72 [Reserved]

§ 4.73 Schedule of ratings—muscle injuries.

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

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

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

THE SHOULDER GIRDLE AND ARM—Continued

	Rating	
	Dominant	Nondominant
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

THE FOREARM AND HAND—Continued

	Rating	
	Dominant	Nondominant
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
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

THE FOOT AND LEG—Continued

	Rating
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
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

THE PELVIC GIRDLE AND THIGH—Continued

	Rating
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
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.	

MISCELLANEOUS—Continued

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

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

[62 FR 30239, June 3, 1997, as amemded 85 FR 76464, Nov. 30, 2020]

THE ORGANS OF SPECIAL SENSE

§ 4.75 General considerations for evaluating visual impairment.

(a) *Visual impairment.* The evaluation of visual impairment is based on impairment of visual acuity (excluding developmental errors of refraction), visual field, and muscle function.

(b) *Examination for visual impairment.* The examination must be conducted by a licensed optometrist or by a licensed ophthalmologist. The examiner must identify the disease, injury, or other pathologic process responsible for any visual impairment found. Examinations of visual fields or muscle function will be conducted only when there is a medical indication of disease or injury that may be associated with visual field defect or impaired muscle function. Unless medically contraindicated, the fundus must be examined with the claimant's pupils dilated.

(c) *Service-connected visual impairment of only one eye.* Subject to the provisions of 38 CFR 3.383(a), if visual impairment of only one eye is service-connected, the visual acuity of the other eye will be considered to be 20/40 for purposes of evaluating the service-connected visual impairment.

(d) *Maximum evaluation for visual impairment of one eye.* The evaluation for visual impairment of one eye must not exceed 30 percent unless there is anatomical loss of the eye. Combine the evaluation for visual impairment of one eye with evaluations for other disabilities of the same eye that are not based on visual impairment (e.g., disfigurement under diagnostic code 7800).

(e) *Anatomical loss of one eye with inability to wear a prosthesis.* When the claimant has anatomical loss of one eye and is unable to wear a prosthesis, increase the evaluation for visual acuity under diagnostic code 6063 by 10 percent, but the maximum evaluation for visual impairment of both eyes must not exceed 100 percent. A 10-percent increase under this paragraph precludes an evaluation under diagnostic code 7800 based on gross distortion or asymmetry of the eye but not an evaluation under diagnostic code 7800 based on other characteristics of disfigurement.

(f) *Special monthly compensation.* When evaluating visual impairment, refer to 38 CFR 3.350 to determine whether the claimant may be entitled to special monthly compensation. Footnotes in the schedule indicate levels of visual impairment that potentially establish entitlement to special monthly compensation; however, other levels of visual impairment combined with disabilities of other body systems may also establish entitlement.

(Authority: 38 U.S.C. 1114 and 1155)

[73 FR 66549, Nov. 10, 2008]

§ 4.76 Visual acuity.

(a) *Examination of visual acuity*. Examination of visual acuity must include the central *uncorrected* and *corrected* visual acuity for *distance* and *near* vision using Snellen's test type or its equivalent.

(b) *Evaluation of visual acuity*. (1) Evaluate central visual acuity on the basis of corrected distance vision with central fixation, even if a central scotoma is present. However, when the lens required to correct distance vision in the poorer eye differs by more than three diopters from the lens required to correct distance vision in the better eye (and the difference is not due to congenital or developmental refractive error), and either the poorer eye or both eyes are service connected, evaluate the visual acuity of the poorer eye using either its uncorrected or corrected visual acuity, whichever results in better combined visual acuity.

(2) Provided that he or she customarily wears contact lenses, evaluate the visual acuity of any individual affected by a corneal disorder that results in severe irregular astigmatism that can be improved more by contact lenses than by eyeglass lenses, as corrected by contact lenses.

(3) In any case where the examiner reports that there is a difference equal to two or more scheduled steps between near and distance corrected vision, with the near vision being worse, the examination report must include at least two recordings of near and distance corrected vision and an explanation of the reason for the difference. In these cases, evaluate based on corrected distance vision adjusted to one step poorer than measured.

(4) To evaluate the impairment of visual acuity where a claimant has a reported visual acuity that is between two sequentially listed visual acuities, use the visual acuity which permits the higher evaluation.

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

[73 FR 66549, Nov. 10, 2008]

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

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

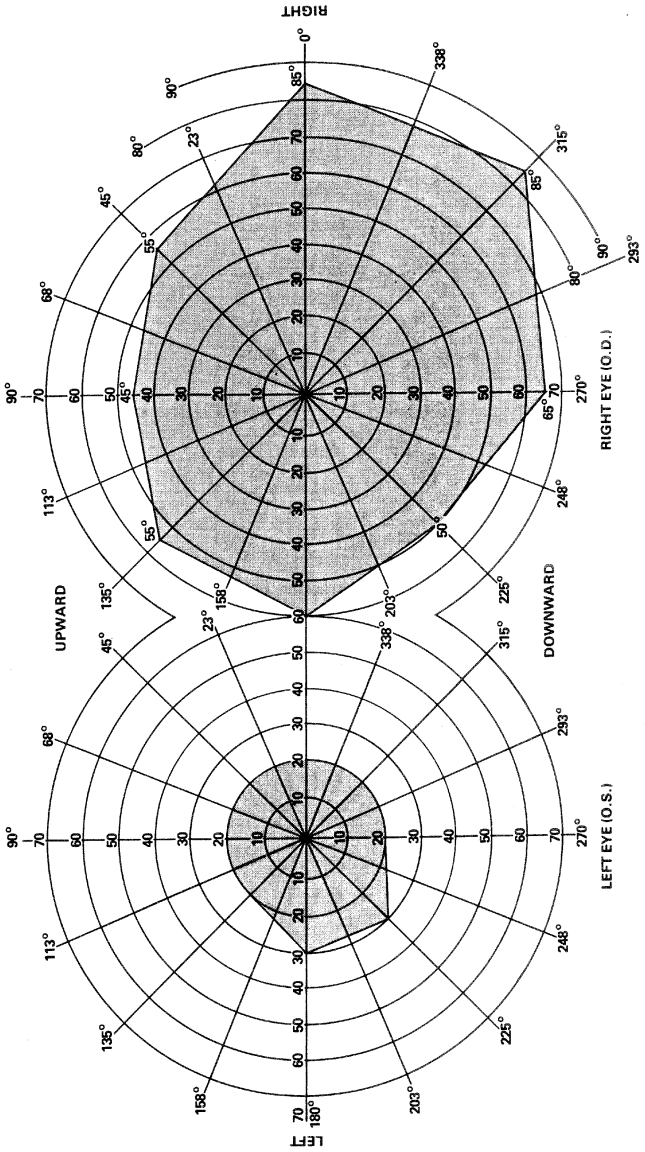


Figure 1. Chart of visual field showing normal field right eye and abnormal contraction visual field left eye.

TS-19

52a

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.

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

[43 FR 45352, Oct. 2, 1978, as amended at 73 FR 66549, Nov. 10, 2008]

§4.77 Visual fields.

(a) *Examination of visual fields.* Examiners must use either Goldmann kinetic perimetry or automated perimetry using Humphrey Model 750, Octopus Model 101, or later versions of these perimetric devices with simulated kinetic Goldmann testing capability. For phakic (normal) individuals, as well as for pseudophakic or aphakic individuals who are well adapted to intraocular lens implant or contact lens correction, visual field examinations must be conducted using a standard target size and luminance, which is Goldmann's equivalent III/4e. For aphakic individuals not well adapted to contact lens correction or pseudophakic individuals not well adapted to intraocular lens implant, visual field examinations must be conducted using Goldmann's equivalent IV/4e. The examiner must document the results for at least 16 meridians 22½ degrees apart for each eye and indicate the Goldmann equivalent used. See Table III for the normal extent (in degrees) of the visual fields at the 8 principal meridians (45 degrees apart). When the examiner indicates that additional testing is necessary to evaluate visual fields, the additional testing must be conducted using either a tangent screen or a 30-degree threshold visual field with the Goldmann III stimulus size. The examination report must document the results of either the tangent screen or of the 30-degree threshold visual field with the Goldmann III stimulus size.

(b) *Evaluation of visual fields.* Determine the average concentric contraction of the visual field of each eye by measuring the remaining visual field (in degrees) at each of eight principal meridians 45 degrees apart, adding them, and dividing the sum by eight.

(c) *Combination of visual field defect and decreased visual acuity.* To determine the evaluation for visual impairment when both decreased visual acuity and visual field defect are present in one or both eyes and are service connected, separately evaluate the visual acuity and visual field defect (expressed as a level of visual acuity), and combine them under the provisions of §4.25.

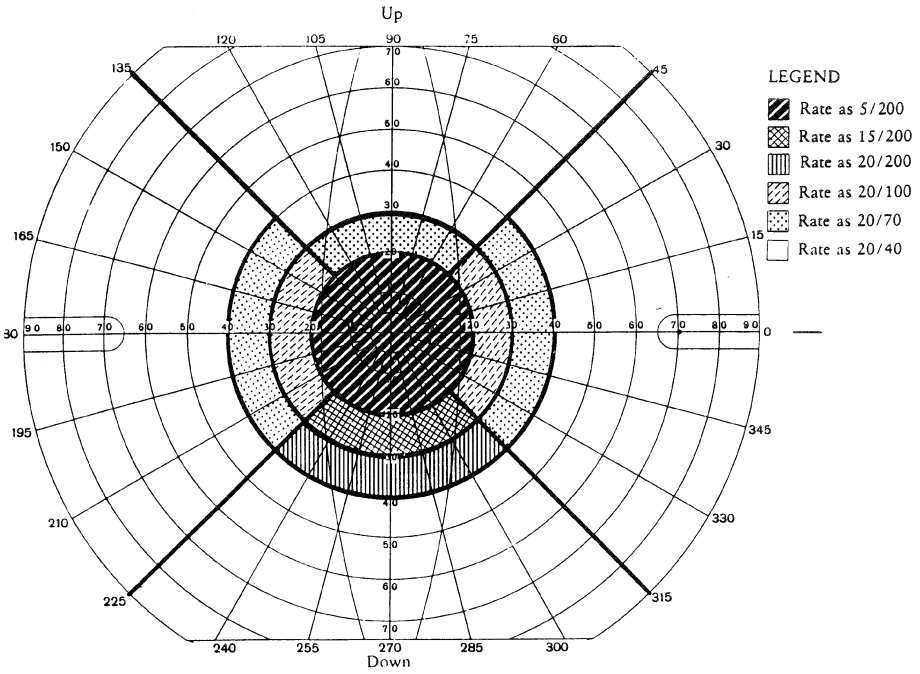


Figure 2. Goldmann Perimeter Chart

52c

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

[53 FR 30262, Aug. 11, 1988, as amended at 73 FR 66549, Nov. 10, 2008; 74 FR 7648, Feb. 19, 2009; 83 FR 15320, Apr. 10, 2018]

§ 4.78 Muscle function.

(a) *Examination of muscle function.* The examiner must use a Goldmann perimeter chart or the Tangent Screen method that identifies the four major quadrants (upward, downward, left, and right lateral) and the central field (20 degrees or less) (see Figure 2). The examiner must document the results of muscle function testing by identifying the quadrant(s) and range(s) of degrees in which diplopia exists.

(b) *Evaluation of muscle function.* (1) An evaluation for diplopia will be assigned to only one eye. When a claimant has both diplopia and decreased visual acuity or visual field defect, assign a level of corrected visual acuity for the poorer eye (or the affected eye, if disability of only one eye is service-connected) that is: one step poorer than it would otherwise warrant if the evaluation for diplopia under diagnostic code 6090 is 20/70 or 20/100; two steps poorer if the evaluation under diagnostic code 6090 is 20/200 or 15/200; or three steps poorer if the evaluation under diagnostic code 6090 is 5/200. This adjusted level of corrected visual acuity, however, must not exceed a level of 5/200. Use the adjusted visual acuity for the poorer eye (or the affected eye, if

disability of only one eye is service-connected), and the corrected visual acuity for the better eye (or visual acuity of 20/40 for the other eye, if only one eye is service-connected) to determine the percentage evaluation for visual impairment under diagnostic codes 6065 through 6066.

(2) When diplopia extends beyond more than one quadrant or range of degrees, evaluate diplopia based on the quadrant and degree range that provides the highest evaluation.

(3) When diplopia exists in two separate areas of the same eye, increase the equivalent visual acuity under diagnostic code 6090 to the next poorer level of visual acuity, not to exceed 5/200.

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

[73 FR 66550, Nov. 10, 2008, as amended at 83 FR 15321, Apr. 10, 2018]

§ 4.79 Schedule of ratings—eye.

DISEASES OF THE EYE

		Rating
	General Rating Formula for Diseases of the Eye:	
	Evaluate on the basis of either visual impairment due to the particular condition or on incapacitating episodes, whichever results in a higher evaluation	
	With documented incapacitating episodes requiring 7 or more treatment visits for an eye condition during the past 12 months	60
	With documented incapacitating episodes requiring at least 5 but less than 7 treatment visits for an eye condition during the past 12 months	40
	With documented incapacitating episodes requiring at least 3 but less than 5 treatment visits for an eye condition during the past 12 months	20
	With documented incapacitating episodes requiring at least 1 but less than 3 treatment visits for an eye condition during the past 12 months	10
	Note (1): For the purposes of evaluation under 38 CFR 4.79, an incapacitating episode is an eye condition severe enough to require a clinic visit to a provider specifically for treatment purposes.	
	Note (2): Examples of treatment may include but are not limited to: Systemic immunosuppressants or biologic agents; intravitreal or periocular injections; laser treatments; or other surgical interventions.	
	Note (3): For the purposes of evaluating visual impairment due to the particular condition, refer to 38 CFR 4.75–4.78 and to § 4.79, diagnostic codes 6061–6091.	
6000	Choroidopathy, including uveitis, iritis, cyclitis, or choroiditis.	
6001	Keratopathy.	
6002	Scleritis.	
6006	Retinopathy or maculopathy not otherwise specified	
6007	Intraocular hemorrhage.	
6008	Detachment of retina.	
6009	Unhealed eye injury.	
	Note: This code includes orbital trauma, as well as penetrating or non-penetrating eye injury	
6010	Tuberculosis of eye:	
	Active	100
	Inactive: Evaluate under § 4.88c or § 4.89 of this part, whichever is appropriate.	
6011	Retinal scars, atrophy, or irregularities:	
	Localized scars, atrophy, or irregularities of the retina, unilateral or bilateral, that are centrally located and that result in an irregular, duplicated, enlarged, or diminished image	10
	Alternatively, evaluate based on the General Rating Formula for Diseases of the Eye, if this would result in a higher evaluation	
6012	Angle-closure glaucoma	
	Evaluate under the General Rating Formula for Diseases of the Eye. Minimum evaluation if continuous medication is required	10
6013	Open-angle glaucoma	
	Evaluate under the General Rating Formula for Diseases of the Eye. Minimum evaluation if continuous medication is required	10
6014	Malignant neoplasms of the eye, orbit, and adnexa (excluding skin):	
	Malignant neoplasms of the eye, orbit, and adnexa (excluding skin) that require therapy that is comparable to those used for systemic malignancies, i.e., systemic chemotherapy, X-ray therapy more extensive than to the area of the eye, or surgery more extensive than enucleation	100
	Note: Continue the 100 percent rating 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 will be determined by mandatory VA examination. 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, evaluate based on residuals	
	Malignant neoplasms of the eye, orbit, and adnexa (excluding skin) that do not require therapy comparable to that for systemic malignancies:	
	Separately evaluate visual and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations.	
6015	Benign neoplasms of the eye, orbit, and adnexa (excluding skin):	

DISEASES OF THE EYE—Continued

		Rating
	Separately evaluate visual and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations	
6016	Nystagmus, central	10
6017	Trachomatous conjunctivitis:	
	Active: Evaluate under the General Rating Formula for Diseases of the Eye, minimum rating	30
	Inactive: Evaluate based on residuals, such as visual impairment and disfigurement (diagnostic code 7800)	
6018	Chronic conjunctivitis (nontrachomatous):	
	Active: Evaluate under the General Rating Formula for Diseases of the Eye, minimum rating	10
	Inactive: Evaluate based on residuals, such as visual impairment and disfigurement (diagnostic code 7800)	
6019	Ptosis, unilateral or bilateral:	
	Evaluate based on visual impairment or, in the absence of visual impairment, on disfigurement (diagnostic code 7800).	
6020	Ectropion:	
	Bilateral	20
	Unilateral	10
6021	Entropion:	
	Bilateral	20
	Unilateral	10
6022	Lagophthalmos:	
	Bilateral	20
	Unilateral	10
6023	Loss of eyebrows, complete, unilateral or bilateral	10
6024	Loss of eyelashes, complete, unilateral or bilateral	10
6025	Disorders of the lacrimal apparatus (epiphora, dacryocystitis, etc.):	
	Bilateral	20
	Unilateral	10
6026	Optic neuropathy	
6027	Cataract:	
	Preoperative: Evaluate under the General Rating Formula for Diseases of the Eye	
	Postoperative: If a replacement lens is present (pseudophakia), evaluate under the General Rating Formula for Diseases of the Eye. If there is no replacement lens, evaluate based on aphakia (diagnostic code 6029)	
6029	Aphakia or dislocation of crystalline lens:	
	Evaluate based on visual impairment, and elevate the resulting level of visual impairment one step.	
	Minimum (unilateral or bilateral)	30
6030	Paralysis of accommodation (due to neuropathy of the Oculomotor Nerve (cranial nerve III)).	20
6032	Loss of eyelids, partial or complete:	
	Separately evaluate both visual impairment due to eyelid loss and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations.	
6034	Pterygium:	
	Evaluate under the General Rating Formula for Diseases of the Eye, disfigurement (diagnostic code 7800), conjunctivitis (diagnostic code 6018), etc., depending on the particular findings, and combine in accordance with § 4.25	
6035	Keratoconus	
6036	Status post corneal transplant:	
	Evaluate under the General Rating Formula for Diseases of the Eye. Minimum, if there is pain, photophobia, and glare sensitivity	10
6037	Pinguecula:	
	Evaluate based on disfigurement (diagnostic code 7800).	
6040	Diabetic retinopathy	
6042	Retinal dystrophy (including retinitis pigmentosa, wet or dry macular degeneration, early-onset macular degeneration, rod and/or cone dystrophy)	
6046	Post-chiasmal disorders	
	Impairment of Central Visual Acuity	
6061	Anatomical loss of both eyes [1]	100
6062	No more than light perception in both eyes [1]	100
6063	Anatomical loss of one eye: [1]	
	In the other eye 5/200 (1.5/60)	100
	In the other eye 10/200 (3/60)	90
	In the other eye 15/200 (4.5/60)	80
	In the other eye 20/200 (6/60)	70
	In the other eye 20/100 (6/30)	60
	In the other eye 20/70 (6/21)	60
	In the other eye 20/50 (6/15)	50
	In the other eye 20/40 (6/12)	40
6064	No more than light perception in one eye: [1]	
	In the other eye 5/200 (1.5/60)	100
	In the other eye 10/200 (3/60)	90
	In the other eye 15/200 (4.5/60)	80

DISEASES OF THE EYE—Continued

	Rating
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
6065 Vision in one eye 5/200 (1.5/60):	
In the other eye 5/200 (1.5/60)	[1]100
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
6066 Visual acuity in one eye 10/200 (3/60) or better:	
Vision in one eye 10/200 (3/60):	
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
Vision in one eye 15/200 (4.5/60):	
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	40
In the other eye 20/50 (6/15)	30
In the other eye 20/40 (6/12)	20
Vision in one eye 20/200 (6/60):	
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	40
In the other eye 20/50 (6/15)	30
In the other eye 20/40 (6/12)	20
Vision in one eye 20/100 (6/30):	
In the other eye 20/100 (6/30)	50
In the other eye 20/70 (6/21)	30
In the other eye 20/50 (6/15)	20
In the other eye 20/40 (6/12)	10
Vision in one eye 20/70 (6/21):	
In the other eye 20/70 (6/21)	30
In the other eye 20/50 (6/15)	20
In the other eye 20/40 (6/12)	10
Vision in one eye 20/50 (6/15):	
In the other eye 20/50 (6/15)	10
In the other eye 20/40 (6/12)	10
Vision in one eye 20/40 (6/12):	
In the other eye 20/40 (6/12)	0

[1] Review for entitlement to special monthly compensation under 38 CFR 3.350.

RATINGS FOR IMPAIRMENT OF VISUAL FIELDS

	Rating
6080 Visual field defects:	
Homonymous hemianopsia	30
Loss of temporal half of visual field:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21).	
Loss of nasal half of visual field:	
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15).	
Loss of inferior half of visual field:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21).	
Loss of superior half of visual field:	

RATINGS FOR IMPAIRMENT OF VISUAL FIELDS—Continued

	Rating
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15).	
Concentric contraction of visual field:	
With remaining field of 5 degrees: [1]	
Bilateral	100
Unilateral	30
Or evaluate each affected eye as 5/200 (1.5/60).	
With remaining field of 6 to 15 degrees:	
Bilateral	70
Unilateral	20
Or evaluate each affected eye as 20/200 (6/60).	
With remaining field of 16 to 30 degrees:	
Bilateral	50
Unilateral	10
Or evaluate each affected eye as 20/100 (6/30).	
With remaining field of 31 to 45 degrees:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21).	
With remaining field of 46 to 60 degrees:	
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15).	
6081 Scotoma, unilateral:	
Minimum, with scotoma affecting at least one-quarter of the visual field (quadrantanopsia) or with centrally located scotoma of any size	10
Alternatively, evaluate based on visual impairment due to scotoma, if that would result in a higher evaluation.	

[1] Review for entitlement to special monthly compensation under 38 CFR 3.350.

RATINGS FOR IMPAIRMENT OF MUSCLE FUNCTION

Degree of diplopia	Equivalent visual acuity
6090 Diplopia (double vision):	
(a) Central 20 degrees	5/200 (1.5/60)
(b) 21 degrees to 30 degrees	
(1) Down	15/200 (4.5/60)
(2) Lateral	20/100 (6/30)
(3) Up	20/70 (6/21)
(c) 31 degrees to 40 degrees	
(1) Down	20/200 (6/60)
(2) Lateral	20/70 (6/21)
(3) Up	20/40 (6/12)
Note: In accordance with 38 CFR 4.31, diplopia that is occasional or that is correctable with spectacles is evaluated at 0 percent.	
6091 Symblepharon:	
Evaluate under the General Rating Formula for Diseases of the Eye, lagophthalmos (diagnostic code 6022), disfigurement (diagnostic code 7800), etc., depending on the particular findings, and combine in accordance with § 4.25	

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

[73 FR 66550, Nov. 10, 2008, as amended at 83 FR 15321, Apr. 10, 2018]

§§ 4.80–4.84 [Reserved]

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 discrimination	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:	
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.

NOTE: Rate any residual disability of infection within the appropriate body system as indicated by the notes in the evaluation criteria. As applicable, consider the long-term health effects potentially associated with infectious diseases as listed in §3.317(d) of this chapter, specifically Brucellosis, Campylobacter jejuni, Coxiella burnetii (Q fever), Malaria, Mycobacterium Tuberculosis, Nontyphoid Salmonella, Shigella, Visceral Leishmaniasis, and West Nile virus.

		Rating
	General Rating Formula for Infectious Diseases:	
	For active disease	100
	After active disease has resolved, rate at 0 percent for infection. Rate any residual disability of infection within the appropriate body system.	
6300	Vibriosis (Cholera, Non-cholera):	
	Evaluate under the General Rating Formula.	
	Note: Rate residuals of cholera and non-cholera vibrio infections, such as renal failure, skin, and musculoskeletal conditions, within the appropriate body system.	
6301	Visceral leishmaniasis:	
	As active disease	100
	Note 1: Continue a 100 percent evaluation beyond the cessation of treatment for active disease. Six months after discontinuance of such treatment, determine the appropriate disability rating 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. Thereafter, rate under the appropriate body system any residual disability of infection, which includes, but is not limited to liver damage and bone marrow disease.	
	Note 2: Confirm the recurrence of active infection by culture, histopathology, or other diagnostic laboratory testing.	
6302	Leprosy (Hansen's disease):	
	As active disease	100
	Note: Continue a 100 percent evaluation beyond the cessation of treatment for active disease. Six months after discontinuance of such treatment, determine the appropriate disability rating 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. Thereafter, rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, skin lesions, peripheral neuropathy, or amputations.	
6304	Malaria:	
	Evaluate under the General Rating Formula.	
	Note 1: The diagnosis of malaria, both initially and during relapse, depends on the identification of the malarial parasites in blood smears or other specific diagnostic laboratory tests such as antigen detection, immunologic (immunochromatographic) tests, and molecular testing such as polymerase chain reaction tests.	
	Note 2: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, liver or splenic damage, and central nervous system conditions.	
6305	Lymphatic filariasis, to include elephantiasis:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, epididymitis, lymphangitis, lymphatic obstruction, or lymphedema affecting extremities, genitals, and/or breasts.	
6306	Bartonellosis:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, endocarditis or skin lesions.	
6307	Plague:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection.	
6308	Relapsing Fever:	
	Evaluate under the General Rating Formula.	

		Rating
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, liver or spleen damage, iritis, uveitis, or central nervous system involvement.	
6309	Rheumatic fever:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, heart damage.	
6310	Syphilis, and other treponema infections:	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, diseases of the nervous system, vascular system, eyes, or ears (*see* DC 7004, DC 8013, DC 8014, DC 8015, and DC 9301).	
6311	Tuberculosis, miliary:	
	As active disease	100
	Inactive disease: *See* §§ 4.88c and 4.89.	
	Note 1: Confirm the recurrence of active infection by culture, histopathology, or other diagnostic laboratory testing.	
	Note 2: Rate under the appropriate body system any residual disability of infection which includes, but is not limited to, skin conditions and conditions of the respiratory, central nervous, musculoskeletal, ocular, gastrointestinal, and genitourinary systems and those residuals listed in § 4.88c.	
6312	Nontuberculosis mycobacterium infection:	
	As active disease	100
	Note 1: Continue the rating of 100 percent for the duration of treatment for active disease followed by a mandatory VA exam. If there is no relapse, rate on residuals. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
	Note 2: Confirm the recurrence of active infection by culture, histopathology, or other diagnostic laboratory testing.	
	Note 3: Rate under the appropriate body system any residual disability of infection which includes, but is not limited to, skin conditions and conditions of the respiratory, central nervous, musculoskeletal, ocular, gastrointestinal, and genitourinary systems and those residuals listed in § 4.88c.	
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
	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:	
	Evaluate under the General Rating Formula.	
	Note 1: Culture, serologic testing, or both must confirm the initial diagnosis and recurrence of active infection.	
	Note 2: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, meningitis, liver, spleen and musculoskeletal conditions.	
6317	Rickettsial, ehrlichia, and anaplasma infections:	
	Evaluate under the General Rating Formula.	
	Note 1: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, bone marrow, spleen, central nervous system, and skin conditions.	
	Note 2: This diagnostic code includes, but is not limited to, scrub typhus, Rickettsial pox, African tick-borne fever, Rocky Mountain spotted fever, ehrlichiosis, or anaplasmosis.	
6318	Melioidosis:	
	Evaluate under the General Rating Formula.	
	Note 1: Confirm by culture or other specific diagnostic laboratory tests the initial diagnosis and any relapse or chronic activity of infection.	
	Note 2: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, arthritis, lung lesions, or meningitis.	
6319	Lyme disease:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, arthritis, Bell's palsy, radiculopathy, ocular, or cognitive dysfunction.	
6320	Parasitic diseases otherwise not specified:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection.	
6325	Hyperinfection syndrome or disseminated strongyloidiasis:	

		Rating
	As active disease	100
	Note: Continue the rating of 100 percent through active disease followed by a mandatory VA exam. If there is no relapse, rate on residual disability. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.	
6326	Schistosomiasis:	
	As acute or asymptomatic chronic disease	0
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, conditions of the liver, intestinal system, female genital tract, genitourinary tract, or central nervous system.	
6329	Hemorrhagic fevers, including dengue, yellow fever, and others:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, conditions of the central nervous system, liver, or kidney.	
6330	Campylobacter jejuni infection:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, Guillain-Barre syndrome, reactive arthritis, or uveitis.	
6331	Coxiella burnetii infection (Q fever):	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, chronic hepatitis, endocarditis, osteomyelitis, post Q-fever chronic fatigue syndrome, or vascular infections.	
6333	Nontyphoid salmonella infections:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, reactive arthritis.	
6334	Shigella infections:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, hemolytic-uremic syndrome or reactive arthritis.	
6335	West Nile virus infection:	
	Evaluate under the General Rating Formula.	
	Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, variable physical, functional, or cognitive disabilities.	
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 (see Note 3) or with secondary diseases afflicting multiple body systems; HIV-related illness with debility and progressive weight loss	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 use of approved medication(s); or minimum rating with T4 cell count less than 200	30
	Following development of HIV-related constitutional symptoms; T4 cell count between 200 and 500; use of 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: In addition to standard therapies and regimens, the term ''approved medication(s)'' includes treatment regimens and medications prescribed as part of a research protocol at an accredited medical institution.	
	Note 2: Diagnosed psychiatric illness, central nervous system manifestations, opportunistic infections, and neoplasms may be rated separately under the appropriate diagnostic codes if a higher overall evaluation results, provided the disability symptoms do not overlap with evaluations otherwise assignable above.	
	Note 3: The following list of opportunistic infections are considered AIDS-defining conditions, that is, a diagnosis of AIDS follows if a person has HIV and one more of these infections, regardless of the CD4 count—candidiasis of the bronchi, trachea, esophagus, or lungs; invasive cervical cancer; coccidioidomycosis; cryptococcosis; cryptosporidiosis; cytomegalovirus (particularly CMV retinitis); HIV-related encephalopathy; herpes simplex-chronic ulcers for greater than one month, or bronchitis, pneumonia, or esophagitis; histoplasmosis; isosporiasis (chronic intestinal); Kaposi's sarcoma; lymphoma; mycobacterium avium complex; tuberculosis; pneumocystis jirovecii (carinii) pneumonia; pneumonia, recurrent; progressive multifocal leukoencephalopathy; salmonella septicemia, recurrent; toxoplasmosis of the brain; and wasting syndrome due to HIV.	
6354	Chronic fatigue syndrome (CFS):	
	Debilitating fatigue, cognitive impairments (such as inability to concentrate, forgetfulness, or 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

	Rating
Which are nearly constant and restrict routine daily activities from 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, incapacitation exists only when a licensed physician prescribes bed rest and treatment.	

[61 FR 39875, July 31, 1996, as amended at 84 FR 28230, June 18, 2019]

§ 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.

(d) *Special provisions for the application of evaluation criteria for diagnostic codes 6600, 6603, 6604, 6825–6833, and 6840–6845.* (1) Pulmonary function tests (PFT's) are required to evaluate these conditions except:

(i) When the results of a maximum exercise capacity test are of record and are 20 ml/kg/min or less. If a maximum exercise capacity test is not of record, evaluate based on alternative criteria.

(ii) When pulmonary hypertension (documented by an echocardiogram or cardiac catheterization), cor pulmonale, or right ventricular hypertrophy has been diagnosed.

(iii) When there have been one or more episodes of acute respiratory failure.

(iv) When outpatient oxygen therapy is required.

(2) If the DLCO (SB) (Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method) test is not of record, evaluate based on alternative criteria as long as the examiner states why the test would not be useful or valid in a particular case.

(3) When the PFT's are not consistent with clinical findings, evaluate based on the PFT's unless the examiner states why they are not a valid indication of respiratory functional impairment in a particular case.

(4) Post-bronchodilator studies are required when PFT's are done for disability evaluation purposes except when the results of pre-bronchodilator pulmonary function tests are normal or when the examiner determines that post-bronchodilator studies should not be done and states why.

(5) When evaluating based on PFT's, use post-bronchodilator results in applying the evaluation criteria in the rating schedule unless the post-bronchodilator results were poorer than the pre-bronchodilator results. In those cases, use the pre-bronchodilator values for rating purposes.

(6) When there is a disparity between the results of different PFT's (FEV–1 (Forced Expiratory Volume in one second), FVC (Forced Vital Capacity), etc.), so that the level of evaluation would differ depending on which test result is used, use the test result that the examiner states most accurately reflects the level of disability.

(7) If the FEV–1 and the FVC are both greater than 100 percent, do not assign

a compensable evaluation based on a decreased FEV–1/FVC ratio.

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

[34 FR 5062, Mar. 11, 1969, as amended at 61 FR 46727, Sept. 5, 1996; 71 FR 52459, Sept. 6, 2006]

§ 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:	
	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:	

	Rating
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:	
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

		Rating
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 Veterans Service Center 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
	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.	

	Rating
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. 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

		Rating
	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, as amended at 71 FR 28586, May 17, 2006]

THE CARDIOVASCULAR SYSTEM

§ 4.100 Application of the general rating formula for diseases of the heart.

(a) Whether or not cardiac hypertrophy or dilatation (documented by electrocardiogram, echocardiogram, or X-ray) is present and whether or not there is a need for continuous medication must be ascertained in all cases.

(b) Even if the requirement for a 10% (based on the need for continuous medication) or 30% (based on the presence of cardiac hypertrophy or dilatation) evaluation is met, METs testing is required in all cases except:

(1) When there is a medical contraindication.

(2) When a 100% evaluation can be assigned on another basis.

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

[71 FR 52460, Sept. 6, 2006, as amended at 86 FR 54093, Sept. 30, 2021; 86 FR 67654, Nov. 29, 2021]

§§ 4.101–4.103 [Reserved]

§ 4.104 Schedule of ratings—cardiovascular system.

DISEASES OF THE HEART

[Unless otherwise directed, use this general rating formula to evaluate 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.	
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 breathlessness, 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, a medical examiner may estimate the level of activity (expressed in METs and supported by specific examples, such as slow stair climbing or shoveling snow) that results in those symptoms.	
Note (3): For this general formula, heart failure symptoms include, but are not limited to, breathlessness, fatigue, angina, dizziness, arrhythmia, palpitations, or syncope.	
GENERAL RATING FORMULA FOR DISEASES OF THE HEART:	
Workload of 3.0 METs or less results in heart failure symptoms	100
Workload of 3.1–5.0 METs results in heart failure symptoms	60

DISEASES OF THE HEART—Continued

[Unless otherwise directed, use this general rating formula to evaluate diseases of the heart.]

	Rating
Workload of 5.1–7.0 METs results in heart failure symptoms; or evidence of cardiac hypertrophy or dilatation confirmed by echocardiogram or equivalent (e.g., multigated acquisition scan or magnetic resonance imaging)	30
Workload of 7.1–10.0 METs results in heart failure symptoms; or continuous medication required for control	10
7000 Valvular heart disease (including rheumatic heart disease),	
7001 Endocarditis, or	
7002 Pericarditis:	
During active infection with cardiac involvement and for three months following cessation of therapy for the active infection	100
Thereafter, with diagnosis confirmed by findings on physical examination and either echocardiogram, Doppler echocardiogram, or cardiac catheterization, use the General Rating Formula.	
7003 Pericardial adhesions.	
7004 Syphilitic heart disease:	
Note: Evaluate syphilitic aortic aneurysms under DC 7110 (Aortic aneurysm: Ascending, thoracic, abdominal).	
7005 Arteriosclerotic heart disease (coronary artery disease).	
Note: If non-service-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, confirmed by laboratory tests	100
Thereafter, use the General Rating Formula.	
7007 Hypertensive heart disease.	
7008 Hyperthyroid heart disease:	
Rate under the appropriate cardiovascular diagnostic code, depending on particular findings.	
For DCs 7009, 7010, 7011, and 7015, a single evaluation will be assigned under the diagnostic code that reflects the predominant disability picture.	
7009 Bradycardia (Bradyarrhythmia), symptomatic, requiring permanent pacemaker implantation:	
For one month following hospital discharge for implantation or re-implantation	100
Thereafter, use the General Rating Formula.	
Note (1): Bradycardia (bradyarrhythmia) refers to conduction abnormalities that produce a heart rate less than 60 beats/min. There are five general classes of bradyarrhythmia: Sinus bradycardia, including sinoatrial block; atrioventricular (AV) junctional (nodal) escape rhythm; AV heart block (second or third degree) or AV dissociation; atrial fibrillation or flutter with a slow ventricular response; and, idioventricular escape rhythm.	
Note (2): Asymptomatic bradycardia (bradyarrhythmia) is a medical finding only. It is not a disability subject to compensation.	
7010 Supraventricular tachycardia:	
Confirmed by ECG, with five or more treatment interventions per year	30
Confirmed by ECG, with one to four treatment interventions per year; or, confirmed by ECG with either continuous use of oral medications to control or use of vagal maneuvers to control	10
Note (1): Examples of supraventricular tachycardia include, but are not limited to: Atrial fibrillation, atrial flutter, sinus tachycardia, sinoatrial nodal reentrant tachycardia, atrioventricular nodal reentrant tachycardia, atrioventricular reentrant tachycardia, atrial tachycardia, junctional tachycardia, and multifocal atrial tachycardia.	
Note (2): For the purposes of this diagnostic code, a treatment intervention occurs whenever a symptomatic patient requires intravenous pharmacologic adjustment, cardioversion, and/or ablation for symptom relief.	
7011 Ventricular arrhythmias (sustained):	
For an indefinite period from the date of inpatient hospital admission for initial medical therapy for a sustained ventricular arrhythmia; or, for an indefinite period from the date of inpatient hospital admission for ventricular aneurysmectomy; or, with an automatic implantable cardioverter-defibrillator (AICD) in place	100
Note: When inpatient hospitalization for sustained ventricular arrhythmia or ventricular aneurysmectomy is required, a 100-percent evaluation begins on the date of hospital admission with a mandatory VA examination six months following hospital discharge. Evaluate post-surgical residuals under the General Rating Formula. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination.	
7015 Atrioventricular block:	
Benign (First-Degree and Second-Degree, Type I):	
Evaluate under the General Rating Formula.	
Non-Benign (Second-Degree, Type II and Third-Degree):	
Evaluate under DC 7018 (implantable cardiac pacemakers).	
7016 Heart valve replacement (prosthesis):	
For an indefinite period following date of hospital admission for valve replacement	100
Thereafter, use the General Rating Formula.	
Note: Six months following discharge from inpatient hospitalization, disability evaluation shall be conducted by mandatory VA examination using the General Rating Formula. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination.	
7017 Coronary bypass surgery:	
For three months following hospital admission for surgery	100
Thereafter, use the General Rating Formula.	
7018 Implantable cardiac pacemakers:	
For one month following hospital discharge for implantation or re-implantation	100
Thereafter:	

DISEASES OF THE HEART—Continued

[Unless otherwise directed, use this general rating formula to evaluate diseases of the heart.]

DISEASES OF THE HEART—Continued

[Unless otherwise directed, use this general rating formula to evaluate diseases of the heart.]

	Rating
Evaluate as supraventricular tachycardia (DC 7010), ventricular arrhythmias (DC 7011), or atrioventricular block (DC 7015).	
Minimum	10
Note: Evaluate automatic implantable cardioverter-defibrillators (AICDs) under DC 7011.	
7019 Cardiac transplantation:	
For a minimum of one year from the date of hospital admission for cardiac transplantation	100
Thereafter:	
Evaluate under the General Rating Formula.	
Minimum	30
Note: One year following discharge from inpatient hospitalization, determine the appropriate disability rating by mandatory VA examination. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination.	
7020 Cardiomyopathy.	
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.	
NOTE (3): Evaluate hypertension separately from hypertensive heart disease and other types of heart disease.	
7110 Aortic aneurysm: Ascending, thoracic, or abdominal:	
Evaluate at 100 percent if the aneurysm is any one of the following: Five centimeters or larger in diameter; symptomatic (e.g., precludes exertion); or requires surgery	100
Otherwise	0
Evaluate non-cardiovascular residuals of surgical correction according to organ systems affected.	

DISEASES OF THE HEART—Continued

[Unless otherwise directed, use this general rating formula to evaluate diseases of the heart.]

	Rating
Note: When surgery is required, a 100-percent evaluation begins on the date a physician recommends surgical correction with a mandatory VA examination six months following hospital discharge. Evaluate post-surgical residuals under the General Rating Formula. 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 the period beginning on the date a physician recommends surgical correction and continuing for six months following discharge from inpatient hospital admission for surgical correction	100
Following surgery: Evaluate under DC 7114 (peripheral arterial disease).	
Note: Six months following discharge from inpatient hospitalization for surgery, determine the appropriate disability rating 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 chronic edema, stasis dermatitis, and either ulceration or cellulitis:	
Lower extremity	50
Upper extremity	40
Without cardiac involvement but with chronic edema or stasis dermatitis:	
Lower extremity	30
Upper extremity	20
7114 Peripheral arterial disease:	
At least one of the following: Ankle/brachial index less than or equal to 0.39; ankle pressure less than 50 mm Hg; toe pressure less than 30 mm Hg; or transcutaneous oxygen tension less than 30 mm Hg	100
At least one of the following: Ankle/brachial index of 0.40–0.53; ankle pressure of 50–65 mm Hg; toe pressure of 30–39 mm Hg; or transcutaneous oxygen tension of 30–39 mm Hg	60
At least one of the following: Ankle/brachial index of 0.54–0.66; ankle pressure of 66–83 mm Hg; toe pressure of 40–49 mm Hg; or transcutaneous oxygen tension of 40–49 mm Hg	40
At least one of the following: Ankle/brachial index of 0.67–0.79; ankle pressure of 84–99 mm Hg; toe pressure of 50–59 mm Hg; or transcutaneous oxygen tension of 50–59 mm Hg	20

DISEASES OF THE HEART—Continued

[Unless otherwise directed, use this general rating formula to evaluate diseases of the heart.]

	Rating
Note (1): The ankle/brachial index (ABI) is the ratio of the systolic blood pressure at the ankle divided by the simultaneous brachial artery systolic blood pressure. For the purposes of this diagnostic code, normal ABI will be greater than or equal to 0.80. The ankle pressure (AP) is the systolic blood pressure measured at the ankle. Normal AP is greater than or equal to 100 mm Hg. The toe pressure (TP) is the systolic blood pressure measured at the great toe. Normal TP is greater than or equal to 60 mm Hg. Transcutaneous oxygen tension (T_cPO_2) is measured at the first intercostal space on the foot. Normal T_cPO_2 is greater than or equal to 60 mm Hg. All measurements must be determined by objective testing.	
Note (2): If AP, TP, and T_cPO_2 testing are not of record, evaluate based on ABI unless the examiner states that an AP, TP, or T_cPO_2 test is needed in a particular case because ABI does not sufficiently reflect the severity of the veteran's peripheral arterial disease. In all other cases, evaluate based on the test that provides the highest impairment value.	
Note (3): Evaluate residuals of aortic and large arterial bypass surgery or arterial graft as peripheral arterial disease.	
Note (4): These evaluations involve 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):	
Lower extremity: Rate under DC 7114.	
Upper extremity:	
Deep ischemic ulcers and necrosis of the fingers with persistent coldness of the extremity, trophic changes with pains in the hand during physical activity, and diminished upper extremity pulses	100
Persistent coldness of the extremity, trophic changes with pains in the hands during physical activity, and diminished upper extremity pulses	60
Trophic changes with numbness and paresthesia at the tips of the fingers, and diminished upper extremity pulses	40
Diminished upper extremity pulses	20
Note (1): These evaluations involve 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.	
Note (2): Trophic changes include, but are not limited to, skin changes (thinning, atrophy, fissuring, ulceration, scarring, absence of hair) as well as nail changes (clubbing, deformities).	
7117 Raynaud's syndrome (also known as secondary Raynaud's phenomenon or secondary Raynaud's):	
With two or more digital ulcers plus autoamputation of one or more digits and history of characteristic attacks	100
With two or more digital ulcers and history of characteristic attacks	60
Characteristic attacks occurring at least daily	40
Characteristic attacks occurring four to six times a week	20
Characteristic attacks occurring one to three times a week	10
Note (1): 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 Raynaud's syndrome as a whole, regardless of the number of extremities involved or whether the nose and ears are involved.	
Note (2): This section is for evaluating Raynaud's syndrome (secondary Raynaud's phenomenon or secondary Raynaud's). For evaluation of Raynaud's disease (primary Raynaud's), see DC 7124.	
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:	
Evaluate under diagnostic code 7121.	
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

DISEASES OF THE HEART—Continued

[Unless otherwise directed, use this general rating formula to evaluate diseases of the heart.]

	Rating
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, anhydrosis, X-ray abnormalities (osteoporosis, subarticular punched-out lesions, or osteoarthritis), atrophy or fibrosis of the affected musculature, flexion or extension deformity of distal joints, volar fat pad loss in fingers or toes, avascular necrosis of bone, chronic ulceration, carpal or tarsal tunnel syndrome	30
Arthralgia or other pain, numbness, or cold sensitivity plus one of the following: Tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, anhydrosis, X-ray abnormalities (osteoporosis, subarticular punched-out lesions, or osteoarthritis), atrophy or fibrosis of the affected musculature, flexion or extension deformity of distal joints, volar fat pad loss in fingers or toes, avascular necrosis of bone, chronic ulceration, carpal or tarsal tunnel syndrome	20
Arthralgia or other pain, numbness, or cold sensitivity	10

DISEASES OF THE HEART—Continued

[Unless otherwise directed, use this general rating formula to evaluate diseases of the heart.]

	Rating
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 diagnosed as the residual effects of cold injury, such as Raynaud's syndrome (which is otherwise known as secondary 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
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.	
7124 Raynaud's disease (also known as primary Raynaud's):	
Characteristic attacks associated with trophic change(s), such as tight, shiny skin	10
Characteristic attacks without trophic change(s)	0
Note (1): For purposes of this section, characteristic attacks consist of intermittent and episodic color changes of the digits of one or more extremities, lasting minutes or longer, with occasional 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.	
Note (2): Trophic changes include, but are not limited to, skin changes (thinning, atrophy, fissuring, ulceration, scarring, absence of hair) as well as nail changes (clubbing, deformities).	
Note (3): This section is for evaluating Raynaud's disease (primary Raynaud's). For evaluation of Raynaud's syndrome (also known as secondary Raynaud's phenomenon, or secondary Raynaud's), see DC 7117.	

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

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THE DIGESTIVE SYSTEM

§§ 4.110–4.111 [Reserved]

§ 4.112 Weight loss and nutrition.

The following terms apply when evaluating conditions in § 4.114:

(a) *Weight loss. Substantial weight loss* means involuntary loss greater than 20% of an individual's baseline weight sustained for three months with diminished quality of self-care or work tasks. The term *minor weight loss* means involuntary weight loss between 10% and 20% of an individual's baseline weight sustained for three months with gastrointestinal-related symptoms, involving diminished quality of self-care or work tasks, or decreased food intake. The term *inability to gain weight* means substantial weight loss with the inability to regain it despite following appropriate therapy.

(b) *Baseline weight. Baseline weight* means the clinically documented average weight for the two-year period preceding the onset of illness or, if relevant, the weight recorded at the veteran's most recent discharge physical. If neither of these weights is available or currently relevant, then use ideal body weight as determined by either the Hamwi formula or Body Mass Index tables, whichever is most favorable to the veteran.

(c) *Undernutrition. Undernutrition* means a deficiency resulting from insufficient intake of one or multiple essential nutrients, or the inability of the body to absorb, utilize, or retain such nutrients. Undernutrition is characterized by failure of the body to maintain normal organ functions and healthy tissues. Signs and symptoms may include loss of subcutaneous tissue, edema, peripheral neuropathy, muscle wasting, weakness, abdominal distention, ascites, and Body Mass Index below normal range.

(d) *Nutritional support.* Paragraphs (d)(1) and (2) of this section describe various nutritional support methods used to treat certain digestive conditions.

(1) Total parenteral nutrition (TPN) or hyperalimentation is a special liquid mixture given into the blood through an intravenous catheter. The mixture contains proteins, carbohydrates (sugars), fats, vitamins, and minerals. TPN bypasses the normal digestion in the stomach and bowel.

(2) Assisted enteral nutrition requires a special liquid mixture (containing proteins, carbohydrates (sugar), fats, vitamins, and minerals) to be delivered into the stomach or bowel through a flexible feeding tube. Percutaneous endoscopic gastrostomy is a type of assisted enteral nutrition in which a flexible feeding tube is inserted through the abdominal wall and into the stomach. Nasogastric or nasoenteral feeding tube is a type of assisted parenteral nutrition in which a flexible feeding tube is inserted through the nose into the stomach or bowel.

[89 FR 19743, Mar. 20, 2024]

§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.

Do not combine ratings under diagnostic codes 7301 through 7329 inclusive, 7331, 7342, 7345 through 7350 inclusive, 7352, and 7355 through 7357 inclusive, with each other. Instead, when more than one rating is warranted under those diagnostic codes, assign a single evaluation under the diagnostic code that reflects the predominant disability picture, and elevate it to the next higher evaluation if warranted by the severity of the overall disability.

	Rating
7200 Soft tissue injury of the mouth, other than tongue or lips:	
Rate as for disfigurement (diagnostic codes 7800 and 7804) and impairment of mastication.	
7201 Lips, injuries of:	
Rate as disfigurement (diagnostic codes 7800 and 7804).	
7202 Tongue, loss of whole or part:	
Absent oral nutritional intake	100

	Rating
Intact oral nutritional intake with permanently impaired swallowing function that requires prescribed dietary modification ...	60
Intact oral nutritional intake with permanently impaired swallowing function without prescribed dietary modification	30
Note (1): Rate the residuals of speech impairment as complete organic aphonia (DC 6519) or incomplete aphonia as laryngitis, chronic (DC 6516).	
Note (2): Dietary modifications due to this condition must be prescribed by a medical provider.	
7203 Esophagus, stricture of:	
Documented history of recurrent or refractory esophageal stricture(s) causing dysphagia with at least one of the symptoms present: (1) aspiration, (2) undernutrition, and/or (3) substantial weight loss as defined by § 4.112(a) and treatment with either surgical correction or percutaneous esophago-gastrointestinal tube (PEG tube)	80
Documented history of recurrent or refractory esophageal stricture(s) causing dysphagia which requires at least one of the following (1) dilatation 3 or more times per year, (2) dilatation using steroids at least one time per year, or (3) esophageal stent placement	50
Documented history of recurrent esophageal stricture(s) causing dysphagia which requires dilatation no more than 2 times per year	30
Documented history of esophageal stricture(s) that requires daily medications to control dysphagia otherwise asymptomatic	10
Documented history without daily symptoms or requirement for daily medications	0
Note (1): Findings must be documented by barium swallow, computerized tomography, or esophagogastroduodenoscopy.	
Note (2): Non-gastrointestinal complications of procedures should be rated under the appropriate system.	
Note (3): This diagnostic code applies, but is not limited to, esophagitis, mechanical or chemical; Mallory Weiss syndrome (bleeding at junction of esophagus and stomach due to tears) due to caustic ingestion of alkali or acid; drug-induced or infectious esophagitis due to Candida, virus, or other organism; idiopathic eosinophilic, or lymphocytic esophagitis; esophagitis due to radiation therapy; esophagitis due to peptic stricture; and any esophageal condition that requires treatment with sclerotherapy.	
Note (4): Recurrent esophageal stricture is defined as the inability to maintain target esophageal diameter beyond 4 weeks after the target diameter has been achieved.	
Note (5): Refractory esophageal stricture is defined as the inability to achieve target esophageal diameter despite receiving no fewer than 5 dilatation sessions performed at 2-week intervals.	
7204 Esophageal motility disorder:	
Rate as esophagus, stricture of (DC 7203).	
Note: This diagnostic code applies, but is not limited to, achalasia (cardiospasm), diffuse esophageal spasm (DES), corkscrew esophagus, nutcracker esophagus, and other motor disorders of the esophagus; esophageal rings (including Schatzki rings), mucosal webs or folds, and impairment of the esophagus caused by systemic conditions such as myasthenia gravis, scleroderma, and other neurologic conditions.	
7205 Esophagus, diverticulum of, acquired:	
Rate as esophagus, stricture of (DC 7203).	
Note: This diagnostic code, applies, but is not limited to, pharyngo- esophageal (Zenker's) diverticulum, mid-esophageal diverticulum, and epiphrenic (distal esophagus) diverticulum.	
7206 Gastroesophageal reflux disease:	
Documented history of recurrent or refractory esophageal stricture(s) causing dysphagia with at least one of the symptoms present: (1) aspiration, (2) undernutrition, and/or (3) substantial weight loss as defined by § 4.112(a) and treatment with either surgical correction of esophageal stricture(s) or percutaneous esophago-gastrointestinal tube (PEG tube)	80
Documented history of recurrent or refractory esophageal stricture(s) causing dysphagia which requires at least one of the following (1) dilatation 3 or more times per year, (2) dilatation using steroids at least one time per year, or (3) esophageal stent placement	50
Documented history of recurrent esophageal stricture(s) causing dysphagia which requires dilatation no more than 2 times per year	30
Documented history of esophageal stricture(s) that requires daily medications to control dysphagia otherwise asymptomatic	10
Documented history without daily symptoms or requirement for daily medications	0
Note (1): Findings must be documented by barium swallow, computerized tomography, or esophagogastroduodenoscopy.	
Note (2): Non-gastrointestinal complications of procedures should be rated under the appropriate system.	
Note (3): This diagnostic code applies, but is not limited to, esophagitis, mechanical or chemical; Mallory Weiss syndrome (bleeding at junction of esophagus and stomach due to tears) due to caustic ingestion of alkali or acid; drug-induced or infectious esophagitis due to Candida, virus, or other organism; idiopathic eosinophilic, or lymphocytic esophagitis; esophagitis due to radiation therapy; esophagitis due to peptic stricture; and any esophageal condition that requires treatment with sclerotherapy.	
Note (4): Recurrent esophageal stricture is defined as the inability to maintain target esophageal diameter beyond 4 weeks after the target diameter has been achieved.	
Note (5): Refractory esophageal stricture is defined as the inability to achieve target esophageal diameter despite receiving no fewer than 5 dilatation sessions performed at 2-week intervals.	

	Rating
7207 Barrett's esophagus:	
With esophageal stricture: Rate as esophagus, stricture of (DC 7203).	
Without esophageal stricture:	
Documented by pathologic diagnosis with high-grade dysplasia	30
Documented by pathologic diagnosis with low-grade dysplasia	10
Note (1): If malignancy develops, rate as malignant neoplasms of the digestive system, exclusive of skin growths (DC 7343).	
Note (2): If the condition is resolved via surgery, radiofrequency ablation, or other treatment, rate residuals as esophagus, stricture of (DC 7203).	
7301 Peritoneum, adhesions of, due to surgery, trauma, disease, or infection:	
Persistent partial bowel obstruction that is either inoperable and refractory to treatment, or requires total parenteral nutrition (TPN) for obstructive symptoms	80
Symptomatic peritoneal adhesions, persisting or recurring after surgery, trauma, inflammatory disease process such as chronic cholecystitis or Crohn's disease, or infection, as determined by a healthcare provider; and clinical evidence of recurrent obstruction requiring hospitalization at least once a year; and medically-directed dietary modification other than total parenteral nutrition (TPN); and at least one of the following: (1) abdominal pain, (2) nausea, (3) vomiting, (4) colic, (5) constipation, or (6) diarrhea	50
Symptomatic peritoneal adhesions, persisting or recurring after surgery, trauma, inflammatory disease process such as chronic cholecystitis or Crohn's disease, or infection, as determined by a healthcare provider; and medically-directed dietary modification other than total parenteral nutrition (TPN); and at least one of the following: (1) abdominal pain, (2) nausea, (3) vomiting, (4) colic, (5) constipation, or (6) diarrhea	30
Symptomatic peritoneal adhesions, persisting or recurring after surgery, trauma, inflammatory disease process such as chronic cholecystitis or Crohn's disease, or infection, as determined by a healthcare provider, and at least one of the following: (1) abdominal pain, (2) nausea, (3) vomiting, (4) colic, (5) constipation, or (6) diarrhea	10
History of peritoneal adhesions, currently asymptomatic	0
7303 Chronic complications of upper gastrointestinal surgery:	
Requiring continuous total parenteral nutrition (TPN) or tube feeding for a period longer than 30 consecutive days in the last six months	80
Any one of the following symptoms with or without pain: (1) daily vomiting despite oral dietary modification or medication; (2) six or more watery bowel movements per day every day, or explosive bowel movements that are difficult to predict or control; (3) post-prandial (meal-induced) lightheadedness (syncope) with sweating and the need for medications to specifically treat complications of upper gastrointestinal surgery such as dumping syndrome or delayed gastric emptying	50
With two or more of the following symptoms: (1) vomiting two or more times per week or vomiting despite medical treatment; (2) discomfort or pain within an hour of eating and requiring ongoing oral dietary modification; (3) three to five watery bowel movements per day every day	30
With either nausea or vomiting managed by ongoing medical treatment	10
Post-operative status, asymptomatic	0
Note (1): For resection of small intestine, use DC 7328.	
Note (2): If pancreatic surgery results in a vitamin or mineral deficiency (e.g., B12, iron, calcium, or fat-soluble vitamins), evaluate under the appropriate vitamin/mineral deficiency code and assign the higher rating. For example, evaluate Vitamin A, B, C or D deficiencies under DC 6313; ocular manifestations of vitamin deficiencies, such as night blindness, under DC 6313; keratitis or keratomalacia due to Vitamin A deficiency under DC 6001; Vitamin E deficiency under neuropathy; and Vitamin K deficiency under prolonged clotting (e.g., DC 7705).	
Note (3): This diagnostic code includes operations performed on the esophagus, stomach, pancreas, and small intestine, including bariatric surgery.	
7304 Peptic ulcer disease:	
Post-operative for perforation or hemorrhage, for three months	100
Continuous abdominal pain with intermittent vomiting, recurrent hematemesis (vomiting blood) or melena (tarry stools); and manifestations of anemia which require hospitalization at least once in the past 12 months	60
Episodes of abdominal pain, nausea, or vomiting, that: last for at least three consecutive days in duration; occur four or more times in the past 12 months; and are managed by daily prescribed medication	40
Episodes of abdominal pain, nausea, or vomiting, that: last for at least three consecutive days in duration; occur three times or less in the past 12 months; and are managed by daily prescribed medication	20
History of peptic ulcer disease documented by endoscopy or diagnostic imaging studies	0
Note: After three months at the 100% evaluation, rate on residuals as determined by mandatory VA medical examination. Apply the provisions of §3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination.	
7307 Gastritis, chronic:	

	Rating
Rate as peptic ulcer disease (DC 7304).	
Note: This diagnostic code includes Helicobacter pylori infection, drug-induced gastritis, Zollinger-Ellison syndrome, and portal-hypertensive gastropathy with varix-related complications.	
7308 Postgastrectomy syndrome:	
Rate residuals as chronic complications of upper gastrointestinal surgery (DC 7303).	
7309 Stomach, stenosis of:	
Rate as chronic complications of upper gastrointestinal surgery (DC 7303) or peptic ulcer disease (DC 7304), depending on the predominant disability.	
7310 Stomach, injury of, residuals:	
Pre-operative: Rate as adhesions of peritoneum due to surgery, trauma, disease, or infection (DC 7301). No adhesions are necessary when evaluating under DC 7301.	
Post-operative: Rate as chronic complications of upper gastrointestinal surgery (DC 7303).	
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:	
Liver disease with Model for End-Stage Liver Disease score greater than or equal to 15; or with continuous daily debilitating symptoms, generalized weakness and at least one of the following: (1) ascites (fluid in the abdomen), or (2) a history of spontaneous bacterial peritonitis, or (3) hepatic encephalopathy, or (4) variceal hemorrhage, or (5) coagulopathy, or (6) portal gastropathy, or (7) hepatopulmonary or hepatorenal syndrome	100
Liver disease with Model for End-Stage Liver Disease score greater than 11 but less than 15; or with daily fatigue and at least one episode in the last year of either (1) variceal hemorrhage, or (2) portal gastropathy or hepatic encephalopathy	60
Liver disease with Model for End-Stage Liver Disease score of 10 or 11; or with signs of portal hypertension such as splenomegaly or ascites (fluid in the abdomen) and either weakness, anorexia, abdominal pain, or malaise	30
Liver disease with Model for End-Stage Liver Disease score greater than 6 but less than 10; or with evidence of either anorexia, weakness, abdominal pain or malaise	10
Asymptomatic, but with a history of liver disease	0
Note (1): Rate hepatocellular carcinoma occurring with cirrhosis under DC 7343 (Malignant neoplasms of the digestive system, exclusive of skin growths) in lieu of DC 7312.	
Note (2): Biochemical studies, imaging studies, or biopsy must confirm liver dysfunction (including hyponatremia, thrombocytopenia, and/or coagulopathy).	
Note (3): Rate condition based on symptomatology where the evidence does not contain a Model for End-Stage Liver Disease score.	
7314 Chronic biliary tract disease:	
With three or more clinically documented attacks of right upper quadrant pain with nausea and vomiting during the past 12 months; or requiring dilatation of biliary tract strictures at least once during the past 12 months.	30
With one or two clinically documented attacks of right upper quadrant pain with nausea and vomiting in the past 12 months.	10
Asymptomatic, without history of a clinically documented attack of right upper quadrant pain with nausea and vomiting in the past 12 months.	0
Note: This diagnostic code includes cholangitis, biliary strictures, Sphincter of Oddi dysfunction, bile duct injury, and choledochal cyst. Rate primary sclerosing cholangitis under chronic liver disease without cirrhosis (DC 7345).	
7315 Cholelithiasis, chronic:	
Rate as chronic biliary tract disease (DC 7314).	
7317 Gallbladder, injury of:	
Rate as adhesions of the peritoneum due to surgery, trauma, disease, or infection (DC 7301); or chronic gallbladder and biliary tract disease (DC 7314), or cholecystectomy (gallbladder removal), complications of (such as strictures and biliary leaks) (DC 7318), depending on the predominant disability.	
Note: When rating gallbladder injuries analogous to DC 7301, a finding of adhesions is not necessary.	
7318 Cholecystectomy (gallbladder removal), complications of (such as strictures and biliary leaks):	
With recurrent abdominal pain (post-prandial or nocturnal); and chronic diarrhea characterized by three or more watery bowel movements per day	30
With intermittent abdominal pain; and diarrhea characterized by one to two watery bowel movements per day	10
Asymptomatic	0
7319 Irritable bowel syndrome (IBS):	
Abdominal pain related to defecation at least one day per week during the previous three months; and two or more of the following: (1) change in stool frequency, (2) change in stool form, (3) altered stool passage (straining and/or urgency), (4) mucorrhea, (5) abdominal bloating, or (6) subjective distension	30
Abdominal pain related to defecation for at least three days per month during the previous three months; and two or more of the following: (1) change in stool frequency, (2) change in stool form, (3) altered stool passage (straining and/or urgency), (4) mucorrhea, (5) abdominal bloating, or (6) subjective distension	20
Abdominal pain related to defecation at least once during the previous three months; and two or more of the following: (1) change in stool frequency, (2) change in stool form, (3) altered stool passage (straining and/or urgency), (4) mucorrhea, (5) abdominal bloating, or (6) subjective distension	10

	Rating
Note: This diagnostic code may include functional digestive disorders (see § 3.317 of this chapter), such as dyspepsia, functional bloating and constipation, and diarrhea. Evaluate other symptoms of a functional digestive disorder not encompassed by this diagnostic code under the appropriate diagnostic code, to include gastrointestinal dysmotility syndrome (DC 7356), following the general principles of § 4.14 and this section.	
7323 Colitis, ulcerative:	
Rate as Crohn's disease or undifferentiated form of inflammatory bowel disease (DC 7326).	
7325 Enteritis, chronic:	
Rate as Irritable Bowel Syndrome (DC 7319) or Crohn's disease or undifferentiated form of inflammatory bowel disease (DC 7326), depending on the predominant disability.	
7326 Crohn's disease or undifferentiated form of inflammatory bowel disease:	
Severe inflammatory bowel disease that is unresponsive to treatment; and requires hospitalization at least once per year; and results in either an inability to work or is characterized by recurrent abdominal pain associated with at least two of the following: (1) six or more episodes per day of diarrhea, (2) six or more episodes per day of rectal bleeding, (3) recurrent episodes of rectal incontinence, or (4) recurrent abdominal distension	100
Moderate inflammatory bowel disease that is managed on an outpatient basis with immunosuppressants or other biologic agents; and is characterized by recurrent abdominal pain, four to five daily episodes of diarrhea; and intermittent signs of toxicity such as fever, tachycardia, or anemia	60
Mild to moderate inflammatory bowel disease that is managed with oral and topical agents (other than immunosuppressants or other biologic agents); and is characterized by recurrent abdominal pain with three or less daily episodes of diarrhea and minimal signs of toxicity such as fever, tachycardia, or anemia	30
Minimal to mild symptomatic inflammatory bowel disease that is managed with oral or topical agents (other than immunosuppressants or other biologic agents); and is characterized by recurrent abdominal pain with three or less daily episodes of diarrhea and no signs of systemic toxicity	10
Note (1): Following colectomy/colostomy with persistent or recurrent symptoms, rate either under DC 7326 or DC 7329 (Intestine, large, resection of), whichever provides the highest rating.	
Note (2): VA requires diagnoses under DC 7326 to be confirmed by endoscopy or radiologic studies.	
Note (3): Inflammation may involve small bowel (ileitis), large bowel (colitis), or inflammation of any component of the gastrointestinal tract from the mouth to the anus.	
7327 Diverticulitis and diverticulosis:	
Diverticular disease requiring hospitalization for abdominal distress, fever, and leukocytosis (elevated white blood cells) one or more times in the past 12 months; and with at least one of the following complications: (1) hemorrhage, (2) obstruction, (3) abscess, (4) peritonitis, or (5) perforation	30
Diverticular disease requiring hospitalization for abdominal distress, fever, and leukocytosis (elevated white blood cells) one or more times in the past 12 months; and without associated (1) hemorrhage, (2) obstruction, (3) abscess, (4) peritonitis, or (5) perforation	20
Asymptomatic; or a symptomatic diverticulitis or diverticulosis that is managed by diet and medication	0
Note: For colectomy or colostomy, use DC 7327 or DC 7329 (Intestine, large, resection of), whichever results in a higher evaluation.	
7328 Intestine, small, resection of:	
Status post intestinal resection with undernutrition and anemia; and requiring total parenteral nutrition (TPN)	80
Status post intestinal resection with undernutrition and anemia; and requiring prescribed oral dietary supplementation, continuous medication and intermittent total parenteral nutrition (TPN)	60
Status post intestinal resection with four or more episodes of diarrhea per day resulting in undernutrition and anemia; and requiring prescribed oral dietary supplementation and continuous medication	40
Status post intestinal resection with four or more episodes of diarrhea per day	20
Status post intestinal resection, asymptomatic	0
Note: This diagnostic code includes short bowel syndrome, mesenteric ischemic thrombosis, and post-bariatric surgery complications. Where short bowel syndrome results in high-output syndrome, to include high-output stoma, consider assigning a higher evaluation under DC 7329 (Intestine, large, resection of).	
7329 Intestine, large, resection of:	
Total colectomy with formation of ileostomy, high-output syndrome, and more than two episodes of dehydration requiring intravenous hydration in the past 12 months	100
Total colectomy with or without permanent colostomy or ileostomy without high-output syndrome	60
Partial colectomy with permanent colostomy or ileostomy without high-output syndrome	40
Partial colectomy with reanastomosis (reconnection of the intestinal tube) with loss of ileocecal valve and recurrent episodes of diarrhea more than 3 times per day	20
Partial colectomy with reanastomosis (reconnection of the intestinal tube)	10
7330 Intestinal fistulous disease, external:	

	Rating
Requiring total parenteral nutrition (TPN); or enteral nutritional support along with at least one of the following: (1) daily discharge equivalent to four or more ostomy bags (sized 130 cc), (2) requiring ten or more pad changes per day, or (3) a Body Mass Index (BMI) less than 16 and persistent drainage (any amount) for more than 1 month during the past 12 months ..	100
Requiring enteral nutritional support along with at least one of the following: (1) daily discharge equivalent to three or less ostomy bags (sized 130 cc), (2) requiring fewer than ten pad changes per day, or (3) a Body Mass Index (BMI) of 16 to 18 inclusive and persistent drainage (any amount) for more than 2 months in the past 12 months	60
Intermittent fecal discharge with persistent drainage for more than 3 months in the past 12 months	30
Note: This code applies to external fistulas that have developed as a consequence of abdominal trauma, surgery, radiation, malignancy, infection, or ischemia.	
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 characterized by incontinence or retention that is not responsive to a physician-prescribed bowel program and requires either surgery or digital stimulation, medication (beyond laxative use), and special diet; or incontinence to solids and/or liquids two or more times per day, which requires changing a pad two or more times per day	100
Complete or partial loss of sphincter control characterized by incontinence or retention that is partially responsive to a physician-prescribed bowel program and requires either surgery or digital stimulation, medication (beyond laxative use), and special diet; or incontinence to solids and/or liquids two or more times per week, which requires wearing a pad two or more times per week	60
Complete or partial loss of sphincter control characterized by incontinence or retention that is fully responsive to a physician-prescribed bowel program and requires digital stimulation, medication (beyond laxative use), and special diet; or incontinence to solids and/or liquids two or more times per month, which requires wearing a pad two or more times per month	30
Complete or partial loss of sphincter control characterized by incontinence or retention that is fully responsive to a physician-prescribed bowel program and requires medication or special diet; or incontinence to solids and/or liquids at least once every six months, which requires wearing a pad at least once every six months	10
History of loss of sphincter control, currently asymptomatic	0
Note: Complete or partial loss of sphincter control refers to the inability to retain or expel stool at an appropriate time and place.	
7333 Rectum and anus, stricture of:	
Inability to open the anus with inability to expel solid feces	100
Reduction of the lumen 50% or more, with pain and straining during defecation	60
Reduction of the lumen by less than 50%, with straining during defecation	30
Luminal narrowing with or without straining, managed by dietary intervention	10
Note (1): Conditions rated under this code include dyssynergic defecation (levator ani) and anismus (functional constipation)..	
Note (2): Evaluate an ostomy as Intestine, large, resection of (DC 7329)..	
7334 Rectum, prolapse of:	
Persistent irreducible prolapse, repairable or unrepairable	100
Manually reducible prolapse that is not repairable and occurs at times other than bowel movements, exertion, or while performing the Valsalva maneuver	50
Manually reducible prolapse that is not repairable and occurs only after bowel movements, exertion, or while performing the Valsalva maneuver	30
Spontaneously reducible prolapse that is not repairable	10
Note (1): For repairable prolapse of the rectum, continue the 100% evaluation for two months following repair. Thereafter, determine the appropriate evaluation based on residuals by mandatory VA examination. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination.	
Note (2): Where impairment of sphincter control constitutes the predominant disability, rate under diagnostic code 7332 (Rectum and anus, impairment of sphincter control).	
7335 Ano, fistula in, including anorectal fistula and anorectal abscess:	
More than two constant or near-constant fistulas with abscesses, drainage, and pain, which are refractory to medical and surgical treatment	60
One or two simultaneous fistulas, with abscess, drainage, and pain	40
Two or more simultaneous fistulas with drainage and pain, but without abscesses	20
One fistula with drainage and pain, but without abscess	10
7336 Hemorrhoids, external or internal:	
Internal or external hemorrhoids with persistent bleeding and anemia; or continuously prolapsed internal hemorrhoids with three or more episodes per year of thrombosis	20
Prolapsed internal hemorrhoids with two or less episodes per year of thrombosis; or external hemorrhoids with three or more episodes per year of thrombosis	10
7337 Pruritus ani (anal itching):	
With bleeding or excoriation	10
Without bleeding or excoriation	0
7338 Hernia, including femoral, inguinal, umbilical, ventral, incisional, and other (but not including hiatal).	
Irreparable hernia (new or recurrent) present for 12 months or more; with both of the following present for 12 months or more:	

	Rating
1. Size equal to 15 cm or greater in one dimension; and	
2. Pain when performing at least three of the following activities: (1) bending over, (2) activities of daily living (ADLs), (3) walking, and (4) climbing stairs	100
Irreparable hernia (new or recurrent) present for 12 months or more; with both of the following present for 12 months or more:	
1. Size equal to 15 cm or greater in one dimension; and	
2. Pain when performing two of the following activities: (1) bending over, (2) activities of daily living (ADLs), (3) walking, and (4) climbing stairs	60
Irreparable hernia (new or recurrent) present for 12 months or more; with both of the following present for 12 months or more:	
1. Size equal to 3 cm or greater but less than 15 cm in one dimension; and	
2. Pain when performing at least two of the following activities: (1) bending over, (2) activities of daily living (ADLs), (3) walking, and (4) climbing stairs	30
Irreparable hernia (new or recurrent) present for 12 months or more; with both of the following present for 12 months or more:	
1. Size equal to 3 cm or greater but less than 15 cm in one dimension; and	
2. Pain when performing one of the following activities: (1) bending over, (2) activities of daily living (ADLs), (3) walking, and (4) climbing stairs	20
Irreparable hernia (new or recurrent) present for 12 months or more; with hernia size smaller than 3 cm	10
Asymptomatic hernia; present and repairable, or repaired	0
Note (1): With two compensable inguinal hernias, evaluate the more severely disabling hernia first, and then add 10% to that rating to account for the second compensable hernia. Do not add 10% to that rating if the more severely disabling hernia is rated at 100%.	
Note (2): Any one of the following activities of daily living are sufficient for evaluation: bathing, dressing, hygiene, and/or transfers.	
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 a diagnostic code appropriate to the predominant disability or the specific residuals after treatment.	
Note: This diagnostic code includes lipoma, leiomyoma, colon polyps, or villous adenoma.	
7345 Chronic liver disease without cirrhosis:	
Progressive chronic liver disease requiring use of both parenteral antiviral therapy (direct antiviral agents), and parenteral immunomodulatory therapy (interferon and other); and for six months following discontinuance of treatment	100
Progressive chronic liver disease requiring continuous medication and causing substantial weight loss and at least two of the following: (1) daily fatigue, (2) malaise, (3) anorexia, (4) hepatomegaly, (5) pruritus, and (6) arthralgia	60
Progressive chronic liver disease requiring continuous medication and causing minor weight loss and at least two of the following: (1) daily fatigue, (2) malaise, (3) anorexia, (4) hepatomegaly, (5) pruritus, and (6) arthralgia	40
Chronic liver disease with at least one of the following: (1) intermittent fatigue, (2) malaise, (3) anorexia, (4) hepatomegaly, or (5) pruritus	20
Previous history of liver disease, currently asymptomatic	0
Note (1): 100% evaluation shall continue for six months following discontinuance of parenteral antiviral therapy and administration of parenteral immunomodulatory drugs. Six months after discontinuance of parenteral antiviral therapy and parenteral immunomodulatory drugs, determine the appropriate disability rating by mandatory VA exam. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination.	
Note (2): For individuals for whom physicians recommend both parenteral antiviral therapy and parenteral immunomodulatory drugs, but for whom treatment is medically contraindicated, rate according to DC 7312 (Cirrhosis of the liver).	
Note (3): This diagnostic code includes Hepatitis B (confirmed by serologic testing), primary biliary cirrhosis (PBC), primary sclerosing cholangitis (PSC), autoimmune liver disease, Wilson's disease, Alpha-1-antitrypsin deficiency, hemochromatosis, drug-induced hepatitis, and non-alcoholic steatohepatitis (NASH). Track Hepatitis C (or non-A, non-B hepatitis) under DC 7354 but evaluate it using the criteria in this entry.	
Note (4): 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)	
7346 Hiatal hernia and paraesophageal hernia: Rate as esophagus, stricture of (DC 7203).	
7347 Pancreatitis, chronic:	
Daily episodes of abdominal or mid-back pain that require three or more hospitalizations per year; and pain management by a physician; and maldigestion and malabsorption requiring dietary restriction and pancreatic enzyme supplementation	100

	Rating
Three or more episodes of abdominal or mid-back pain per year and at least one episode per year requiring hospitalization for management either of complications related to abdominal pain or complications of tube enteral feeding	60
At least one episode per year of abdominal or mid-back pain that requires ongoing outpatient medical treatment for pain, digestive problems, or management of related complications including but not limited to cyst, pseudocyst, intestinal obstruction, or ascites	30
Note (1): Appropriate diagnostic studies must confirm that abdominal pain in this condition results from pancreatitis.	
Note (2): Separately rate endocrine dysfunction resulting in diabetes due to pancreatic insufficiency under DC 7913 (Diabetes mellitus).	
7348 Vagotomy with pyloroplasty or gastroenterostomy:	
Following confirmation of postoperative complications of stricture or continuing gastric retention	40
With symptoms and confirmed diagnosis of alkaline gastritis, or with confirmed persisting diarrhea	30
With incomplete vagotomy	20
Note: Rate recurrent ulcer following complete vagotomy under DC 7304 (Peptic ulcer disease), with a minimum rating of 20%; and rate post-operative residuals not addressed by this diagnostic code under DC 7303 (Chronic complications of upper gastrointestinal surgery).	
7350 Liver abscess:	
Assign a rating of 100% for 6 months from the date of initial diagnosis. Six months following initial diagnosis, determine the appropriate disability rating by mandatory VA examination. Thereafter, rate the condition based on chronic residuals under the appropriate body system. Apply the provisions of § 3.105(e) of this chapter to any reduction in evaluation.	
Note:This diagnostic code includes abscesses caused by bacterial, viral, amebic (e.g., E. hystolytica), fungal (e.g., C. albicans), and other agents.	
7351 Liver transplant:	
For an indefinite period from the date of hospital admission for transplant surgery	100
Eligible and awaiting transplant surgery, minimum rating	60
Following transplant surgery, minimum rating	30
Note: Assign a rating of 100% as of the date of hospital admission for transplant surgery. One year following discharge, determine the appropriate disability rating by mandatory VA examination. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination. Rate residuals of any recurrent underlying liver disease under the appropriate diagnostic code and, when appropriate, combine with other post-transplant residuals under the appropriate body system(s), subject to the provisions of § 4.14 and this section.	
7352 Pancreas transplant:	
For an indefinite period from the date of hospital admission for transplant surgery	100
Minimum rating	30
Note: Assign a rating of 100% as of the date of hospital admission for transplant surgery. One year following discharge, determine the appropriate disability rating by mandatory VA examination. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination.	
7354 Hepatitis C (or non-A, non-B hepatitis):	
Rate under DC 7345 (Chronic liver disease without cirrhosis).	
7355 Celiac disease:	
Malabsorption syndrome with weakness which interferes with activities of daily living; and weight loss resulting in wasting and nutritional deficiencies; and with systemic manifestations including but not limited to, weakness and fatigue, dermatitis, lymph node enlargement, hypocalcemia, low vitamin levels; and anemia related to malabsorption; and episodes of abdominal pain and diarrhea due to lactase deficiency or pancreatic insufficiency	80
Malabsorption syndrome with chronic diarrhea managed by medically-prescribed dietary intervention such as prescribed gluten-free diet, with nutritional deficiencies due to lactase and pancreatic insufficiency; and with systemic manifestations including, but not limited to, weakness and fatigue, dermatitis, lymph node enlargement, hypocalcemia, low vitamin levels, or atrophy of the inner intestinal lining shown on biopsy	50
Malabsorption syndrome with chronic diarrhea managed by medically-prescribed dietary intervention such as prescribed gluten-free diet; and without nutritional deficiencies	30
Note (1): An appropriate serum antibody test or endoscopy with biopsy must confirm the diagnosis.	
Note (2): For evaluation of celiac disease with the predominant disability of malabsorption, use the greater evaluation between DC 7328 or celiac disease under DC 7355.	
7356 Gastrointestinal dysmotility syndrome:	
Requiring complete dependence on total parenteral nutrition (TPN) or continuous tube feeding for nutritional support	80
Requiring intermittent tube feeding for nutritional support; with recurrent emergency treatment for episodes of intestinal obstruction or regurgitation due to poor gastric emptying, abdominal pain, recurrent nausea, or recurrent vomiting	50
With symptoms of chronic intestinal pseudo-obstruction (CIPO) or symptoms of intestinal motility disorder, including but not limited to, abdominal pain, bloating, feeling of epigastric fullness, dyspepsia, nausea and vomiting, regurgitation, constipation, and diarrhea, managed by ambulatory care; and requiring prescribed dietary management or manipulation	30
Intermittent abdominal pain with epigastric fullness associated with bloating; and without evidence of a structural gastrointestinal disease	10

		Rating
	Note: Use this diagnostic code for illnesses associated with § 3.317(a)(2)(i)(B)(*3*) of this chapter, other than those which can be evaluated under DC 7319.	
7357	Post pancreatectomy syndrome:	
	Following total or partial pancreatectomy, evaluate under Pancreatitis, chronic (DC 7347), Chronic complications of upper gastrointestinal surgery (DC 7303), or based on residuals such as malabsorption (Intestine, small, resection of, DC 7328), diarrhea (Irritable bowel syndrome, DC 7319, or Crohn's disease or undifferentiated form of inflammatory bowel disease, DC 7326), or diabetes (DC 7913), whichever provides the highest evaluation.	
	Minimum	30

(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; 89 FR 19743, Mar. 20, 2024]

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 decision maker to these specific areas of dysfunction, only the predominant area of dysfunction shall be considered for rating purposes. Distinct disabilities may be evaluated separately under this section, pursuant to § 4.14, if the symptoms do not overlap. 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:	
Chronic kidney disease with glomerular filtration rate (GFR) less than 15 mL/min/1.73 m^2 for at least 3 consecutive months during the past 12 months; or requiring regular routine dialysis; or eligible kidney transplant recipient	100
Chronic kidney disease with GFR from 15 to 29 mL/min/1.73 m^2 for at least 3 consecutive months during the past 12 months	80
Chronic kidney disease with GFR from 30 to 44 mL/min/1.73 m^2 for at least 3 consecutive months during the past 12 months	60
Chronic kidney disease with GFR from 45 to 59 mL/min/1.73 m^2 for at least 3 consecutive months during the past 12 months	30
GFR from 60 to 89 mL/min/1.73 m^2 and either recurrent red blood cell (RBC) casts, white blood cell (WBC) casts, or granular casts for at least 3 consecutive months during the past 12 months; or	
GFR from 60 to 89 mL/min/1.73 m^2 and structural kidney abnormalities (cystic, obstructive, or glomerular) for at least 3 consecutive months during the past 12 months; or	
GFR from 60 to 89 mL/min/1.73 m^2 and albumin/creatinine ratio (ACR) ≥30 mg/g for at least 3 consecutive months during the past 12 months	0
Note: GFR, estimated GFR (eGFR), and creatinine-based approximations of GFR will be accepted for evaluation purposes under this section when determined to be appropriate and calculated by a medical professional.	
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

	Rating
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
Urinary tract infection:	
Poor renal function: Rate as renal dysfunction.	
Recurrent symptomatic infection requiring drainage by stent or nephrostomy tube; or requiring greater than 2 hospitalizations per year; or requiring continuous intensive management	30
Recurrent symptomatic infection requiring 1–2 hospitalizations per year or suppressive drug therapy lasting six months or longer	10
Recurrent symptomatic infection not requiring hospitalization, but requiring suppressive drug therapy for less than 6 months	0

[59 FR 2527, Jan. 18, 1994; 59 FR 10676, Mar. 7, 1994; 86 FR 54085, Sept. 30, 2021]

§ 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	.....
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/Ureterolithiasis/ Nephrocalcinosis:	
Rate as hydronephrosis, except for recurrent stone formation requiring 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
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, fistula of:	
Rate as voiding dysfunction.	
Multiple urethroperineal fistulae	100
7520 Penis, removal of half or more	[1] 30
7521 Penis, removal of glans	[1] 20
7522 Erectile dysfunction, with or without penile deformity	[1] 0
Note: For the purpose of VA disability evaluation, a disease or traumatic injury of the penis resulting in scarring or deformity shall be rated under diagnostic code 7522.	
7523 Testis, atrophy complete:.	

	Rating
Both—20 [1]	
One—0 [1]	
7524 Testis, removal:	
Both	[1] 30
One	[1] 0
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, undescended, or congenitally undeveloped is not a ratable disability.	
7525 Prostatitis, urethritis, epididymitis, orchitis (unilateral or bilateral), 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, bladder outlet obstruction:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	
7528 Malignant neoplasms of the genitourinary system	100
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:	
Rate as renal dysfunction.	
Note: Cystic diseases of the kidneys include, but are not limited to, polycystic disease, uremic medullary cystic disease, medullary sponge kidney, and similar conditions such as Alport's syndrome, cystinosis, primary oxalosis, and Fabry's disease.	
7534 Atherosclerotic renal disease (renal artery stenosis, atheroembolic renal disease, or large vessel disease, unspecified):	
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, including gouty nephropathy, disorders of calcium metabolism:	
Rate as renal dysfunction.	
7538 Papillary necrosis:	
Rate as renal dysfunction.	
7539 Renal amyloid disease:	
Rate as renal dysfunction.	
Note: This diagnostic code pertains to renal involvement secondary to all glomerulonephritis conditions, all vasculitis conditions and their derivatives, and other renal conditions caused by systemic diseases, such as Lupus erythematosus, systemic lupus erythematosus nephritis, Henoch-Schonlein syndrome, scleroderma, hemolytic uremic syndrome, polyarthritis, Wegener's granulomatosis, Goodpasture's syndrome, and sickle cell disease.	
7540 Disseminated intravascular coagulation with renal cortical necrosis:	
Rate as renal dysfunction.	
7541 Renal involvement in diabetes mellitus type I or II:	
Rate as renal dysfunction.	
7542 Neurogenic bladder:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	
7543 Varicocele/Hydrocele	[1] 0
7544 Renal disease caused by viral infection such as human immunodeficiency virus (HIV), Hepatitis B, and Hepatitis C:	
Rate as renal dysfunction.	
7545 Bladder, diverticulum of:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	

[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; 86 FR 54086, Sept. 30, 2021]

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 or clitoris, 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
Note: For the purpose of VA disability evaluation, a disease, injury, or adhesions of the ovaries resulting in ovarian dysfunction affecting the menstrual cycle, such as dysmenorrhea and secondary amenorrhea, shall be rated under diagnostic code 7615	
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
Note: In cases of the removal of one ovary as the result of a service-connected injury or disease, with the absence or nonfunctioning of a second ovary unrelated to service, an evaluation of 30 percent will be assigned for the service-connected ovarian loss	
7620 Ovaries, atrophy of both, complete	[1] 20
7621 Complete or incomplete pelvic organ prolapse due to injury, disease, or surgical complications of pregnancy	10
Note: Pelvic organ prolapse occurs when a pelvic organ such as bladder, urethra, uterus, vagina, small bowel, or rectum drops (prolapse) from its normal place in the abdomen. Conditions associated with pelvic organ prolapse include: uterine or vaginal vault prolapse, cystocele, urethrocele, rectocele, enterocele, or any combination thereof. Evaluate pelvic organ prolapse under DC 7621. Evaluate separately any genitourinary, digestive, or skin symptoms under the appropriate diagnostic code(s) and combine all evaluations with the 10 percent evaluation under DC 7621	
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..	

	Rating
(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	100
Note: A rating of 100 percent 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. Rate chronic residuals to include scars, lymphedema, disfigurement, and/or other impairment of function under the appropriate diagnostic code(s) within the appropriate body system	
7628 Benign neoplasms of gynecological system. Rate chronic residuals to include scars, lymphedema, disfigurement, and/or other impairment of function under the appropriate diagnostic code(s) within the appropriate body system	
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.	
7630 Malignant neoplasms of the breast	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation, 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. Rate chronic residuals according to impairment of function due to scars, lymphedema, or disfigurement (e.g., limitation of arm, shoulder, and wrist motion, or loss of grip strength, or loss of sensation, or residuals from harvesting of muscles for reconstructive purposes), and/or under diagnostic code 7626	
7631 Benign neoplasms of the breast and other injuries of the breast. Rate chronic residuals according to impairment of function due to scars, lymphedema, or disfigurement (e.g., limitation of arm, shoulder, and wrist motion, or loss of grip strength, or loss of sensation, or residuals from harvesting of muscles for reconstructive purposes), and/or under diagnostic code 7626	
7632 Female sexual arousal disorder (FSAD)	[1] 0

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

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

[60 FR 19855, Apr. 21, 1995, as amended at 67 FR 6874, Feb. 14, 2002; 67 FR 37695, May 30, 2002; 83 FR 15071, Apr. 9, 2018]

THE HEMATOLOGIC AND LYMPHATIC SYSTEMS

§4.117 Schedule of ratings—hemic and lymphatic systems.

	Rating
7702 Agranulocytosis, acquired:	
Requiring bone marrow transplant; or infections recurring, on average, at least once every six weeks per 12-month period	100
Requiring intermittent myeloid growth factors (granulocyte colony-stimulating factor (G–CSF) or granulocyte-macrophage colony-stimulating factor (GM–CSF) or continuous immunosuppressive therapy such as cyclosporine to maintain absolute neutrophil count (ANC) greater than 500/microliter (μl) but less than 1000/μl; or infections recurring, on average, at least once every three months per 12-month period	60
Requiring intermittent myeloid growth factors to maintain ANC greater than 1000/μl; or infections recurring, on average, at least once per 12-month period but less than once every three months per 12-month period	30
Requiring continuous medication (e.g., antibiotics) for control; or requiring intermittent use of a myeloid growth factor to maintain ANC greater than or equal to 1500/μl	10
Note: A 100 percent evaluation 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 (except for chronic myelogenous leukemia):	
When there is active disease or during a treatment phase	100
Otherwise rate residuals under the appropriate diagnostic code(s).	
Chronic lymphocytic leukemia or monoclonal B-cell lymphocytosis (MBL), asymptomatic, Rai Stage 0	0
Note (1): A 100 percent evaluation shall continue beyond the cessation of any surgical therapy, radiation therapy, 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	
Note (2): Evaluate symptomatic chronic lymphocytic leukemia that is at Rai Stage I, II, III, or IV the same as any other leukemia evaluated under this diagnostic code	
Note (3): Evaluate residuals of leukemia or leukemia therapy under the appropriate diagnostic code(s). Myeloproliferative Disorders: (Diagnostic Codes 7704, 7718, 7719)	

	Rating
7704 Polycythemia vera:	
Requiring peripheral blood or bone marrow stem-cell transplant or chemotherapy (including myelosuppressants) for the purpose of ameliorating the symptom burden	100
Requiring phlebotomy 6 or more times per 12-month period or molecularly targeted therapy for the purpose of controlling RBC count	60
Requiring phlebotomy 4–5 times per 12-month period, or if requiring continuous biologic therapy or myelosuppressive agents, to include interferon, to maintain platelets <200,000 or white blood cells (WBC) <12,000	30
Requiring phlebotomy 3 or fewer times per 12-month period or if requiring biologic therapy or interferon on an intermittent basis as needed to maintain all blood values at reference range levels	10
Note (1): Rate complications such as hypertension, gout, stroke, or thrombotic disease separately	
Note (2): If the condition undergoes leukemic transformation, evaluate as leukemia under diagnostic code 7703	
Note (3): A 100 percent evaluation shall be assigned as of the date of hospital admission for peripheral blood or bone marrow stem cell transplant; or during the period of treatment with chemotherapy (including myelosuppressants). Six months following hospital discharge or, in the case of chemotherapy treatment, six months after completion of treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	
7705 Immune thrombocytopenia:	
Requiring chemotherapy for chronic refractory thrombocytopenia; or a platelet count 30,000 or below despite treatment	100
Requiring immunosuppressive therapy; or for a platelet count higher than 30,000 but not higher than 50,000, with history of hospitalization because of severe bleeding requiring intravenous immune globulin, high-dose parenteral corticosteroids, and platelet transfusions	70
Platelet count higher than 30,000 but not higher than 50,000, with either immune thrombocytopenia or mild mucous membrane bleeding which requires oral corticosteroid therapy or intravenous immune globulin	30
Platelet count higher than 30,000 but not higher than 50,000, not requiring treatment	10
Platelet count above 50,000 and asymptomatic; or for immune thrombocytopenia in remission	0
Note (1): Separately evaluate splenectomy under diagnostic code 7706 and combine with an evaluation under this diagnostic code	
Note (2): A 100 percent evaluation shall continue beyond the cessation of chemotherapy. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	
7706 Splenectomy	20
Note: Separately rate complications such as systemic infections with encapsulated bacteria	
Note: Separately rate complications such as systemic infections with encapsulated bacteria	
7707 Spleen, injury of, healed.	
Rate for any residuals.	
7709 Hodgkin's lymphoma:	
With active disease or during a treatment phase	100
Note: A 100 percent evaluation shall continue beyond the cessation of any surgical therapy, radiation therapy, 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 reduction 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 under the appropriate diagnostic code(s).	
7710 Adenitis, tuberculous, active or inactive:	
Rate under § 4.88c or 4.89 of this part, whichever is appropriate.	
7712 Multiple myeloma:	
Symptomatic multiple myeloma	100
Asymptomatic, smoldering, or monoclonal gammopathy of undetermined significance (MGUS)	0
Note (1): Current validated biomarkers of symptomatic multiple myeloma and asymptomatic multiple myeloma, smoldering, or monoclonal gammopathy of undetermined significance (MGUS) are acceptable for the diagnosis of multiple myeloma as defined by the American Society of Hematology (ASH) and International Myeloma Working Group (IMWG)	
Note (2): The 100 percent evaluation shall continue for five years after the diagnosis of symptomatic multiple myeloma, at which time the appropriate disability evaluation shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) and § 3.344 (a) and (b) of this chapter	
7714 Sickle cell anemia:	
With at least 4 or more painful episodes per 12-month period, occurring in skin, joints, bones, or any major organs, caused by hemolysis and sickling of red blood cells, with anemia, thrombosis, and infarction, with residual symptoms precluding even light manual labor	100
With 3 painful episodes per 12-month period or with symptoms precluding other than light manual labor	60
With 1 or 2 painful episodes per 12-month period	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 Service, for consideration under § 3.321(b)(1) of this chapter	
7715 Non-Hodgkin's lymphoma:	

	Rating
When there is active disease, during treatment phase, or with indolent and non-contiguous phase of low grade NHL	100
Note: A 100 percent evaluation shall continue beyond the cessation of any surgical therapy, radiation therapy, antineoplastic chemotherapy, or other therapeutic procedures. Two years after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction 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 under the appropriate diagnostic code(s)	
7716 Aplastic anemia:	
Requiring peripheral blood or bone marrow stem cell transplant; or requiring transfusion of platelets or red cells, on average, at least once every six weeks per 12-month period; or infections recurring, on average, at least once every six weeks per 12-month period	100
Requiring transfusion of platelets or red cells, on average, at least once every three months per 12-month period; or infections recurring, on average, at least once every three months per 12-month period; or using continuous therapy with immunosuppressive agent or newer platelet stimulating factors	60
Requiring transfusion of platelets or red cells, on average, at least once per 12-month period; or infections recurring, on average, at least once per 12-month period	30
Note (1): A 100 percent evaluation for peripheral blood or bone marrow stem cell 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	
Note (2): The term ''newer platelet stimulating factors'' includes medication, factors, or other agents approved by the United States Food and Drug Administration	
7717 AL amyloidosis (primary amyloidosis)	100
7718 Essential thrombocythemia and primary myelofibrosis:	
Requiring either continuous myelosuppressive therapy, or, for six months following hospital admission for any of the following treatments: peripheral blood or bone marrow stem cell transplant, or chemotherapy, or interferon treatment	100
Requiring continuous or intermittent myelosuppressive therapy, or chemotherapy, or interferon treatment to maintain platelet count $<500 \times 10^9$/L	70
Requiring continuous or intermittent myelosuppressive therapy, or chemotherapy, or interferon treatment to maintain platelet count of 200,000–400,000, or white blood cell (WBC) count of 4,000–10,000	30
Asymptomatic	0
Note (1): If the condition undergoes leukemic transformation, evaluate as leukemia under diagnostic code 7703.	
Note (2): A 100 percent evaluation shall be assigned as of the date of hospital admission for peripheral blood or bone marrow stem cell transplant; or during the period of treatment with chemotherapy (including myelosuppressants) or interferon treatment. Six months following hospital discharge or, in the case of chemotherapy treatment, six months after completion of treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.	
7719 Chronic myelogenous leukemia (CML) (chronic myeloid leukemia or chronic granulocytic leukemia):	
Requiring peripheral blood or bone marrow stem cell transplant, or continuous myelosuppressive or immunosuppressive therapy treatment	100
Requiring intermittent myelosuppressive therapy, or molecularly targeted therapy with tyrosine kinase inhibitors, or interferon treatment when not in apparent remission	60
In apparent remission on continuous molecularly targeted therapy with tyrosine kinase inhibitors	30
Note (1): If the condition undergoes leukemic transformation, evaluate as leukemia under diagnostic code 7703	
Note (2): A 100 percent evaluation shall be assigned as of the date of hospital admission for peripheral blood or bone marrow stem cell transplant; or during the period of treatment with chemotherapy (including myelosuppressants). Six months following hospital discharge or, in the case of chemotherapy treatment, six months after completion of treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105 of this chapter	
7720 Iron deficiency anemia:	
Requiring intravenous iron infusions 4 or more times per 12-month period	30
Requiring intravenous iron infusions at least 1 time but less than 4 times per 12-month period, or requiring continuous treatment with oral supplementation	10
Asymptomatic or requiring treatment only by dietary modification	0
Note: Do not evaluate iron deficiency anemia due to blood loss under this diagnostic code. Evaluate iron deficiency anemia due to blood loss under the criteria for the condition causing the blood loss	
7721 Folic acid deficiency:	
Requiring continuous treatment with high-dose oral supplementation	10
Asymptomatic or requiring treatment only by dietary modification	0
7722 Pernicious anemia and Vitamin B_{12} deficiency anemia:	
For initial diagnosis requiring transfusion due to severe anemia, or if there are signs or symptoms related to central nervous system impairment, such as encephalopathy, myelopathy, or severe peripheral neuropathy, requiring parenteral B_{12} therapy	100

	Rating
Requiring continuous treatment with Vitamin B_{12} injections, Vitamin B_{12} sublingual or high-dose oral tablets, or Vitamin B_{12} nasal spray or gel	10
Note: A 100 percent evaluation for pernicious anemia and Vitamin B_{12} deficiency shall be assigned as of the date of the initial diagnosis requiring transfusion due to severe anemia or parenteral B_{12} therapy and shall continue with a mandatory VA examination six months following hospital discharge or cessation of parenteral B_{12} therapy. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. Thereafter, evaluate at 10 percent and separately evaluate any residual effects of pernicious anemia, such as neurologic involvement causing peripheral neuropathy, myelopathy, dementia, or related gastrointestinal residuals, under the most appropriate diagnostic code	
7723 Acquired hemolytic anemia:	
Requiring a bone marrow transplant or continuous intravenous or immunosuppressive therapy (e.g., prednisone, Cytoxan, azathioprine, or rituximab)	100
Requiring immunosuppressive medication 4 or more times per 12-month period	60
Requiring at least 2 but less than 4 courses of immunosuppressive therapy per 12-month period	30
Requiring one course of immunosuppressive therapy per 12-month period	10
Asymptomatic	0
Note (1): A 100 percent evaluation for bone marrow transplant shall be assigned as of the date of hospital admission and shall continue for six months after hospital discharge with a mandatory VA examination six months following hospital discharge. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	
Note (2): Separately evaluate splenectomy under diagnostic code 7706 and combine with an evaluation under diagnostic code 7723	
7724 Solitary plasmacytoma:	
Solitary plasmacytoma, when there is active disease or during a treatment phase	100
Note (1): A 100 percent evaluation shall continue beyond the cessation of any surgical therapy, radiation therapy, antineoplastic chemotherapy, or other therapeutic procedures (including autologous stem cell transplantation). 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 residuals under the appropriate diagnostic codes	
Note (2): Rate a solitary plasmacytoma that has developed into multiple myeloma as symptomatic multiple myeloma	
Note (3): Rate residuals of plasma cell dysplasia (e.g., thrombosis) and adverse effects of medical treatment (e.g., neuropathy) under the appropriate diagnostic codes	
7725 Myelodysplastic syndromes:	
Requiring peripheral blood or bone marrow stem cell transplant; or requiring chemotherapy	100
Requiring 4 or more blood or platelet transfusions per 12-month period; or infections requiring hospitalization 3 or more times per 12-month period	60
Requiring at least 1 but no more than 3 blood or platelet transfusions per 12-month period; infections requiring hospitalization at least 1 but no more than 2 times per 12-month period; or requiring biologic therapy on an ongoing basis or erythropoiesis stimulating agent (ESA) for 12 weeks or less per 12-month period	30
Note (1): If the condition progresses to leukemia, evaluate as leukemia under diagnostic code 7703	
Note (2): A 100 percent evaluation shall be assigned as of the date of hospital admission for peripheral blood or bone marrow stem cell transplant, or during the period of treatment with chemotherapy, and shall continue with a mandatory VA examination six months following hospital discharge or, in the case of chemotherapy treatment, six months after completion of treatment. Any reduction 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, residuals will be rated under the appropriate diagnostic codes	

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THE SKIN

§ 4.118 Schedule of ratings—skin.

(a) For the purposes of this section, systemic therapy is treatment that is administered through any route (orally, injection, suppository, intranasally) other than the skin, and topical therapy is treatment that is administered through the skin.

(b) Two or more skin conditions may be combined in accordance with § 4.25 only if separate areas of skin are involved. If two or more skin conditions involve the same area of skin, then only the highest evaluation shall be used.

	Rating
7800 Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other 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

	Rating
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.	
Note (4): Separately evaluate disabling effects other than disfigurement that are associated with individual scar(s) of the head, face, or neck, such as pain, instability, and residuals of associated muscle or nerve injury, under the appropriate diagnostic code(s) and apply §4.25 to combine the evaluation(s) with the evaluation assigned under this diagnostic code.	
Note (5): The characteristic(s) of disfigurement may be caused by one scar or by multiple scars; the characteristic(s) required to assign a particular evaluation need not be caused by a single scar in order to assign that evaluation.	
7801 Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck, that are associated with underlying soft tissue damage:	
Area or areas of 144 square inches (929 sq. cm.) or greater	40
Area or areas of at least 72 square inches (465 sq. cm.) but less than 144 square inches (929 sq. cm.)	30
Area or areas of at least 12 square inches (77 sq. cm.) but less than 72 square inches (465 sq. cm.)	20
Area or areas of at least 6 square inches (39 sq. cm.) but less than 12 square inches (77 sq. cm.)	10
Note (1): For the purposes of DCs 7801 and 7802, the six (6) zones of the body are defined as each extremity, anterior trunk, and posterior trunk. The midaxillary line divides the anterior trunk from the posterior trunk.	
Note (2): A separate evaluation may be assigned for each affected zone of the body under this diagnostic code if there are multiple scars, or a single scar, affecting multiple zones of the body. Combine the separate evaluations under §4.25. Alternatively, if a higher evaluation would result from adding the areas affected from multiple zones of the body, a single evaluation may also be assigned under this diagnostic code.	
7802 Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck, that are not associated with underlying soft tissue damage:	
Area or areas of 144 square inches (929 sq. cm.) or greater	10
Note (1): For the purposes of DCs 7801 and 7802, the six (6) zones of the body are defined as each extremity, anterior trunk, and posterior trunk. The midaxillary line divides the anterior trunk from the posterior trunk.	
Note (2): A separate evaluation may be assigned for each affected zone of the body under this diagnostic code if there are multiple scars, or a single scar, affecting multiple zones of the body. Combine the separate evaluations under §4.25. Alternatively, if a higher evaluation would result from adding the areas affected from multiple zones of the body, a single evaluation may also be assigned under this diagnostic code.	
7804 Scar(s), unstable or painful:.	
Five or more scars that are unstable or painful	30
Three or four scars that are unstable or painful	20
One or two scars that are unstable or painful	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): If one or more scars are both unstable and painful, add 10 percent to the evaluation that is based on the total number of unstable or painful scars	
Note (3): Scars evaluated under diagnostic codes 7800, 7801, 7802, or 7805 may also receive an evaluation under this diagnostic code, when applicable	
7805 Scars, other; and other effects of scars evaluated under diagnostic codes 7800, 7801, 7802, or 7804:	
Evaluate any disabling effect(s) not considered in a rating provided under diagnostic codes 7800–04 under an appropriate diagnostic code.	
General Rating Formula For The Skin For DCs 7806, 7809, 7813–7816, 7820–7822, and 7824:	
At least one of the following	60
Characteristic lesions involving more than 40 percent of the entire body or more than 40 percent of exposed areas affected; or	

	Rating
Constant or near-constant systemic therapy including, but not limited to, corticosteroids, phototherapy, retinoids, biologics, photochemotherapy, psoralen with long-wave ultraviolet-A light (PUVA), or other immunosuppressive drugs required over the past 12-month period	60
At least one of the following	30
Characteristic lesions involving 20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected; or Systemic therapy including, but not limited to, corticosteroids, phototherapy, retinoids, biologics, photochemotherapy, PUVA, or other immunosuppressive drugs required for a total duration of 6 weeks or more, but not constantly, over the past 12-month period.	
At least one of the following	10
Characteristic lesions involving at least 5 percent, but less than 20 percent, of the entire body affected; or	
At least 5 percent, but less than 20 percent, of exposed areas affected; or	
Intermittent systemic therapy including, but not limited to, corticosteroids, phototherapy, retinoids, biologics, photochemotherapy, PUVA, or other immunosuppressive drugs required for a total duration of less than 6 weeks over the past 12-month period.	
No more than topical therapy required over the past 12-month period and at least one of the following	0
Characteristic lesions involving less than 5 percent of the entire body affected; or	
Characteristic lesions involving less than 5 percent of exposed areas affected.	
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability. This rating instruction does not apply to DC 7824.	
7806 Dermatitis or eczema.	
Evaluate under the General Rating Formula for the Skin.	
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.	
Evaluate under the General Rating Formula for the Skin.	
Note: 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 (onychomycosis); of inguinal area (jock itch), tinea cruris; tinea versicolor).	
Evaluate under the General Rating Formula for the Skin.	
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).	
Evaluate under the General Rating Formula for the Skin.	
Note: Rate complications and residuals of mucosal involvement (ocular, oral, gastrointestinal, respiratory, or genitourinary) separately under the appropriate diagnostic code.	
7816 Psoriasis.	
Evaluate under the General Rating Formula for the Skin.	
Note: Rate complications such as psoriatic arthritis and other clinical manifestations (*e.g.,* oral mucosa, nails) separately under the appropriate diagnostic code.	
7817 Erythroderma:	
Generalized involvement of the skin with systemic manifestations (such as fever, weight loss, or hypoproteinemia) AND one of the following	100
Constant or near-constant systemic therapy such as therapeutic doses of corticosteroids, other immunosuppressive drugs, retinoids, PUVA (psoralen with long-wave ultraviolet-A light), UVB (ultraviolet-B light) treatments, biologics, or electron beam therapy required over the past 12 month period; or	
No current treatment due to a documented history of treatment failure with 2 or more treatment regimens	100
Generalized involvement of the skin without systemic manifestations and one of the following.	
Constant or near-constant systemic therapy such as therapeutic doses of corticosteroids, other immunosuppressive drugs, retinoids, PUVA, UVB treatments, biologics, or electron beam therapy required over the past 12-month period; or	
No current treatment due to a documented history of treatment failure with 1 treatment regimen	60
Any extent of involvement of the skin, and any of the following therapies required for a total duration of 6 weeks or more, but not constantly, over the past 12-month period: systemic therapy such as therapeutic doses of corticosteroids, other immunosuppressive drugs, retinoids, PUVA, UVB treatments, biologics, or electron beam therapy	30
Any extent of involvement of the skin, and any of the following therapies required for a total duration of less than 6 weeks over the past 12-month period: systemic therapy such as therapeutic doses of corticosteroids, other immunosuppressive drugs, retinoids, PUVA, UVB treatments, biologics, or electron beam therapy	10

	Rating
Any extent of involvement of the skin, and no more than topical therapy required over the past 12-month period	0
Note: Treatment failure is defined as either disease progression, or less than a 25 percent reduction in the extent and severity of disease after four weeks of prescribed therapy, as documented by medical records.	
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).	
Evaluate under the General Rating Formula for the Skin.	
7821 Cutaneous manifestations of collagen-vascular diseases not listed elsewhere (including scleroderma, calcinosis cutis, subacute cutaneous lupus erythematosus, and dermatomyositis).	
Evaluate under the General Rating Formula for the Skin.	
7822 Papulosquamous disorders not listed elsewhere (including lichen planus, large or small plaque parapsoriasis, pityriasis lichenoides et varioliformis acuta (PLEVA), lymphomatoid papulosus, mycosis fungoides, and pityriasis rubra pilaris (PRP)).	
Evaluate under the General Rating Formula for the Skin.	
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).	
Evaluate under the General Rating Formula for the Skin.	
7825 Chronic urticaria:	
For the purposes of this diagnostic code, chronic urticaria is defined as continuous urticaria at least twice per week, off treatment, for a period of six weeks or more.	
Chronic refractory urticaria that requires third line treatment for control (e.g., plasmapheresis, immunotherapy, immunosuppressives) due to ineffectiveness with first and second line treatments	60
Chronic urticaria that requires second line treatment (e.g., corticosteroids, sympathomimetics, leukotriene inhibitors, neutrophil inhibitors, thyroid hormone) for control	30
Chronic urticaria that requires first line treatment (antihistamines) for control	10
7826 Vasculitis, primary cutaneous:	
Persistent documented vasculitis episodes refractory to continuous immunosuppressive therapy	60
All of the following	30
Recurrent documented vasculitic episodes occurring four or more times over the past 12-month period; and	
Requiring intermittent systemic immunosuppressive therapy for control	30
At least one of the following	10
Recurrent documented vasculitic episodes occurring one to three times over the past 12-month period, and requiring intermittent systemic immunosuppressive therapy for control; or	
Without recurrent documented vasculitic episodes but requiring continuous systemic medication for control.	
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability.	
7827 Erythema multiforme; Toxic epidermal necrolysis:	
Recurrent mucosal, palmar, or plantar involvement impairing mastication, use of hands, or ambulation occurring four or more times over the past 12-month period despite ongoing immunosuppressive therapy	60
All of the following	30
Recurrent mucosal, palmar, or plantar involvement not impairing mastication, use of hands, or ambulation, occurring four or more times over the past 12-month period; andrequiring intermittent systemic therapy.	
At least one of the following	10
One to three episodes of mucosal, palmar, or plantar involvement not impairing mastication, use of hands, or ambulation, occurring over the past 12-month period AND requiring intermittent systemic therapy; or	
Without recurrent episodes, but requiring continuous systemic medication for control.	
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability.	
Note: For the purposes of this DC only, systemic therapy may consist of one or more of the following treatment agents: immunosuppressives, antihistamines, or sympathomimetics.	
7828 Acne:	
Deep acne (deep inflamed nodules and pus-filled cysts) affecting 40 percent or more of the face and neck	30

	Rating
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) of any extent	0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 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 the intertriginous areas (the axilla of the arm, the anogenital region, skin folds of the breasts, or between digits)	20
Deep acne (deep inflamed nodules and pus-filled cysts) affecting less than 40 percent of the face and neck; or deep acne affecting non-intertriginous areas of the body (other than the face and neck)	10
Superficial acne (comedones, papules, pustules) of any extent	0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability.	
7830 Scarring alopecia:	
Affecting more than 40 percent of the scalp	20
Affecting 20 to 40 percent of the scalp	10
Affecting less than 20 percent of the scalp	0
7831 Alopecia areata:	
With loss of all body hair	10
With loss of hair limited to scalp and face	0
7832 Hyperhidrosis:	
Unable to handle paper or tools because of moisture, and unresponsive to therapy	30
Able to handle paper or tools after therapy	0
7833 Malignant melanoma:	
Rate as scars (DC's 7801, 7802, 7803, 7804, 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)

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THE ENDOCRINE SYSTEM

§ 4.119 Schedule of ratings—endocrine system.

	Rating
7900 Hyperthyroidism, including, but not limited to, Graves' disease:	
For six months after initial diagnosis	30
Thereafter, rate residuals of disease or complications of medical treatment within the appropriate diagnostic code(s) within the appropriate body system.	
Note (1): If hyperthyroid cardiovascular or cardiac disease is present, separately evaluate under DC 7008 (hyperthyroid heart disease).	
Note (2): Separately evaluate eye involvement occurring as a manifestation of Graves' Disease as diplopia (DC 6090); impairment of central visual acuity (DCs 6061–6066); or under the most appropriate DCs in § 4.79.	
7901 Thyroid enlargement, toxic:	
Note (1): Evaluate symptoms of hyperthyroidism under DC 7900, hyperthyroidism, including, but not limited to, Graves' disease.	
Note (2): If disfigurement of the neck is present due to thyroid disease or enlargement, separately evaluate under DC 7800 (burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck).	
7902 Thyroid enlargement, nontoxic:	
Note (1): Evaluate symptoms due to pressure on adjacent organs (such as the trachea, larynx, or esophagus) under the appropriate diagnostic code(s) within the appropriate body system.	
Note (2): If disfigurement of the neck is present due to thyroid disease or enlargement, separately evaluate under DC 7800 (burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck).	
7903 Hypothyroidism:	
Hypothyroidism manifesting as myxedema (cold intolerance, muscular weakness, cardiovascular involvement (including, but not limited to hypotension, bradycardia, and pericardial effusion), and mental disturbance (including, but not limited to dementia, slowing of thought and depression))	100
Note (1): This evaluation shall continue for six months beyond the date that an examining physician has determined crisis stabilization. Thereafter, the residual effects of hypothyroidism shall be rated under the appropriate diagnostic code(s) within the appropriate body system(s) (*e.g.,* eye, digestive, and mental disorders).	
Hypothyroidism without myxedema	30

	Rating
Note (2): This evaluation shall continue for six months after initial diagnosis. Thereafter, rate residuals of disease or medical treatment under the most appropriate diagnostic code(s) under the appropriate body system (*e.g.,* eye, digestive, mental disorders).	
Note (3): If eye involvement, such as exophthalmos, corneal ulcer, blurred vision, or diplopia, is also present due to thyroid disease, also separately evaluate under the appropriate diagnostic code(s) in §4.79, Schedule of Ratings—Eye (such as diplopia (DC 6090) or impairment of central visual acuity (DCs 6061–6066)).	
7904 Hyperparathyroidism:	
For six months from date of discharge following surgery	100
Note (1): After six months, rate on residuals under the appropriate diagnostic code(s) within the appropriate body system(s) based on a VA examination.	
Hypercalcemia (indicated by at least one of the following: Total Ca greater than 12 mg/dL (3–3.5 mmol/L), Ionized Ca greater than 5.6 mg/dL (2–2.5 mmol/L), creatinine clearance less than 60 mL/min, bone mineral density T-score less than 2.5 SD (below mean) at any site or previous fragility fracture)	60
Note (2): Where surgical intervention is indicated, this evaluation shall continue until the day of surgery, at which time the provisions pertaining to a 100-percent evaluation shall apply.	
Note (3): Where surgical intervention is not indicated, this evaluation shall continue for six months after pharmacologic treatment begins. After six months, rate on residuals under the appropriate diagnostic code(s) within the appropriate body system(s) based on a VA examination.	
Symptoms such as fatigue, anorexia, nausea, or constipation that occur despite surgery; or in individuals who are not candidates for surgery but require continuous medication for control	10
Asymptomatic	0
Note (4): Following surgery or other treatment, evaluate chronic residuals, such as nephrolithiasis (kidney stones), decreased renal function, fractures, vision problems, and cardiovascular complications, under the appropriate diagnostic codes.	
7905 Hypoparathyroidism:	
For three months after initial diagnosis	100
Thereafter, evaluate chronic residuals, such as nephrolithiasis (kidney stones), cataracts, decreased renal function, and congestive heart failure under the appropriate diagnostic codes.	
7906 Thyroiditis:	
With normal thyroid function (euthyroid)	0
Note: Manifesting as hyperthyroidism, evaluate as hyperthyroidism, including, but not limited to, Graves' disease (DC 7900); manifesting as hypothyroidism, evaluate as hypothyroidism (DC 7903).	
7907 Cushing's syndrome:	
As active, progressive disease, including areas of osteoporosis, hypertension, and proximal upper and lower extremity muscle wasting that results in inability to rise from squatting position, climb stairs, rise from a deep chair without assistance, or raise arms	100
Proximal upper or lower extremity muscle wasting that results in inability to rise from squatting position, climb stairs, rise from a deep chair without assistance, or raise arms	60
With striae, obesity, moon face, glucose intolerance, and vascular fragility	30
Note: The evaluations specifically indicated under this diagnostic code shall continue for six months following initial diagnosis. After six months, rate on residuals under the appropriate diagnostic code(s) within the appropriate body system(s).	
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
Enlargement of acral parts or overgrowth of long bones	30
7909 Diabetes insipidus:	
For three months after initial diagnosis	30
Note: Thereafter, if diabetes insipidus has subsided, rate residuals under the appropriate diagnostic code(s) within the appropriate body system.	
With persistent polyuria or requiring continuous hormonal therapy	10
7911 Addison's disease (adrenocortical insufficiency):	
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 Polyglandular syndrome (multiple endocrine neoplasia, autoimmune polyglandular syndrome):	
Evaluate according to major manifestations to include, but not limited to, Type I diabetes mellitus, hyperthyroidism, hypothyroidism, hypoparathyroidism, or Addison's disease.	
7913 Diabetes mellitus:	

	Rating
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 one or more daily injection of 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 one or more daily injection of insulin, restricted diet, and regulation of activities	40
Requiring one or more daily injection of 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 DC 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):	
Note: Evaluate as malignant or benign neoplasm, as appropriate.	
7917 Hyperaldosteronism (benign or malignant):	
Note: Evaluate as malignant or benign neoplasm, as appropriate.	
7918 Pheochromocytoma (benign or malignant):	
Note: Evaluate as malignant or benign neoplasm as appropriate.	
7919 C-cell hyperplasia of the thyroid:	
If antineoplastic therapy is required, evaluate as a malignant neoplasm under DC 7914. If a prophylactic thyroidectomy is performed (based upon genetic testing) and antineoplastic therapy is not required, evaluate as hypothyroidism under DC 7903.	

[61 FR 20446, May 7, 1996, as amended at 82 FR 50804, Nov. 2, 2017]

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

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
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	100
NOTE: Consider the need for special monthly compensation.	
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
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 Residuals of traumatic brain injury (TBI):	
There are three main areas of dysfunction that may result from TBI and have profound effects on functioning: cognitive (which is common in varying degrees after TBI), emotional/behavioral, and physical. Each of these areas of dysfunction may require evaluation..	
Cognitive impairment is defined as decreased memory, concentration, attention, and executive functions of the brain. Executive functions are goal setting, speed of information processing, planning, organizing, prioritizing, self-monitoring, problem solving, judgment, decision making, spontaneity, and flexibility in changing actions when they are not productive. Not all of these brain functions may be affected in a given individual with cognitive impairment, and some functions may be affected more severely than others. In a given individual, symptoms may fluctuate in severity from day to day. Evaluate cognitive impairment under the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.''.	
Subjective symptoms may be the only residual of TBI or may be associated with cognitive impairment or other areas of dysfunction. Evaluate subjective symptoms that are residuals of TBI, whether or not they are part of cognitive impairment, under the subjective symptoms facet in the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.'' However, separately evaluate any residual with a distinct diagnosis that may be evaluated under another diagnostic code, such as migraine headache or Meniere's disease, even if that diagnosis is based on subjective symptoms, rather than under the ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' table.	
Evaluate emotional/behavioral dysfunction under § 4.130 (Schedule of ratings—mental disorders) when there is a diagnosis of a mental disorder. When there is no diagnosis of a mental disorder, evaluate emotional/behavioral symptoms under the criteria in the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.''.	
Evaluate physical (including neurological) dysfunction based on the following list, under an appropriate diagnostic code: Motor and sensory dysfunction, including pain, of the extremities and face; visual impairment; hearing loss and tinnitus; loss of sense of smell and taste; seizures; gait, coordination, and balance problems; speech and other communication difficulties, including aphasia and related disorders, and dysarthria; neurogenic bladder; neurogenic bowel; cranial nerve dysfunctions; autonomic nerve dysfunctions; and endocrine dysfunctions..	

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
The preceding list of types of physical dysfunction does not encompass all possible residuals of TBI. For residuals not listed here that are reported on an examination, evaluate under the most appropriate diagnostic code. Evaluate each condition separately, as long as the same signs and symptoms are not used to support more than one evaluation, and combine under § 4.25 the evaluations for each separately rated condition. The evaluation assigned based on the ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' table will be considered the evaluation for a single condition for purposes of combining with other disability evaluations.	
Consider the need for special monthly compensation for such problems as loss of use of an extremity, certain sensory impairments, erectile dysfunction, the need for aid and attendance (including for protection from hazards or dangers incident to the daily environment due to cognitive impairment), being housebound, etc.	
Evaluation of Cognitive Impairment and Subjective Symptoms	
The table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' contains 10 important facets of TBI related to cognitive impairment and subjective symptoms. It provides criteria for levels of impairment for each facet, as appropriate, ranging from 0 to 3, and a 5th level, the highest level of impairment, labeled ''total.'' However, not every facet has every level of severity. The Consciousness facet, for example, does not provide for an impairment level other than ''total,'' since any level of impaired consciousness would be totally disabling. Assign a 100-percent evaluation if ''total'' is the level of evaluation for one or more facets. If no facet is evaluated as ''total,'' assign the overall percentage evaluation based on the level of the highest facet as follows: 0 = 0 percent; 1 = 10 percent; 2 = 40 percent; and 3 = 70 percent. For example, assign a 70 percent evaluation if 3 is the highest level of evaluation for any facet..	
Note (1): There may be an overlap of manifestations of conditions evaluated under the table titled ''Evaluation Of Cognitive Impairment And Other Residuals Of TBI Not Otherwise Classified'' with manifestations of a comorbid mental or neurologic or other physical disorder that can be separately evaluated under another diagnostic code. In such cases, do not assign more than one evaluation based on the same manifestations. If the manifestations of two or more conditions cannot be clearly separated, assign a single evaluation under whichever set of diagnostic criteria allows the better assessment of overall impaired functioning due to both conditions. However, if the manifestations are clearly separable, assign a separate evaluation for each condition..	
Note (2): Symptoms listed as examples at certain evaluation levels in the table are only examples and are not symptoms that must be present in order to assign a particular evaluation..	
Note (3): ''Instrumental activities of daily living'' refers to activities other than self-care that are needed for independent living, such as meal preparation, doing housework and other chores, shopping, traveling, doing laundry, being responsible for one's own medications, and using a telephone. These activities are distinguished from ''Activities of daily living,'' which refers to basic self-care and includes bathing or showering, dressing, eating, getting in or out of bed or a chair, and using the toilet..	
Note (4): The terms ''mild,'' ''moderate,'' and ''severe'' TBI, which may appear in medical records, refer to a classification of TBI made at, or close to, the time of injury rather than to the current level of functioning. This classification does not affect the rating assigned under diagnostic code 8045..	
Note (5): A veteran whose residuals of TBI are rated under a version of § 4.124a, diagnostic code 8045, in effect before October 23, 2008 may request review under diagnostic code 8045, irrespective of whether his or her disability has worsened since the last review. VA will review that veteran's disability rating to determine whether the veteran may be entitled to a higher disability rating under diagnostic code 8045. A request for review pursuant to this note will be treated as a claim for an increased rating for purposes of determining the effective date of an increased rating awarded as a result of such review; however, in no case will the award be effective before October 23, 2008. For the purposes of determining the effective date of an increased rating awarded as a result of such review, VA will apply 38 CFR 3.114, if applicable..	
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.	

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
Memory, attention, concentration, executive functions.	0	No complaints of impairment of memory, attention, concentration, or executive functions.
	1	A complaint of mild loss of memory (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing.
	2	Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment.
	3	Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment.
	Total	Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment.
Judgment	0	Normal.
	1	Mildly impaired judgment. For complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.
	2	Moderately impaired judgment. For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions.
	3	Moderately severely impaired judgment. For even routine and familiar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.
	Total	Severely impaired judgment. For even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision. For example, unable to determine appropriate clothing for current weather conditions or judge when to avoid dangerous situations or activities.
Social interaction	0	Social interaction is routinely appropriate.
	1	Social interaction is occasionally inappropriate.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
	2	Social interaction is frequently inappropriate.
	3	Social interaction is inappropriate most or all of the time.
Orientation	0	Always oriented to person, time, place, and situation.
	1	Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation.
	2	Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation.
	3	Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation.
	Total	Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation.
Motor activity (with intact motor and sensory system).	0	Motor activity normal.
	1	Motor activity normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function).
	2	Motor activity mildly decreased or with moderate slowing due to apraxia.
	3	Motor activity moderately decreased due to apraxia.
	Total	Motor activity severely decreased due to apraxia.
Visual spatial orientation	0	Normal.
	1	Mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system).
	2	Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system).
	3	Moderately severely impaired. Gets lost even in familiar surroundings, unable to use assistive devices such as GPS (global positioning system).
	Total	Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment.
Subjective symptoms	0	Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples are: mild or occasional headaches, mild anxiety.
	1	Three or more subjective symptoms that mildly interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
	2	Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days.
Neurobehavioral effects ..	0	One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction. Examples of neurobehavioral effects are: Irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, belligerence, apathy, lack of empathy, moodiness, lack of cooperation, inflexibility, and impaired awareness of disability. Any of these effects may range from slight to severe, although verbal and physical aggression are likely to have a more serious impact on workplace interaction and social interaction than some of the other effects.
	1	One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them.
	2	One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them.
	3	One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others.
Communication	0	Able to communicate by spoken and written language (expressive communication), and to comprehend spoken and written language.
	1	Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.
	2	Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time. Can generally communicate complex ideas.
	3	Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs.
	Total	Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
Consciousness	Total	Persistently altered state of consciousness, such as vegetative state, minimally responsive state, coma.

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

DISEASES OF THE CRANIAL NERVES—Continued

	Rating
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

DISEASES OF THE PERIPHERAL NERVES—Continued

Schedule of ratings	Rating	
	Major	Minor
Mild	10	10
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

	Rating
Incomplete:	
Severe	20
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.	
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.	

THE EPILEPSIES—Continued

Mental Disorders in Epilepsies: A nonpsychotic organic brain syndrome will be rated separately under the appropriate diagnostic code (e.g., 9304 or 9326). 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 9326).

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 Compensation Service or the Director, Pension and Fiduciary 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; 70 FR 75399, Dec. 20, 2005; 73 FR 54705, Sept. 23, 2008; 73 FR 69554, Nov. 19, 2008; 76 FR 78824, Dec. 20, 2011; 79 FR 2100, Jan. 13, 2014]

MENTAL DISORDERS

§ 4.125 Diagnosis of mental disorders.

(a) If the diagnosis of a mental disorder does not conform to DSM–5 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. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5), American Psychiatric Association (2013), is incorporated by reference into this section with the approval of the Director of the Federal Register under 5 U.S.C. 552(a) and 1 CFR part 51. To enforce any edition other than that specified in this section, the Department of Veterans Affairs must publish notice of change in the FEDERAL REGISTER and the material must be available to the public. All approved material is available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209–3901, 703–907–7300, *http://www.dsm5.org*. It is also available for inspection at the Office of Regulation Policy and Management, Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420. It is also available for inspection at the National Archives and Records Administration (NARA). For information on the availability of this information at NARA, call 202–741–6030 or go to *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_publications.html*.

(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, as amended at 79 FR 45099, Aug. 4, 2014]

§ 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) Neurocognitive 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 neurocognitive disorders (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, as amended at 79 FR 45099, Aug. 4, 2014]

§ 4.127 Intellectual disability (intellectual developmental disorder) and personality disorders.

Intellectual disability (intellectual developmental disorder) 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 intellectual disability (intellectual developmental disorder) or a personality disorder may be service-connected.

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

[79 FR 45100, Aug. 4, 2014]

§ 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 American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5) (see § 4.125 for availability information). 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:

9201 Schizophrenia
9202 [Removed]
9203 [Removed]
9204 [Removed]
9205 [Removed]
9208 Delusional disorder
9210 Other specified and unspecified schizophrenia spectrum and other psychotic disorders
9211 Schizoaffective disorder
9300 Delirium
9301 Major or mild neurocognitive disorder due to HIV or other infections
9304 Major or mild neurocognitive disorder due to traumatic brain injury
9305 Major or mild vascular neurocognitive disorder
9310 Unspecified neurocognitive disorder
9312 Major or mild neurocognitive disorder due to Alzheimer's disease
9326 Major or mild neurocognitive disorder due to another medical condition or substance/medication-induced major or mild neurocognitive disorder
9327 [Removed]
9400 Generalized anxiety disorder
9403 Specific phobia; social anxiety disorder (social phobia)
9404 Obsessive compulsive disorder
9410 Other specified anxiety disorder
9411 Posttraumatic stress disorder
9412 Panic disorder and/or agoraphobia
9413 Unspecified anxiety disorder
9416 Dissociative amnesia; dissociative identity disorder
9417 Depersonalization/Derealization disorder
9421 Somatic symptom disorder
9422 Other specified somatic symptom and related disorder
9423 Unspecified somatic symptom and related disorder

9424 Conversion disorder (functional neurological symptom disorder)
9425 Illness anxiety disorder
9431 Cyclothymic disorder
9432 Bipolar disorder
9433 Persistent depressive disorder (dysthymia)
9434 Major depressive disorder
9435 Unspecified depressive disorder
9440 Chronic adjustment disorder

GENERAL RATING FORMULA FOR MENTAL DISORDERS

	Rating
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

9520 Anorexia nervosa
9521 Bulimia nervosa

RATING FORMULA FOR EATING DISORDERS

	Rating
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 1: An incapacitating episode is a period during which bed rest and treatment by a physician are required.
Note 2: Ratings under diagnostic codes 9201 to 9440 will be evaluated using the General Rating Formula for Mental Disorders. Ratings under diagnostic codes 9520 and 9521 will be evaluated using the General Rating Formula for Eating Disorders.

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

[79 FR 45100, Aug. 4, 2014]

DENTAL AND ORAL CONDITIONS

§ 4.149 [Reserved]

§ 4.150 Schedule of ratings—dental and oral conditions.

	Rating
Note (1): For VA compensation purposes, diagnostic imaging studies include, but are not limited to, conventional radiography (X-ray), computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), radionuclide bone scanning, or ultrasonography	
Note (2): Separately evaluate loss of vocal articulation, loss of smell, loss of taste, neurological impairment, respiratory dysfunction, and other impairments under the appropriate diagnostic code and combine under § 4.25 for each separately rated condition	
9900 Maxilla or mandible, chronic osteomyelitis, osteonecrosis or osteoradionecrosis of:	
Rate as osteomyelitis, chronic under diagnostic code 5000..	
9901 Mandible, loss of, complete, between angles	100
9902 Mandible, loss of, including ramus, unilaterally or bilaterally:	
Loss of one-half or more,.	
Involving temporomandibular articulation.	
Not replaceable by prosthesis	70
Replaceable by prosthesis	50
Not involving temporomandibular articulation.	
Not replaceable by prosthesis	40
Replaceable by prosthesis	30
Loss of less than one-half,	
Involving temporomandibular articulation.	
Not replaceable by prosthesis	70
Replaceable by prosthesis	50
Not involving temporomandibular articulation.	
Not replaceable by prosthesis	20
Replaceable by prosthesis	10
9903 Mandible, nonunion of, confirmed by diagnostic imaging studies:	
Severe, with false motion	30
Moderate, without false motion	10
9904 Mandible, malunion of:	
Displacement, causing severe anterior or posterior open bite	20
Displacement, causing moderate anterior or posterior open bite	10
Displacement, not causing anterior or posterior open bite	0
9905 Temporomandibular disorder (TMD):	
Interincisal range:	
0 to 10 millimeters (mm) of maximum unassisted vertical opening.	
With dietary restrictions to all mechanically altered foods	50
Without dietary restrictions to mechanically altered foods	40
11 to 20 mm of maximum unassisted vertical opening.	
With dietary restrictions to all mechanically altered foods	40
Without dietary restrictions to mechanically altered foods	30
21 to 29 mm of maximum unassisted vertical opening.	
With dietary restrictions to full liquid and pureed foods	40
With dietary restrictions to soft and semi-solid foods	30
Without dietary restrictions to mechanically altered foods	20
30 to 34 mm of maximum unassisted vertical opening.	
With dietary restrictions to full liquid and pureed foods	30
With dietary restrictions to soft and semi-solid foods	20
Without dietary restrictions to mechanically altered foods	10
Lateral excursion range of motion:	
0 to 4 mm	10
Note (1): Ratings for limited interincisal movement shall not be combined with ratings for limited lateral excursion.	
Note (2): For VA compensation purposes, the normal maximum unassisted range of vertical jaw opening is from 35 to 50 mm.	
Note (3): For VA compensation purposes, mechanically altered foods are defined as altered by blending, chopping, grinding or mashing so that they are easy to chew and swallow. There are four levels of mechanically altered foods: full liquid, puree, soft, and semisolid foods. To warrant elevation based on mechanically altered foods, the use of texture-modified diets must be recorded or verified by a physician.	
9908 Condyloid process, loss of, one or both sides	30
9909 Coronoid process, loss of:	
Bilateral	20
Unilateral	10
9911 Hard palate, loss of:	
Loss of half or more, not replaceable by prosthesis	30
Loss of less than half, not replaceable by prosthesis	20
Loss of half or more, replaceable by prosthesis	10
Loss of less than half, 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

	Rating
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:	
Nonunion,	
With false motion	30
Without false motion	10
Malunion,	
With displacement, causing severe anterior or posterior open bite	30
With displacement, causing moderate anterior or posterior open bite	10
With displacement, causing mild anterior or posterior open bite	0
Note: For VA compensation purposes, the severity of maxillary nonunion is dependent upon the degree of abnormal mobility of maxilla fragments following treatment (*i.e.*, presence or absence of false motion), and maxillary nonunion must be confirmed by diagnostic imaging studies.	
9917 Neoplasm, hard and soft tissue, benign:	
Rate as loss of supporting structures (bone or teeth) and/or functional impairment due to scarring.	
9918 Neoplasm, hard and soft tissue, malignant	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation, 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 such as loss of supporting structures (bone or teeth) and/or functional impairment due to scarring.	

[59 FR 2530, Jan. 18, 1994, as amended at 82 FR 36083, Aug. 3, 2017]

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

Sec.	Diagnostic code No.	
4.71a	5000	Evaluation February 1, 1962.
4.71a	5001	Evaluation March 11, 1969; criterion February 7, 2021.
	5002	Evaluation March 1, 1963; title, criteria, note February 7, 2021.
	5003	Added July 6, 1950; title February 7, 2021.
	5009	Title, evaluation, note February 7, 2021.
	5010	Title, criteria February 7, 2021.
	5011	Title, criteria February 7, 2021.
	5012	Criterion March 10, 1976; title, note February 7, 2021.
	5013	Title February 7, 2021.
	5014	Title February 7, 2021.
	5015	Title February 7, 2021.
	5018	Removed February 7, 2021.
	5020	Removed November 30, 2020.
	5022	Removed February 7, 2021.
	5023	Title February 7, 2021.
	5024	Criterion March 1, 1963; title, criteria February 7, 2021.
	5025	Added May 7, 1996.
	5051	Added September 22, 1978; note February 7, 2021.
	5052	Added September 22, 1978; note February 7, 2021.
	5053	Added September 22, 1978; note February 7, 2021.
	5054	Added September 22, 1978; title, criterion, and note February 7, 2021.
	5055	Added September 22, 1978; title, criterion, and note February 7, 2021.
	5056	Added September 22, 1978; note February 7, 2021.
	5100–5103	Removed March 10, 1976.
	5104	Criterion March 10, 1976.
	5105	Criterion March 10, 1976.
	5120	Title, criterion February 7, 2021.
	5160	Title, criterion, note February 7, 2021.
	5164	Evaluation June 9, 1952.
	5166	Criterion September 22, 1978.
	5170	Title February 7, 2021.
	5172	Added July 6, 1950.
	5173	Added June 9, 1952.
	5174	Added September 9, 1975; removed September 22, 1978.

Sec.	Diagnostic code No.	
	5201	Criterion February 7, 2021.
	5202	Criterion February 7, 2021.
	5211	Criterion September 22, 1978.
	5212	Criterion September 22, 1978.
	5214	Criterion September 22, 1978.
	5216	Preceding paragraph criterion September 22, 1978.
	5217	Criterion August 26, 2002.
	5218	Criterion August 26, 2002.
	5219	Criterion September 22, 1978; criterion August 26, 2002.
	5220	Preceding paragraph criterion September 22, 1978; criterion August 26, 2002.
	5223	Criterion August 26, 2002.
	5224	Criterion August 26, 2002.
	5225	Criterion August 26, 2002.
	5226	Criterion August 26, 2002.
	5227	Criterion September 22, 1978; criterion August 26, 2002.
	5228	Added August 26, 2002.
	5229	Added August 26, 2002.
	5230	Added August 26, 2002.
	5235	Replaces 5285–5295 September 26, 2003.
	5236	Replaces 5285–5295 September 26, 2003.
	5237	Replaces 5285–5295 September 26, 2003.
	5238	Replaces 5285–5295 September 26, 2003.
	5239	Replaces 5285–5295 September 26, 2003.
	5240	Replaces 5285–5295 September 26, 2003.
	5241	Replaces 5285–5295 September 26, 2003.
	5242	Replaces 5285–5295 September 26, 2003; Title February 7, 2021.
	5243	Replaces 5285–5295 September 26, 2003; Criterion September 26, 2003; Title February 7, 2021.
	5244	Added February 7, 2021.
	5255	Criterion July 6, 1950; criterion February 7, 2021.
	5257	Evaluation July 6, 1950; criterion and note February 7, 2021.
	5262	Criterion February 7, 2021.
	5264	Added September 9, 1975; removed September 22, 1978.
	5269	Added February 7, 2021.
	5271	Criterion February 7, 2021.
	5275	Criterion March 10, 1976; criterion September 22, 1978.
	5293	Criterion March 10, 1976; criterion September 23, 2002; revised and moved to 5235–5243 September 26, 2003.
	5294	Evaluation March 10, 1976; revised and moved to 5235–5243 September 26, 2003.
	5295	Evaluation March 10, 1976; revised and moved to 5235–5243 September 26, 2003.
	5296	Criterion March 10, 1976.
	5297	Criterion August 23, 1948; criterion February 1, 1962.
	5298	Added August 23, 1948.
4.73		Introduction **Note** criterion July 3, 1997; second **Note** added February 7, 2021.
	5317	Criterion September 22, 1978.
	5324	Added February 1, 1962.
	5325	Criterion July 3, 1997.
	5327	Added March 10, 1976; criterion October 15, 1991; criterion July 3, 1997.
	5328	Added NOTE March 10, 1976.
	5329	Added NOTE July 3, 1997.
	5330	Added February 7, 2021.
	5331	Added February 7, 2021.
4.77		Revised May 13, 2018.
4.78		Revised May 13, 2018.
4.79		Introduction criterion May 13, 2018; Revised General Rating Formula for Diseases of the Eye NOTE revised May 13, 2018.
	6000	Criterion May 13, 2018.
	6001	Criterion May 13, 2018.
	6002	Criterion May 13, 2018.
	6006	Title May 13, 2018. Criterion May 13, 2018.
	6007	Criterion May 13, 2018.
	6008	Criterion May 13, 2018.
	6009	Criterion May 13, 2018.
	6011	Evaluation May 13, 2018.
	6012	Evaluation May 13, 2018.
	6013	Evaluation May 13, 2018.
	6014	Title May 13, 2018.
	6015	Title May 13, 2018.
	6017	Evaluation May 13, 2018.
	6018	Evaluation May 13, 2018.
	6019	Evaluation.

Sec.	Diagnostic code No.	
	6026	Evaluation May 13, 2018.
	6027	Evaluation *May 13, 2018.*
	6034	Evaluation May 13, 2018.
	6035	Evaluation *May 13, 2018.*
	6036	Evaluation May 13, 2018.
	6040	Added May 13, 2018.
	6042	Added May 13, 2018.
	6046	Added May 13, 2018.
	6091	Evaluation May 13, 2018.
4.84a	.....	Table V criterion July 1, 1994.
	6010	Criterion March 11, 1969.
	6019	Criterion September 22, 1978.
	6029	NOTE August 23, 1948; criterion September 22, 1978.
	6035	Added September 9, 1975.
	6050–6062	Removed March 10, 1976.
	6061	Added March 10, 1976.
	6062	Added March 10, 1976.
	6063–6079	Criterion September 22, 1978.
	6064	Criterion March 10, 1976.
	6071	Criterion March 10, 1976.
	6076	Evaluation August 23, 1948.
	6080	Criterion September 22, 1978.
	6081	Criterion March 10, 1976.
	6090	Criterion September 22, 1978; criterion September 12, 1988.
4.84b	6260	Added October 1, 1961; criterion October 1, 1961; evaluation March 10, 1976; removed December 18, 1987; re-designated § 4.87a December 18, 1987.
4.87	.....	Tables VI and VII replaced by new Tables VI, VIA, and VII December 18, 1987. 6200–6260 revised and re-designated § 4.87 June 10, 1999.
4.87a	6200–6260	Moved to § 4.87 June 10, 1999.
	6275–6276	Moved from § 4.87b June 10, 1999.
	6277–6297	March 23, 1956 removed, December 17, 1987; Table II revised Table V March 10, 1976; Table II revised to Table VII September 22, 1978; text from § 4.84b Schedule of ratings-ear re-designated from § 4.87 December 17, 1987.
	6286	Removed December 17, 1987.
	6291	Criterion March 10, 1976; removed December 17, 1987.
	6297	Criterion March 10, 1976; removed December 17, 1987.
4.87b	.....	Removed June 10, 1999.
4.88a	.....	March 11, 1969; re-designated § 4.88b November 29, 1994; § 4.88a added to read "Chronic fatigue syndrome"; criterion November 29, 1994.
4.88b	.....	Added March 11, 1969; re-designated § 4.88c November 29, 1994; § 4.88a re-designated to § 4.88b November 29, 1994; General Rating Formula for Infectious Diseases added August 11, 2019.
	6300	Criterion August 30, 1996; title, criterion, and note August 11, 2019.
	6301	Criterion, note August 11, 2019.
	6302	Criterion September 22, 1978; criterion August 30, 1996; criterion, note August 11, 2019.
	6304	Evaluation August 30, 1996; criterion, note August 11, 2019.
	6305	Criterion March 1, 1989; evaluation August 30, 1996; title, criterion, note August 11, 2019.
	6306	Evaluation August 30, 1996; criterion, note August 11, 2019.
	6307	Criterion May 13, 2018; criterion, note August 11, 2019.
	6308	Criterion August 30, 1996; criterion, note August 11, 2019.
	6309	Added March 1, 1963; criterion March 1, 1989; criterion August 30, 1996; criterion, note August 11, 2019.
	6310	Criterion, note August 11, 2019.
	6311	Criterion, note August 11, 2019.
	6312	Added August 11, 2019.
	6314	Evaluation March 1, 1989; evaluation August 30, 1996.
	6315	Criterion August 30, 1996.
	6316	Evaluation March 1, 1989; evaluation August 30, 1996; criterion, note August 11, 2019.
	6317	Criterion August 30, 1996; title, criterion, note August 11, 2019.
	6318	Added March 1, 1989; criterion August 30, 1996; criterion, note August 11, 2019.
	6319	Added August 30, 1996; criterion, note August 11, 2019.
	6320	Added August 30, 1996; criterion, note August 11, 2019.
	6325	Added August 11, 2019.
	6326	Added August 11, 2019.
	6329	Added August 11, 2019.
	6330	Added August 11, 2019.
	6331	Added August 11, 2019.
	6333	Added August 11, 2019.
	6334	Added August 11, 2019.
	6335	Added August 11, 2019.

Sec.	Diagnostic code No.	
	6350	Evaluation March 1, 1963; evaluation March 10, 1976; evaluation August 30, 1996.
	6351	Added March 1, 1989; evaluation March 24, 1992; criterion August 30, 1996; criterion, note August 11, 2019.
	6352	Added March 1, 1989; removed March 24, 1992.
	6353	Added March 1, 1989; removed March 24, 1992.
	6354	Added November 29, 1994; criterion August 30, 1996; title, criterion, note August 11, 2019.
4.88c	.....	Re-designated from § 4.88b November 29, 1994.
4.89	.....	Ratings for nonpulmonary TB December 1, 1949; criterion March 11, 1969.
4.97	6502	Criterion October 7, 1996.
	6504	Criterion October 7, 1996.
	6510–6514	Criterion October 7, 1996.
	6515	Criterion March 11, 1969.
	6516	Criterion October 7, 1996.
	6517	Removed October 7, 1996.
	6518	Criterion October 7, 1996.
	6519	Criterion October 7, 1996.
	6520	Criterion October 7, 1996.
	6521	Added October 7, 1996.
	6522	Added October 7, 1996.
	6523	Added October 7, 1996.
	6524	Added October 7, 1996.
	6600	Evaluation September 9, 1975; criterion October 7, 1996.
	6601	Criterion October 7, 1996.
	6602	Criterion September 9, 1975; criterion October 7, 1996.
	6603	Added September 9, 1975; criterion October 7, 1996.
	6604	Added October 7, 1996.
	6701	Evaluation October 7, 1996.
	6702	Evaluation October 7, 1996.
	6703	Evaluation October 7, 1996.
	6704	Subparagraph (1) following December 1, 1949; criterion March 11, 1969; criterion September 22, 1978.
	6705	Removed March 11, 1969.
	6707–6710	Added March 11, 1969; removed September 22, 1978.
	6721	Criterion July 6, 1950; criterion September 22, 1978.
	6724	Second note following December 1, 1949; criterion March 11, 1969; evaluation October 7, 1996.
	6725–6728	Added March 11, 1969; removed September 22, 1978.
	6730	Added September 22, 1978; criterion October 7, 1996.
	6731	Evaluation September 22, 1978; criterion October 7, 1996.
	6732	Criterion March 11, 1969.
	6800	Criterion September 9, 1975; removed October 7, 1996.
	6801	Removed October 7, 1996.
	6802	Criterion September 9, 1975; removed October 7, 1996.
	6810–6813	Removed October 7, 1996.
	6814	Criterion March 10, 1976; removed October 7, 1996.
	6815	Removed October 7, 1996.
	6816	Removed October 7, 1996.
	6817	Evaluation October 7, 1996.
	6818	Removed October 7, 1996.
	6819	Criterion March 10, 1976; criterion October 7, 1996.
	6821	Evaluation August 23, 1948.
	6822–6847	Added October 7, 1996.
4.104	.....	General Rating Formula for Diseases of the Heart November 14, 2021.
	7000	Evaluation July 6, 1950; evaluation September 22, 1978, evaluation January 12, 1998; criterion November 14, 2021.
	7001	Evaluation January 12, 1998; criterion November 14, 2021.
	7002	Evaluation January 12, 1998; criterion November 14, 2021.
	7003	Evaluation January 12, 1998; criterion November 14, 2021.
	7004	Criterion September 22, 1978; evaluation January 12, 1998; criterion November 14, 2021.
	7005	Evaluation September 9, 1975; evaluation September 22, 1978; evaluation January 12, 1998; criterion November 14, 2021.
	7006	Evaluation January 12, 1998; criterion November 14, 2021.
	7007	Evaluation September 22, 1978; evaluation January 12, 1998; criterion November 14, 2021.
	7008	Evaluation January 12, 1998; criterion December 10, 2017; evaluation November 14, 2021.
	7009	Added November 14, 2021.
	7010	Evaluation January 12, 1998; title, criterion November 14, 2021.
	7011	Evaluation January 12, 1998; note, criterion November 14, 2021.
	7013	Removed January 12, 1998.

Sec.	Diagnostic code No.	
	7014	Removed January 12, 1998.
	7015	Evaluation September 9, 1975; criterion January 12, 1998; criterion November 14, 2021.
	7016	Added September 9, 1975; criterion January 12, 1998; note, criterion November 14, 2021.
	7017	Added September 22, 1978; evaluation January 12, 1998; criterion November 14, 2021.
	7018	Added January 12, 1998; criterion November 14, 2021.
	7019	Added January 12, 1998; note, criterion November 14, 2021.
	7020	Added January 12, 1998; criterion November 14, 2021.
	7100	Evaluation July 6, 1950.
	7101	Criterion September 1, 1960; criterion September 9, 1975; criterion January 12, 1998.
	7110	Evaluation September 9, 1975; evaluation January 12, 1998; title, criterion, note November 14, 2021.
	7111	Criterion September 9, 1975; evaluation January 12, 1998; note, criterion November 14, 2021.
	7112	Evaluation January 12, 1998.
	7113	Evaluation January 12, 1998; criterion November 14, 2021.
	7114	Added June 9, 1952; evaluation January 12, 1998; title, criterion, note November 14, 2021.
	7115	Added June 9, 1952; evaluation January 12, 1998; note, criterion, evaluation November 14, 2021.
	7116	Added June 9, 1952; evaluation March 10, 1976; removed January 12, 1998.
	7117	Added June 9, 1952; evaluation January 12, 1998; title, note November 14, 2021.
	7118	Criterion January 12, 1998.
	7119	Evaluation January 12, 1998.
	7120	Note following July 6, 1950; evaluation January 12, 1998; criterion November 14, 2021.
	7121	Criterion July 6, 1950; evaluation March 10, 1976; evaluation January 12, 1998.
	7122	Last sentence of Note following July 6, 1950; evaluation January 12, 1998; criterion August 13, 1998; criterion November 14, 2021.
	7123	Added October 15, 1991; criterion January 12, 1998.
	7124	Added November 14, 2021.
4.110	.....	Removed and reserved May 19, 2024.
4.111	.....	Removed and reserved May 19, 2024.
4.112	.....	Revised May 19, 2024.
4.114	.....	Introduction paragraph revised March 10, 1976; introduction paragraph revised May 19, 2024.
	7200	Title, criterion May 19, 2024.
	7201	Criterion May 19, 2024.
	7202	Evaluation, criterion, note May 19, 2024.
	7203	Evaluation, criterion, note May 19, 2024.
	7204	Title, note May 19, 2024.
	7205	Note May 19, 2024.
	7206	Added May 19, 2024.
	7207	Added May 19, 2024.
	7301	Title, Evaluation, criterion, note May 19, 2024.
	7302	Removed April 8, 1959.
	7303	Added May 19, 2024.
	7304	Evaluation November 1, 1962; title, evaluation, criterion, and note May 19, 2024.
	7305	Evaluation November 1, 1962; Removed May 19, 2024.
	7306	Criterion April 8, 1959; Removed May 19, 2024.
	7307	Evaluation May 22, 1964; Criterion May 22, 1964; Note May 22, 1964; title, evaluation, criterion, and note May 19, 2024.
	7308	Title April 8, 1959; evaluation April 8, 1959; evaluation and criterion May 19, 2024.
	7309	Evaluation May 19, 2024.
	7310	Evaluation May 19, 2024.
	7311	Criterion July 2, 2001.
	7312	Evaluation March 10, 1976; evaluation July 2, 2001; title, evaluation, criterion, and note May 19, 2024.
	7313	Evaluation March 10, 1976; removed July 2, 2001.
	7314	Title, evaluation, note May 19, 2024.
	7315	Evaluation May 19, 2024.
	7316	Removed May 19, 2024.
	7317	Note May 19, 2024.
	7318	Title, evaluation, and criterion May 19, 2024.
	7319	Title November 1, 1962; evaluation November 1, 1962; title, evaluation, criterion, and note May 19, 2024.
	7321	Evaluation July 6, 1950; criterion March 10, 1976; Removed May 19, 2024.
	7322	Removed May 19, 2024.

Sec.	Diagnostic code No.	
	7323	Criterion and note May 19, 2024.
	7324	Removed May 19, 2024.
	7325	Note November 1, 1962; note May 19, 2024.
	7326	Note November 1, 1962; title, evaluation, criterion and note May 19, 2024.
	7327	Evaluation November 1, 1962; criterion November 1, 1962; note November 1, 1962; title, evaluation, criterion, and note May 19, 2024.
	7328	Evaluation November 1, 1962; title, evaluation, criterion, and note May 19, 2024.
	7329	Evaluation November 1, 1962; evaluation, criterion, and note May 19, 2024.
	7330	Evaluation November 1, 1962; criterion and note May 19, 2024.
	7331	Criterion March 11, 1969.
	7332	Evaluation November 1, 1962; evaluation, criterion, and note May 19, 2024.
	7333	Evaluation, criterion, and note May 19, 2024.
	7334	Evaluation July 6, 1950; evaluation November 1, 1962; evaluation, criterion, and note May 19, 2024.
	7335	Evaluation and criterion May 19, 2024.
	7336	Criterion November 1, 1962; criterion May 19, 2024.
	7337	Title, evaluation, and criterion May 19, 2024.
	7338	Title, evaluation, criterion, and note May 19, 2024.
	7339	Criterion March 10, 1976; removed May 19, 2024.
	7340	Removed May 19, 2024.
	7341	Removed March 10, 1976.
	7343	Criterion March 10, 1976; criterion July 2, 2001.
	7344	Criterion July 2, 2001; note May 19, 2024.
	7345	Evaluation August 23, 1948; evaluation February 17, 1955; evaluation July 2, 2001; title May 19, 2024; evaluation, criterion, and note May 19, 2024.
	7346	Evaluation February 1, 1962; title May 19, 2024; evaluation, criterion, and note May 19, 2024.
	7347	Added September 9, 1975; title May 19, 2024; evaluation, criterion, and note May 19, 2024.
	7348	Added March 10, 1976; criterion and note May 19, 2024.
	7350	Added May 19, 2024.
	7351	Added July 2, 2001; evaluation, criterion, and note May 19, 2024.
	7352	Added May 19, 2024.
	7354	Added July 2, 2001; evaluation, criterion, and note May 19, 2024.
	7355	Added May 19, 2024.
	7356	Added May 19, 2024.
	7357	Added May 19, 2024.
4.115a	.....	Re-designated and revised as §4.115b; new §4.115a ''Ratings of the genitourinary system-dysfunctions'' added February 17, 1994; revised November 14, 2021.
4.115b	7500	Note July 6, 1950; evaluation February 17, 1994, criterion September 8, 1994; criterion November 14, 2021.
	7501	Evaluation February 17, 1994; criterion November 14, 2021.
	7502	Evaluation February 17, 1994; criterion November 14, 2021.
	7503	Removed February 17, 1994.
	7504	Evaluation February 17, 1994; criterion November 14, 2021.
	7505	Criterion March 11, 1969; evaluation February 17, 1994.
	7507	Evaluation February 17, 1994; criterion November 14, 2021.
	7508	Evaluation February 17, 1994; title, criterion November 14, 2021.
	7509	Evaluation February 17, 1994; criterion November 14, 2021.
	7510	Evaluation February 17, 1994; removed November 14, 2021.
	7511	Evaluation February 17, 1994; criterion November 14, 2021.
	7512	Evaluation February 17, 1994.
	7513	Removed February 17, 1994.
	7514	Criterion March 11, 1969; removed February 17, 1994.
	7515	Criterion February 17, 1994.
	7516	Evaluation February 17, 1994; criterion November 14, 2021.
	7517	Criterion February 17, 1994.
	7518	Evaluation February 17, 1994.
	7519	Evaluation March 10, 1976; evaluation February 17, 1994.
	7520	Criterion February 17, 1994; criterion, footnote November 14, 2021.
	7521	Criterion February 17, 1994; criterion, footnote November 14, 2021.
	7522	Criterion September 8, 1994; title, criterion, note November 14, 2021.
	7523	Criterion September 8, 1994.
	7524	Note July 6, 1950; evaluation February 17, 1994; evaluation September 8, 1994; note November 14, 2021.
	7525	Criterion March 11, 1969; evaluation February 17, 1994; title and criterion November 14, 2021.
	7526	Removed February 17, 1994.
	7527	Criterion February 17, 1994; title and criterion November 14, 2021.
	7528	Criterion March 10, 1976; criterion February 17, 1994; criterion November 14, 2021.
	7529	Evaluation February 17, 1994; criterion November 14, 2021.

Sec.	Diagnostic code No.	
	7530	Added September 9, 1975; evaluation February 17, 1994; criterion November 14, 2021.
	7531	Added September 9, 1975; criterion February 17, 1994; criterion November 14, 2021.
	7532	Evaluation February 17, 1994; criterion November 14, 2021.
	7533	Added February 17, 1994; title, criterion, and note November 14, 2021.
	7534	Added February 17, 1994; title and criterion November 14, 2021.
	7535	Evaluation February 17, 1994; criterion November 14, 2021.
	7536	Evaluation February 17, 1994; criterion November 14, 2021.
	7537	Added February 17, 1994; title and criterion November 14, 2021.
	7538	Evaluation February 17, 1994; criterion November 14, 2021.
	7539	Added February 17, 1994; note and criterion November 14, 2021.
	7540	Evaluation February 17, 1994; criterion November 14, 2021.
	7541	Added February 17, 1994; title and criterion November 14, 2021.
	7542	Added February 17, 1994; criterion November 14, 2021.
	7543	Added November 14, 2021.
	7544	Added November 14, 2021.
	7545	Added November 14, 2021.
4.116	.....	§ 4.116 removed and § 4.116a re-designated § 4.116 ''Schedule of ratings-gynecological conditions and disorders of the breasts'' May 22, 1995.
	7610	Criterion May 22, 1995; title May 13, 2018.
	7611	Criterion May 22, 1995.
	7612	Criterion May 22, 1995.
	7613	Criterion May 22, 1995.
	7614	Criterion May 22, 1995.
	7615	Criterion May 22, 1995; note May 13, 2018.
	7617	Criterion May 22, 1995.
	7618	Criterion May 22, 1995.
	7619	Criterion May 22, 1995; note May 13, 2018.
	7620	Criterion May 22, 1995.
	7621	Criterion May 22, 1995; evaluation May 13, 2018.
	7622	Removed May 13, 2018.
	7623	Removed May 13, 2018.
	7624	Criterion August 9, 1976; evaluation May 22, 1995.
	7625	Criterion August 9, 1976; evaluation May 22, 1995.
	7626	Criterion May 22, 1995; criterion March 18, 2002.
	7627	Criterion March 10, 1976; criterion May 22, 1995; title, note May 13, 2018.
	7628	Added May 22, 1995; title, criterion May 13, 2018.
	7629	Added May 22, 1995.
	7630	Added May 13, 2018.
	7631	Added May 13, 2018.
	7632	Added May 13, 2018.
4.117	7700	Removed December 9, 2018.
	7701	Removed October 23, 1995.
	7702	Evaluation October 23, 1995; title December 9, 2018; evaluation December 9, 2018.
	7703	Evaluation August 23, 1948; criterion October 23, 1995; evaluation December 9, 2018; criterion December 9, 2018.
	7704	Evaluation October 23, 1995; evaluation December 9, 2018.
	7705	Evaluation October 23, 1995; title December 9, 2018; evaluation December 9, 2018; criterion December 9, 2018.
	7706	Evaluation October 23, 1995; note December 9, 2018; criterion October 23, 1995.
	7707	Criterion October 23, 1995.
	7709	Evaluation March 10, 1976; criterion October 23, 1995; title December 9, 2018; criterion December 9, 2018.
	7710	Criterion October 23, 1995; criterion December 9, 2018.
	7711	Criterion October 23, 1995.
	7712	Added December 9, 2018.
	7713	Removed October 23, 1995.
	7714	Added September 9, 1975; criterion October 23, 1995; criterion December 9, 2018.
	7715	Added October 26, 1990; criterion December 9, 2018.
	7716	Added October 23, 1995; evaluation December 9, 2018; criterion December 9, 2018.
	7717	Added March 9, 2012.
	7718	Added December 9, 2018.
	7719	Added December 9, 2018.
	7720	Added December 9, 2018.
	7721	Added December 9, 2018.
	7722	Added December 9, 2018.
	7723	Added December 9, 2018.
	7724	Added December 9, 2018.

Sec.	Diagnostic code No.	
	7725	Added December 9, 2018.
4.118	7800	Evaluation August 30, 2002; criterion October 23, 2008.
	7801	Criterion July 6, 1950; criterion August 30, 2002; criterion October 23, 2008; title, note 1, note 2 August 13, 2018.
	7802	Criterion September 22, 1978; criterion August 30, 2002; criterion October 23, 2008; title, note 1, note 2 August 13, 2018.
	7803	Criterion August 30, 2002; removed October 23, 2008.
	7804	Criterion July 6, 1950; criterion September 22, 1978; criterion and evaluation October 23, 2008.
	7805	Criterion October 23, 2008; title August 13, 2018. General Rating Formula for DCs 7806, 7809, 7813–7816, 7820–7822, and 7824 added August 13, 2018.
	7806	Criterion September 9, 1975; evaluation August 30, 2002; criterion August 13, 2018.
	7807	Criterion August 30, 2002.
	7808	Criterion August 30, 2002.
	7809	Criterion August 30, 2002; title, criterion August 13, 2018.
	7810	Removed August 30, 2002.
	7811	Criterion March 11, 1969; evaluation August 30, 2002.
	7812	Removed August 30, 2002.
	7813	Criterion August 30, 2002; title, criterion August 13, 2018.
	7814	Removed August 30, 2002.
	7815	Evaluation August 30, 2002; criterion, note August 13, 2018.
	7816	Evaluation August 30, 2002; criterion, note August 13, 2018.
	7817	Evaluation August 30, 2002; title, criterion, note August 13, 2018.
	7818	Criterion August 30, 2002.
	7819	Criterion August 30, 2002.
	7820	Added August 30, 2002; criterion August 13, 2018.
	7821	Added August 30, 2002; title, criterion August 13, 2018.
	7822	Added August 30, 2002; title, criterion August 13, 2018.
	7823	Added August 30, 2002; criterion August 13, 2018.
	7824	Added August 30, 2002; criterion August 13, 2018.
	7825	Added August 30, 2002; title, criterion August 13, 2018.
	7826	Added August 30, 2002; criterion August 13, 2018.
	7827	Added August 30, 2002; criterion August 13, 2018.
	7828	Added August 30, 2002; criterion August 13, 2018.
	7829	Added August 30, 2002; criterion August 13, 2018.
	7830	Added August 30, 2002; criterion August 13, 2018.
	7831	Added August 30, 2002; criterion August 13, 2018.
	7832	Added August 30, 2002; criterion August 13, 2018.
	7833	Added August 30, 2002; criterion August 13, 2018.
4.119	7900	Criterion August 13, 1981; evaluation June 9, 1996; title December 10, 2017; evaluation December 10, 2017; criterion December 10, 2017; note December 10, 2017.
	7901	Criterion August 13, 1981; evaluation June 9, 1996; title December 10, 2017; evaluation December 10, 2017; criterion December 10, 2017; note December 10, 2017.
	7902	Evaluation August 13, 1981; criterion June 9, 1996; title December 10, 2017; evaluation December 10, 2017; criterion December 10, 2017; note December 10, 2017.
	7903	Criterion August 13, 1981; evaluation June 9, 1996; evaluation December 10, 2017; criterion December 10, 2017; note December 10, 2017.
	7904	Criterion August 13, 1981; evaluation June 9, 1996; evaluation December 10, 2017; criterion December 10, 2017; note *December 10, 2017.*
	7905	Evaluation; August 13, 1981; evaluation June 9, 1996; evaluation December 10, 2017; criterion December 10, 2017.
	7906	Added December 10, 2017.
	7907	Evaluation; August 13, 1981; evaluation June 9, 1996; criterion December 10, 2017; note December 10, 2017.
	7908	Criterion August 13, 1981; criterion June 9, 1996; criterion December 10, 2017.
	7909	Evaluation August 13, 1981; criterion June 9, 1996; evaluation June 9, 1996; criterion December 10, 2017; evaluation *December 10, 2017;* note *December 10, 2017.*
	7910	Removed June 9, 1996.
	7911	Evaluation March 11, 1969; evaluation August 13, 1981; criterion June 9, 1996; title December 10, 2017; note *December 10, 2017.*
	7912	Title December 10, 2017; criterion *December 10, 2017.*
	7913	Criterion September 9, 1975; criterion August 13, 1981; criterion June 6, 1996; evaluation June 9, 1996; criterion December 10, 2017; note *December 10, 2017.*
	7914	Criterion March 10, 1976; criterion August 13, 1981; criterion June 9, 1996.
	7915	Criterion June 9, 1996; criterion *December 10, 2017.*
	7916	Added June 9, 1996; note *December 10, 2017.*

Sec.	Diagnostic code No.	
	7917	Added June 9, 1996; note *December 10, 2017.*
	7918	Added June 9, 1996; note *December 10, 2017.*
	7919	Added June 9, 1996; evaluation June 9, 1996; criterion December 10, 2017; note *December 10, 2017.*
4.124a	8002	Criterion September 22, 1978.
	8021	Criterion September 22, 1978; criterion October 1, 1961; criterion March 10, 1976; criterion March 1, 1989.
	8045	Criterion and evaluation October 23, 2008.
	8046	Added October 1, 1961; criterion March 10, 1976; criterion March 1, 1989.
	8100	Evaluation June 9, 1953.
	8540	Added October 15, 1991.
	8910	Added October 1, 1961.
	8911	Added October 1, 1961; evaluation September 9, 1975.
	8912	Added October 1, 1961.
	8913	Added October 1, 1961.
	8914	Added October 1, 1961; criterion September 9, 1975; criterion March 10, 1976.
	8910–8914	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.
4.130	.....	Re-designated from § 4.132 November 7, 1996.
	9200	Removed February 3, 1988.
	9201	Criterion February 3, 1988; Title August 4, 2014.
	9202	Criterion February 3, 1988; removed August 4, 2014.
	9203	Criterion February 3, 1988; removed August 4, 2014.
	9204	Criterion February 3, 1988; removed August 4, 2014.
	9205	Criterion February 3, 1988; criterion November 7, 1996; Removed August 4, 2014.
	9206	Criterion February 3, 1988; removed November 7, 1996.
	9207	Criterion February 3, 1988; removed November 7, 1996.
	9208	Criterion February 3, 1988; removed November 7, 1996.
	9209	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9210	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9211	Added November 7, 1996.
	9300	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996.
	9301	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9302	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9303	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9304	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9305	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9306	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9307	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9308	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9309	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9310	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9311	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9312	Added March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9313	Added March 10, 1976; removed February 3, 1988.
	9314	Added March 10, 1976; removed February 3, 1988.
	9315	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9316–9321	Added March 10, 1976; removed February 3, 1988.
	9322	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9323	Added March 10, 1976; removed February 3, 1988.
	9324	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9325	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9326	Added March 10, 1976; removed February 3, 1988; added November 7, 1996; Title August 4, 2014.
	9327	Added November 7, 1996; removed August 4, 2014.
	9400–9411	Evaluations February 3, 1988.
	9400	Criterion March 10, 1976; criterion February 3, 1988.

Sec.	Diagnostic code No.	
	9401	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9402	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9403	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9410	Added March 10, 1976; criterion February 3, 1988; Title August 4, 2014.
	9411	Added February 3, 1988.
	9412	Added November 7, 1996.
	9413	Added November 7, 1996; Title August 4, 2014.
	9416	Added November 7, 1996; Title August 4, 2014.
	9417	Added November 7, 1996; Title August 4, 2014.
	9421	Added November 7, 1996; Title August 4, 2014.
	9422	Added November 7, 1996; Title August 4, 2014.
	9423	Added November 7, 1996; Title August 4, 2014.
	9424	Added November 7, 1996; Title August 4, 2014.
	9425	Added November 7, 1996; Title August 4, 2014.
	9431	Added November 7, 1996.
	9432	Added November 7, 1996.
	9433	Added November 7, 1996; Title August 4, 2014.
	9434	Added November 7, 1996.
	9435	Added November 7, 1996; Title August 4, 2014.
	9440	Added November 7, 1996.
	9500	Criterion March 10, 1976; criterion February 3, 1988.
	9501	Criterion March 10, 1976; criterion February 3, 1988.
	9502	Criterion March 10, 1976; criterion February 3, 1988.
	9503	Removed March 10, 1976.
	9504	Criterion September 9, 1975; removed March 10, 1976.
	9505	Added March 10, 1976; criterion February 3, 1988.
	9506	Added March 10, 1976; criterion February 3, 1988.
	9507	Added March 10, 1976; criterion February 3, 1988.
	9508	Added March 10, 1976; criterion February 3, 1988.
	9509	Added March 10, 1976; criterion February 3, 1988.
	9510	Added March 10, 1976; criterion February 3, 1988.
	9511	Added March 10, 1976; criterion February 3, 1988.
	9520	Added November 7, 1996.
	9521	Added November 7, 1996.
4.132	.....	Re-designated as § 4.130 November 7, 1996.
4.150	9900	Criterion September 22, 1978; criterion February 17, 1994; title September 10, 2017.
	9901	Criterion February 17, 1994.
.....	9902	Criterion February 17, 1994; evaluation September 10, 2017; title September 10, 2017.
.....	9903	Criterion February 17, 1994; evaluation September 10, 2017; title September 10, 2017.
.....	9904	Criterion September 10, 2017.
	9905	Criterion September 22, 1978; evaluation February 17, 1994; evaluation September 10, 2017; title September 10, 2017.
	9906	Removed September 10, 2017.
	9907	Removed September 10, 2017.
	9910	Removed February 17, 1994.
	9911	Criterion and title September 10, 2017.
	9912	Removed September 10, 2017.
	9913	Criterion February 17, 1994.
	9914	Added February 17, 1994.
	9915	Added February 17, 1994.
	9916	Added February 17, 1994; criterion September 10, 2017.
	9917	Added September 10, 2017.
	9918	Added September 10, 2017.

[72 FR 12983, Mar. 20, 2007; 72 FR 16728, Apr. 5, 2007, as amended at 73 FR 54708, 54711, Sept. 23, 2008; 73 FR 69554, Nov. 19, 2008; 77 FR 6467, Feb. 8, 2012; 79 FR 45101, Aug. 4, 2014; 80 FR 42042, July 16, 2015; 82 FR 36084, Aug. 3, 2017; 82 FR 50806, Nov. 2, 2017; 83 FR 15072, Apr. 9, 2018; 83 FR 15323, Apr. 10, 2018; 83 FR 32600, July 13, 2018; 83 FR 54257, Oct. 29, 2018; 84 FR 28233, June 18, 2019; 85 FR 76464, Nov. 30, 2020; 86 FR 8143, Feb. 4, 2021; 86 FR 54087, 54096, Sept. 30, 2021; 89 FR 19749, Mar. 20, 2024]

APPENDIX B TO PART 4—NUMERICAL INDEX OF DISABILITIES

Diagnostic Code No.	
	THE MUSCULOSKELETAL SYSTEM **Acute, Subacute, or Chronic Diseases**
5000	Osteomyelitis, acute, subacute, or chronic.
5001	Bones and Joints, tuberculosis.
5002	Multi-joint arthritis (except post-traumatic and gout), 2 or more joints, as an active process.
5003	Degenerative arthritis, other than post-traumatic.
5004	Arthritis, gonorrheal.
5005	Arthritis, pneumococcic.
5006	Arthritis, typhoid.
5007	Arthritis, syphilitic.
5008	Arthritis, streptococcic.
5009	Other specified forms of arthropathy (excluding gout).
5010	Post-traumatic arthritis.
5011	Decompression illness.
5012	Bones, neoplasm, malignant, primary or secondary.
5013	Osteoporosis, residuals of.
5014	Osteomalacia, residuals of.
5015	Bones, neoplasm, benign.
5016	Osteitis deformans.
5017	Gout.
5018	[Removed]
5019	Bursitis.
5020	[Removed]
5021	Myositis.
5022	[Removed]
5023	Heterotopic ossification.
5024	Tenosynovitis, tendinitis, tendinosis or tendinopathy.
5025	Fibromyalgia.
	Prosthetic Implants
5051	Shoulder replacement (prosthesis).
5052	Elbow replacement (prosthesis).
5053	Wrist replacement (prosthesis).
5054	Hip, resurfacing or replacement (prosthesis).
5055	Knee, resurfacing or replacement (prosthesis).
5056	Ankle replacement (prosthesis).
	Combination of Disabilities
5104	Anatomical loss of one hand and loss of use of one foot.
5105	Anatomical loss of one foot and loss of use of 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	Complete amputation, upper extremity.
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.
	Multiple Finger Amputations
5126	Five digits of one hand.
Four digits of one hand:	
5127	Thumb, index, long and ring.
5128	Thumb, index, long and little.
5129	Thumb, index, ring and little.
5130	Thumb, long, ring and little.
5131	Index, long, ring and little.

Diagnostic Code No.	
Three digits of one hand:	
5132	Thumb, index and long.
5133	Thumb, index and ring.
5134	Thumb, index and little.
5135	Thumb, long and ring.
5136	Thumb, long and little.
5137	Thumb, ring and little.
5138	Index, long and ring.
5139	Index, long and little.
5140	Index, ring and little.
5141	Long, ring and little.
Two digits of one hand:	
5142	Thumb and index.
5143	Thumb and long.
5144	Thumb and ring.
5145	Thumb and little.
5146	Index and long.
5147	Index and ring.
5148	Index and little.
5149	Long and ring.
5150	Long and little.
5151	Ring and little.
Single finger:	
5152	Thumb.
5153	Index finger.
5154	Long finger.
5155	Ring finger.
5156	Little finger.
Amputations: Lower Extremity	
Thigh amputation of:	
5160	Complete amputation, lower extremity.
5161	Upper third.
5162	Middle or lower thirds.
Leg amputation of:	
5163	With defective stump.
5164	Not improvable by prosthesis controlled by natural knee action.
5165	At a lower level, permitting prosthesis.
5166	Forefoot, proximal to metatarsal bones.
5167	Foot, loss of use of.
5170	Toes, all, amputation of, without metatarsal loss or transmetatarsal, amputation of, with up to half of metatarsal loss.
5171	Toe, great.
5172	Toes, other than great, with removal of metatarsal head.
5173	Toes, three or more, without metatarsal involvement.
Shoulder and Arm	
5200	Scapulohumeral articulation, ankylosis.
5201	Arm, limitation of motion.
5202	Humerus, other impairment.
5203	Clavicle or scapula, impairment.
Elbow and Forearm	
5205	Elbow, ankylosis.
5206	Forearm, limitation of flexion.
5207	Forearm, limitation of extension.
5208	Forearm, flexion limited.
5209	Elbow, other impairment.
5210	Radius and ulna, nonunion.
5211	Ulna, impairment.
5212	Radius, impairment.
5213	Supination and pronation, impairment.
Wrist	
5214	Wrist, ankylosis.
5215	Wrist, limitation of motion.

Diagnostic Code No.	
Limitation of Motion	
Multiple Digits: Unfavorable Ankylosis:	
5216	Five digits of one hand.
5217	Four digits of one hand.
5218	Three digits of one hand.
5219	Two digits of one hand.
Multiple Digits: Favorable Ankylosis:	
5220	Five digits of one hand.
5221	Four digits of one hand.
5222	Three digits of one hand.
5223	Two digits of one hand.
Ankylosis of Individual Digits:	
5224	Thumb.
5225	Index finger.
5226	Long finger.
5227	Ring or little finger.
Limitation of Motion of Individual Digits:	
5228	Thumb.
5229	Index or long finger.
5230	Ring or little finger.
Spine	
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, degenerative disc disease other than intervertebral disc syndrome (also, see either DC 5003 or 5010).
5243	Intervertebral disc syndrome.
5244	Traumatic paralysis, complete.
Hip and Thigh	
5250	Hip, ankylosis.
5251	Thigh, limitation of extension.
5252	Thigh, limitation of flexion.
5253	Thigh, impairment.
5254	Hip, flail joint.
5255	Femur, impairment.
Knee and Leg	
5256	Knee, ankylosis.
5257	Knee, other impairment.
5258	Cartilage, semilunar, dislocated.
5259	Cartilage, semilunar, removal.
5260	Leg, limitation of flexion.
5261	Leg, limitation of extension.
5262	Tibia and fibula, impairment.
5263	Genu recurvatum.
Ankle	
5270	Ankle, ankylosis.
5271	Ankle, limited motion.
5272	Subastragalar or tarsal joint, ankylosis.
5273	Os calcis or astragalus, malunion.
5274	Astragalectomy.
Shortening of the Lower Extremity	
5275	Bones, of the lower extremity
The Foot	
5269	Plantar fasciitis.

Diagnostic Code No.	
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.
5284	Foot injuries, other.
The Skull	
5296	Loss of part of.
The Ribs	
5297	Removal of.
The Coccyx	
5298	Removal of.
MUSCLE INJURIES Shoulder Girdle and Arm	
5301	Group I Function: Upward rotation of scapula.
5302	Group II Function: Depression of arm.
5303	Group III Function: Elevation and abduction of arm.
5304	Group IV Function: Stabilization of shoulder.
5305	Group V Function: Elbow supination.
5306	Group VI Function: Extension of elbow.
Forearm and Hand	
5307	Group VII Function: Flexion of wrist and fingers.
5308	Group VIII Function: Extension of wrist, fingers, thumb.
5309	Group IX Function: Forearm muscles.
Foot and Leg	
5310	Group X Function: Movement of forefoot and toes.
5311	Group XI Function: Propulsion of foot.
5312	Group XII Function: Dorsiflexion.
Pelvic Girdle and Thigh	
5313	Group XIII Function: Extension of hip and flexion of knee.
5314	Group XIV Function: Extension of knee.
5315	Group XV Function: Adduction of hip.
5316	Group XVI Function: Flexion of hip.
5317	Group XVII Function: Extension of hip.
5318	Group XVIII Function: Outward rotation of thigh.
Torso and Neck	
5319	Group XIX Function: Abdominal wall and lower thorax.
5320	Group XX Function: Postural support of body.
5321	Group XXI Function: Respiration.
5322	Group XXII Function: Rotary and forward movements, head.
5323	Group XXIII Function: Movements of head.
Miscellaneous	
5324	Diaphragm, rupture.
5325	Muscle injury, facial muscles.
5326	Muscle hernia.
5327	Muscle, neoplasm of, malignant.
5328	Muscle, neoplasm of, benign.
5329	Sarcoma, soft tissue.
5330	Rhabdomyolysis, residuals of.
5331	Compartment syndrome.
THE EYE Diseases of the Eye	
6000	Choroidopathy, including uveitis, iritis, cyclitis, or choroiditis.

Diagnostic Code No.	
6001	Keratopathy.
6002	Scleritis.
6003	Iritis.
6004	Cyclitis.
6005	Choroiditis.
6006	Retinopathy or maculopathy not otherwise specified.
6007	Intraocular hemorrhage.
6008	Detachment of retina.
6009	Unhealed eye injury.
6010	Tuberculosis of eye.
6011	Retinal scars, atrophy, or irregularities.
6012	Angle-closure glaucoma.
6013	Open-angle glaucoma.
6014	Malignant neoplasms of the eye, orbit, and adnexa (excluding skin).
6015	Benign neoplasms of the eye, orbit, and adnexa (excluding skin).
6016	Nystagmus, central.
6017	Conjunctivitis, trachomatous, chronic.
6018	Conjunctivitis, other, chronic.
6019	Ptosis unilateral or bilateral.
6020	Ectropion.
6021	Entropion.
6022	Lagophthalmos.
6023	Eyebrows, loss.
6024	Eyelashes, loss.
6025	Disorders of the lacrimal apparatus (epiphora, dacrocystitis, etc.).
6026	Optic neuropathy.
6027	Cataract.
6028	Cataract, senile, and others.
6029	Aphakia.
6030	Accommodation, paralysis.
6031	Dacryocystitis.
6032	Eyelids, loss of portion.
6033	Lens, crystalline, dislocation.
6034	Pterygium.
6035	Keratoconus.
6036	Status post corneal transplant.
6040	Diabetic retinopathy.
6042	Retinal dystrophy (including retinitis pigmentosa, wet or dry macular degeneration, early-onset macular degeneration, rod and/or cone dystrophy).
6046	Post-chiasmal disorders.
Impairment of Central Visual Acuity	
6061	Anatomical loss both eyes.
6062	Blindness, both eyes, only light perception.
Anatomical loss of 1 eye:	
6063	Other eye 5/200 (1.5/60).
6064	Other eye 10/200 (3/60).
6064	Other eye 15/200 (4.5/60).
6064	Other eye 20/200 (6/60).
6065	Other eye 20/100 (6/30).
6065	Other eye 20/70 (6/21).
6065	Other eye 20/50 (6/15).
6066	Other eye 20/40 (6/12).
Blindness in 1 eye, only light perception:	
6067	Other eye 5/200 (1.5/60).
6068	Other eye 10/200 (3/60).
6068	Other eye 15/200 (4.5/60).
6068	Other eye 20/200 (6/60).
6069	Other eye 20/100 (6/30).
6069	Other eye 20/70 (6/21).
6069	Other eye 20/50 (6/15).
6070	Other eye 20/40 (6/12).
Vision in 1 eye 5/200 (1.5/60):	
6071	Other eye 5/200 (1.5/60).
6072	Other eye 10/200 (3/60).
6072	Other eye 15/200 (4.5/60).
6072	Other eye 20/200 (6/60).
6073	Other eye 20/100 (6/30).
6073	Other eye 20/70 (6/21).
6073	Other eye 20/50 (6/15).

Diagnostic Code No.	
6074	Other eye 20/40 (6/12).
Vision in 1 eye 10/200 (3/60):	
6075	Other eye 10/200 (3/60).
6075	Other eye 15/200 (4.5/60).
6075	Other eye 20/200 (6/60).
6076	Other eye 20/100 (6/30).
6076	Other eye 20/70 (6/21).
6076	Other eye 20/50 (6/15).
6077	Other eye 20/40 (6/12).
Vision in 1 eye 15/200 (4.5/60):	
6075	Other eye 15/200 (4.5/60).
6075	Other eye 20/200 (6/60).
6076	Other eye 20/100 (6/30).
6076	Other eye 20/70 (6/21).
6076	Other eye 20/50 (6/15).
6077	Other eye 20/40 (6/12).
Vision in 1 eye 20/200 (6/60):	
6075	Other eye 20/200 (6/60).
6076	Other eye 20/100 (6/30).
6076	Other eye 20/70 (6/21).
6076	Other eye 20/50 (6/15).
6077	Other eye 20/40 (6/12).
Vision in 1 eye 20/100 (6/30):	
6078	Other eye 20/100 (6/30).
6078	Other eye 20/70 (6/21).
6078	Other eye 20/50 (6/15).
6079	Other eye 20/40 (6/12).
Vision in 1 eye 20/70 (6/21):	
6078	Other eye 20/70 (6/21).
6078	Other eye 20/50 (6/15).
6079	Other eye 20/40 (6/12).
Vision in 1 eye 20/50 (6/15):	
6078	Other eye 20/50 (6/15).
6079	Other eye 20/40 (6/12).
Impairment of Field Vision:	
6080	Field vision, impairment.
6081	Scotoma.
Impairment of Muscle Function:	
6090	Diplopia.
6091	Symblepharon.
6092	Diplopia, limited muscle function.
THE EAR	
6200	Chronic suppurative otitis media.
6201	Chronic nonsuppurative otitis media.
6202	Otosclerosis.
6204	Peripheral vestibular disorders.
6205	Meniere's syndrome.
6207	Loss of auricle.
6208	Malignant neoplasm.
6209	Benign neoplasm.
6210	Chronic otitis externa.
6211	Tympanic membrane.
6260	Tinnitus, recurrent.
OTHER SENSE ORGANS	
6275	Smell, complete loss.
6276	Taste, complete loss.
INFECTIOUS DISEASES, IMMUNE DISORDERS AND NUTRITIONAL DEFICIENCIES	
6300	Vibriosis (Cholera, Non-cholera).
6301	Visceral Leishmaniasis.
6302	Leprosy (Hansen's Disease).
6304	Malaria.

Diagnostic Code No.	
6305	Lymphatic filariasis, to include elephantiasis.
6306	Bartonellosis.
6307	Plague.
6308	Relapsing fever.
6309	Rheumatic fever.
6310	Syphilis.
6311	Tuberculosis, miliary.
6312	Nontuberculosis mycobacterium infection.
6313	Avitaminosis.
6314	Beriberi.
6315	Pellagra.
6316	Brucellosis.
6317	Rickettsial, ehrlichia, and anaplasma infections.
6318	Melioidosis.
6319	Lyme disease.
6320	Parasitic diseases.
6325	Hyperinfection syndrome or disseminated strongyloidiasis.
6326	Schistosomiasis.
6329	Hemorrhagic fevers, including dengue, yellow fever, and others.
6330	Campylobacter jejuni infection.
6331	Coxiella burnetii infection (Q Fever).
6333	Nontyphoid salmonella infections.
6334	Shigella infections.
6335	West Nile virus infection.
6350	Lupus erythematosus.
6351	HIV-Related Illness.
6354	Chronic Fatigue Syndrome (CFS).
	THE RESPIRATORY SYSTEM
	Nose and Throat
6502	Septum, nasal, deviation.
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.
6518	Laryngectomy, total.
6519	Aphonia, complete organic.
6520	Larynx, stenosis of.
6521	Pharynx, injuries to.
6522	Allergic or vasomotor rhinitis.
6523	Bacterial rhinitis.
6524	Granulomatous rhinitis.
	Trachea and Bronchi
6600	Bronchitis, chronic.
6601	Bronchiectasis.
6602	Asthma, bronchial.
6603	Emphysema, pulmonary.
6604	Chronic obstructive pulmonary disease.
	Lungs and Pleura Tuberculosis
Ratings for Pulmonary Tuberculosis (Chronic) Entitled on August 19, 1968:	
6701	Active, far advanced.
6702	Active, moderately advanced.
6703	Active, minimal.
6704	Active, advancement unspecified.
6721	Inactive, far advanced.
6722	Inactive, moderately advanced.
6723	Inactive, minimal.
6724	Inactive, advancement unspecified.
Ratings for Pulmonary Tuberculosis Initially Evaluated After August 19, 1968:	
6730	Chronic, active.
6731	Chronic, inactive.
6732	Pleurisy, active or inactive.

Diagnostic Code No.	
Nontuberculous Diseases	
6817	Pulmonary Vascular Disease.
6819	Neoplasms, malignant.
6820	Neoplasms, benign.
Bacterial Infections of the Lung	
6822	Actinomycosis.
6823	Nocardiosis.
6824	Chronic lung abscess.
Interstitial Lung Disease	
6825	Fibrosis of lung, diffuse interstitial.
6826	Desquamative interstitial pneumonitis.
6827	Pulmonary alveolar proteinosis.
6828	Eosinophilic granuloma.
6829	Drug-induced, pneumonitis & fibrosis.
6830	Radiation-induced, pneumonitis & fibrosis.
6831	Hypersensitivity pneumonitis.
6832	Pneumoconiosis.
6833	Asbestosis.
Mycotic Lung Disease	
6834	Histoplasmosis.
6835	Coccidioidomycosis.
6836	Blastomycosis.
6837	Cryptococcosis.
6838	Aspergillosis.
6839	Mucormycosis.
Restrictive Lung Disease	
6840	Diaphragm paralysis or paresis.
6841	Spinal cord injury with respiratory insufficiency.
6842	Kyphoscoliosis, pectus excavatum/carinatum.
6843	Traumatic chest wall defect.
6844	Post-surgical residual.
6845	Pleural effusion or fibrosis.
6846	Sarcoidosis.
6847	Sleep Apnea Syndromes.
THE CARDIOVASCULAR SYSTEM Diseases of the Heart	
7000	Valvular heart disease.
7001	Endocarditis.
7002	Pericarditis.
7003	Pericardial adhesions.
7004	Syphilitic heart disease.
7005	Arteriosclerotic heart disease.
7006	Myocardial infarction.
7007	Hypertensive heart disease.
7008	Hyperthyroid heart disease.
7009	Bradycardia (Bradyarrhythmia), symptomatic, requiring permanent pacemaker implantation.
7010	Supraventricular tachycardia.
7011	Ventricular arrhythmias.
7015	Atrioventricular block.
7016	Heart valve replacement.
7017	Coronary bypass surgery.
7018	Implantable cardiac pacemakers.
7019	Cardiac transplantation.
7020	Cardiomyopathy.
Diseases of the Arteries and Veins	
7101	Hypertensive vascular disease.
7110	Aortic aneurysm: ascending, thoracic, abdominal.
7111	Aneurysm, large artery.
7112	Aneurysm, small artery.
7113	Arteriovenous fistula, traumatic.
7114	Peripheral arterial disease.
7115	Thrombo-angiitis obliterans (Buerger's Disease).

Diagnostic Code No.	
7117	Raynaud's syndrome (secondary Raynaud's phenomenon, secondary Raynaud's).
7118	Angioneurotic edema.
7119	Erythromelalgia.
7120	Varicose veins.
7121	Post-phlebitic syndrome.
7122	Cold injury residuals.
7123	Soft tissue sarcoma.
7124	Raynaud's disease (primary Raynaud's).
	The Digestive System
7200	Soft tissue injury of the mouth, other than tongue or lips.
7201	Lips, injuries.
7202	Tongue, loss of whole or part.
7203	Esophagus, stricture.
7204	Esophageal motility disorder.
7205	Esophagus, diverticulum.
7206	Gastroesophageal reflux disease.
7207	Barrett's esophagus.
7301	Peritoneum, adhesions of, due to surgery, trauma, or infection.
7303	Chronic complications of upper gastrointestinal surgery.
7304	Peptic ulcer disease.
7305	[Removed].
7306	[Removed].
7307	Gastritis, chronic.
7308	Postgastrectomy syndromes.
7309	Stomach, stenosis.
7310	Stomach, injury of, residuals.
7311	Liver, injury of, residuals.
7312	Cirrhosis of the liver.
7314	Chronic biliary tract disease.
7315	Cholelithiasis, chronic.
7316	[Removed].
7317	Gallbladder, injury of.
7318	Cholecystectomy (gallbladder removal), complications of (such as strictures and biliary leaks).
7319	Irritable bowel syndrome (IBS).
7321	[Removed].
7322	[Removed].
7323	Colitis, ulcerative.
7324	[Removed].
7325	Enteritis, chronic.
7326	Crohn's disease or undifferentiated form of inflammatory bowel disease.
7327	Diverticulitis and diverticulosis.
7328	Intestine, small, resection of.
7329	Intestine, large, resection.
7330	Intestinal fistulous diseases, external.
7331	Peritonitis.
7332	Rectum and anus, impairment of sphincter control.
7333	Rectum & anus, stricture.
7334	Rectum, prolapse.
7335	Ano, fistula in, including anorectal fistula, anorectal abscess.
7336	Hemorrhoids, external or internal.
7337	Pruritus ani (anal itching).
7338	Hernia, including femoral, inguinal, umbilical, ventral, incisional, and other (but not including hiatal).
7339	[Removed].
7340	[Removed].
7342	Visceroptosis.
7343	Neoplasms, malignant.
7344	Benign neoplasms, exclusive of skin growths.
7345	Chronic liver disease without cirrhosis.
7346	Hiatal hernia and paraesophageal hernia.
7347	Pancreatitis, chronic.
7348	Vagotomy with pyloroplasty or gastroenterostomy.
7350	Liver abscess.
7351	Liver transplant.
7352	Pancreas transplant.
7354	Hepatitis C (or non-A, non-B hepatitis).
7355	Celiac disease.
7356	Gastrointestinal dysmotility syndrome.
7357	Post pancreatectomy syndrome.
	THE GENITOURINARY SYSTEM
7500	Kidney, removal.

Diagnostic Code No.	
7501	Kidney, abscess.
7502	Nephritis, chronic.
7504	Pyelonephritis, chronic.
7505	Kidney, tuberculosis.
7507	Nephrosclerosis, arteriolar.
7508	Nephrolithiasis/Ureterolithiasis/Nephrocalcinosis.
7509	Hydronephrosis.
7511	Ureter, stricture.
7512	Cystitis, chronic.
7515	Bladder, calculus.
7516	Bladder, fistula.
7517	Bladder, injury.
7518	Urethra, stricture.
7519	Urethra, fistula.
7520	Penis, removal of half or more.
7521	Penis, removal of glans.
7522	Erectile dysfunction, with or without penile deformity.
7523	Testis, atrophy, complete.
7524	Testis, removal.
7525	Prostatitis, urethritis, epididymitis, orchitis (unilateral or bilateral), chronic only.
7527	Prostate gland injuries, infections, hypertrophy, postoperative residuals, bladder outlet obstruction.
7528	Malignant neoplasms.
7529	Benign neoplasms.
7530	Renal disease, chronic.
7531	Kidney transplant.
7532	Renal tubular disorders.
7533	Cystic diseases of the kidneys.
7534	Atherosclerotic renal disease (renal artery stenosis, atheroembolic renal disease, or large vessel disease, unspecified).
7535	Toxic nephropathy.
7536	Glomerulonephritis.
7537	Interstitial nephritis, including gouty nephropathy, disorders of calcium metabolism.
7538	Papillary necrosis.
7539	Renal amyloid disease.
7540	Disseminated intravascular coagulation.
7541	Renal involvement in diabetes mellitus type I or II.
7542	Neurogenic bladder.
7543	Varicocele/Hydrocele.
7544	Renal disease caused by viral infection such as HIV, Hepatitis B, and Hepatitis C.
7545	Bladder, diverticulum of.
GYNECOLOGICAL CONDITIONS AND DISORDERS OF THE BREAST	
7610	Vulva or clitoris, disease or injury of (including vulvovaginitis).
7611	Vagina, disease or injury.
7612	Cervix, disease or injury.
7613	Uterus, disease or injury.
7614	Fallopian tube, disease or injury.
7615	Ovary, disease or injury.
7617	Uterus and both ovaries, removal.
7618	Uterus, removal.
7619	Ovary, removal.
7620	Ovaries, atrophy of both.
7621	Complete or incomplete pelvic organ prolapse due to injury or disease or surgical complications of pregnancy.
7624	Fistula, rectovaginal.
7625	Fistula, urethrovaginal.
7626	Breast, surgery.
7627	Malignant neoplasms of gynecological system.
7628	Benign neoplasms of gynecological system.
7629	Endometriosis.
7630	Malignant neoplasms of the breast.
7631	Benign neoplasms of the breast and other injuries of the breast.
7632	Female sexual arousal disorder (FSAD).
The Hematologic and Lymphatic Systems	
7700	[Removed]
7702	Agranulocytosis, acquired.
7703	Leukemia.
7704	Polycythemia vera.
7705	Immune thrombocytopenia.
7706	Splenectomy.

Diagnostic Code No.	
7707	Spleen, injury of, healed.
7709	Hodgkin's lymphoma.
7710	Adenitis, tuberculous.
7712	Multiple myeloma
7714	Sickle cell anemia.
7715	Non-Hodgkin's lymphoma.
7716	Aplastic anemia.
7717	AL amyloidosis (primary amyloidosis).
7718	Essential thrombocythemia and primary myelofibrosis.
7719	Chronic myelogenous leukemia (CML) (chronic myeloid leukemia or chronic granulocytic leukemia).
7720	Iron deficiency anemia.
7721	Folic acid deficiency.
7722	Pernicious anemia and Vitamin B_{12} deficiency anemia.
7723	Acquired hemolytic anemia.
7724	Solitary plasmacytoma.
7725	Myelodysplastic syndromes.
THE SKIN	
7800	Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck.
7801	Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck that are associated with underlying soft tissue damage.
7802	Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck that are not associated with underlying soft tissue damage.
7804	Scar(s), unstable or painful.
7805	Scars, other; and other effects of scars evaluated under diagnostic codes 7800, 7801, 7802, or 7804.
7806	Dermatitis or eczema.
7807	Leishmaniasis, American (New World).
7808	Leishmaniasis, Old World.
7809	Discoid lupus erythematosus.
7811	Tuberculosis luposa (lupus vulgaris).
7813	Dermatophytosis.
7815	Bullous disorders.
7816	Psoriasis.
7817	Erythroderma.
7818	Malignant skin neoplasms.
7819	Benign skin neoplasms.
7820	Infections of the skin.
7821	Cutaneous manifestations of collagen-vascular diseases not listed elsewhere.
7822	Papulosquamous disorders not listed elsewhere.
7823	Vitiligo.
7824	Keratinization, diseases.
7825	Chronic urticaria.
7826	Vasculitis, primary cutaneous.
7827	Erythema multiforme.
7828	Acne.
7829	Chloracne.
7830	Scarring alopecia.
7831	Alopecia areata.
7832	Hyperhidrosis.
7833	Malignant melanoma.
THE ENDOCRINE SYSTEM	
7900	Hyperthyroidism, including, but not limited to, Graves' disease.
7901	Thyroid enlargement, toxic.
7902	Thyroid enlargement, nontoxic.
7903	Hypothyroidism.
7904	Hyperparathyroidism.
7905	Hypoparathyroidism.
7906	Thyroiditis.
7907	Cushing's syndrome.
7908	Acromegaly.
7909	Diabetes insipidus.
7911	Addison's disease (adrenocortical insufficiency).
7912	Polyglandular syndrome (multiple endocrine neoplasia, autoimmune polyglandular syndrome).
7913	Diabetes mellitus.
7914	Malignant neoplasm.
7915	Benign neoplasm.
7916	Hyperpituitarism.
7917	Hyperaldosteronism.

Diagnostic Code No.	
7918	Pheochromocytoma.
7919	C-cell hyperplasia, thyroid.
	NEUROLOGICAL CONDITIONS AND CONVULSIVE DISORDERS **Organic Diseases of the Central Nervous System**
8000	Encephalitis, epidemic, chronic.
	Brain, New Growth of
8002	Malignant.
8003	Benign.
8004	Paralysis agitans.
8005	Bulbar palsy.
8007	Brain, vessels, embolism.
8008	Brain, vessels, thrombosis.
8009	Brain, vessels, hemorrhage.
8010	Myelitis.
8011	Poliomyelitis, anterior.
8012	Hematomyelia.
8013	Syphilis, cerebrospinal.
8014	Syphilis, meningovascular.
8015	Tabes dorsalis.
8017	Amyotrophic lateral sclerosis.
8018	Multiple sclerosis.
8019	Meningitis, cerebrospinal, epidemic.
8020	Brain, abscess.
	Spinal Cord, New Growths
8021	Malignant.
8022	Benign.
8023	Progressive muscular atrophy.
8024	Syringomyelia.
8025	Myasthenia gravis.
8045	Residuals of traumatic brain injury (TBI).
8046	Cerebral arteriosclerosis.
	Miscellaneous Diseases
8100	Migraine
8103	Tic, convulsive.
8104	Paramyoclonus multiplex.
8105	Chorea, Sydenham's.
8106	Chorea, Huntington's.
8107	Athetosis, acquired.
8108	Narcolepsy.
	The Cranial Nerves
8205	Fifth (trigeminal), paralysis.
8207	Seventh (facial), paralysis.
8209	Ninth (glossopharyngeal), paralysis.
8210	Tenth (pneumogastric, vagus), paralysis.
8211	Eleventh (spinal accessory, external branch), paralysis.
8212	Twelfth (hypoglossal), paralysis.
8305	Neuritis, fifth cranial nerve.
8307	Neuritis, seventh cranial nerve.
8309	Neuritis, ninth cranial nerve.
8310	Neuritis, tenth cranial nerve.
8311	Neuritis, eleventh cranial nerve.
8312	Neuritis, twelfth cranial nerve.
8405	Neuralgia, fifth cranial nerve.
8407	Neuralgia, seventh cranial nerve.
8409	Neuralgia, ninth cranial nerve.
8410	Neuralgia, tenth cranial nerve.
8411	Neuralgia, eleventh cranial nerve.
8412	Neuralgia, twelfth cranial nerve.
	Peripheral Nerves
8510	Upper radicular group, paralysis.
8511	Middle radicular group, paralysis.
8512	Lower radicular group, paralysis.
8513	All radicular groups, paralysis.

Diagnostic Code No.	
8514	Musculospiral nerve (radial), paralysis.
8515	Median nerve, paralysis.
8516	Ulnar nerve, paralysis.
8517	Musculocutaneous nerve, paralysis.
8518	Circumflex nerve, paralysis.
8519	Long thoracic nerve, paralysis.
8520	Sciatic nerve, paralysis.
8521	External popliteal nerve (common peroneal), paralysis.
8522	Musculocutaneous nerve (superficial peroneal), paralysis.
8523	Anterior tibial nerve (deep peroneal), paralysis.
8524	Internal popliteal nerve (tibial), paralysis.
8525	Posterior tibial nerve, paralysis.
8526	Anterior crural nerve (femoral), paralysis.
8527	Internal saphenous nerve, paralysis.
8528	Obturator nerve, paralysis.
8529	External cutaneous nerve of thigh, paralysis.
8530	Ilio-inguinal nerve, paralysis.
8540	Soft-tissue sarcoma (Neurogenic origin).
8610	Neuritis, upper radicular group.
8611	Neuritis, middle radicular group.
8612	Neuritis, lower radicular group.
8613	Neuritis, all radicular group.
8614	Neuritis, musculospiral (radial) nerve.
8615	Neuritis, median nerve.
8616	Neuritis, ulnar nerve.
8617	Neuritis, musculocutaneous nerve.
8618	Neuritis, circumflex nerve.
8619	Neuritis, long thoracic nerve.
8620	Neuritis, sciatic nerve.
8621	Neuritis, external popliteal (common peroneal) nerve.
8622	Neuritis, musculocutaneous (superficial peroneal) nerve.
8623	Neuritis, anterior tibial (deep peroneal) nerve.
8624	Neuritis, internal popliteal (tibial) nerve.
8625	Neuritis, posterior tibial nerve.
8626	Neuritis, anterior crural (femoral) nerve.
8627	Neuritis, internal saphenous nerve.
8628	Neuritis, obturator nerve.
8629	Neuritis, external cutaneous nerve of thigh.
8630	Neuritis, ilio-inguinal nerve.
8710	Neuralgia, upper radicular group.
8711	Neuralgia, middle radicular group.
8712	Neuralgia, lower radicular group.
8713	Neuralgia, all radicular groups.
8714	Neuralgia, musculospiral nerve (radial).
8715	Neuralgia, median nerve.
8716	Neuralgia, ulnar nerve.
8717	Neuralgia, musculocutaneous nerve.
8718	Neuralgia, circumflex nerve.
8719	Neuralgia, long thoracic nerve.
8720	Neuralgia, sciatic nerve.
8721	Neuralgia, external popliteal nerve (common peroneal).
8722	Neuralgia, musculocutaneous nerve (superficial peroneal).
8723	Neuralgia, anterior tibial nerve (deep peroneal).
8724	Neuralgia, internal popliteal nerve (tibial).
8725	Neuralgia, posterior tibial nerve.
8726	Neuralgia, anterior crural nerve (femoral).
8727	Neuralgia, internal saphenous nerve.
8728	Neuralgia, obturator nerve.
8729	Neuralgia, external cutaneous nerve of thigh.
8730	Neuralgia, ilio-inguinal nerve.
The Epilepsies	
8910	Grand mal.
8911	Petit mal.
8912	Jacksonian and focal motor or sensory.
8913	Diencephalic.
8914	Psychomotor.
Mental Disorders	
9201	Schizophrenia.
9208	Delusional disorder.
9210	Other specified and unspecified schizophrenia spectrum and other psychotic disorders.

Diagnostic Code No.	
9211	Schizoaffective Disorder.
9300	Delirium.
9301	Major or mild neurocognitive disorder due to HIV or other infections.
9304	Major or mild neurocognitive disorder due to traumatic brain injury.
9305	Major or mild vascular neurocognitive disorder.
9310	Unspecified neurocognitive disorder.
9312	Major or mild neurocognitive disorder due to Alzheimer's disease.
9326	Major or mild neurocognitive disorder due to another medical condition or substance/medication-induced major or mild neurocognitive disorder.
9400	Generalized anxiety disorder.
9403	Specific phobia; social anxiety disorder (social phobia).
9404	Obsessive compulsive disorder.
9410	Other specified anxiety disorder.
9411	Posttraumatic stress disorder.
9412	Panic disorder and/or agoraphobia.
9413	Unspecified anxiety disorder.
9416	Dissociative amnesia; dissociative identity disorder.
9417	Depersonalization/derealization disorder.
9421	Somatic symptom disorder.
9422	Other specified somatic symptom and related disorder.
9423	Unspecified somatic symptom and related disorder.
9424	Conversion disorder (functional neurological symptom disorder).
9425	Illness anxiety disorder.
9431	Cyclothymic disorder.
9432	Bipolar disorder.
9433	Persistent depressive disorder (dysthymia).
9434	Major depressive disorder.
9435	Unspecified depressive disorder.
9440	Chronic adjustment disorder.
9520	Anorexia nervosa.
9521	Bulimia nervosa.
DENTAL AND ORAL CONDITIONS	
9900	Maxilla or mandible, chronic osteomyelitis, osteonecrosis, or osteoradionecrosis of.
9901	Mandible, loss of, complete.
9902	Mandible loss of, including ramus, unilaterally or bilaterally.
9903	Mandible, nonunion of, confirmed by diagnostic imaging studies.
9904	Mandible, malunion.
9905	Temporomandibular disorder (TMD).
9908	Condyloid process.
9909	Coronoid process.
9911	Hard palate, loss of.
9913	Teeth, loss of.
9914	Maxilla, loss of more than half.
9915	Maxilla, loss of half or less.
9916	Maxilla, malunion or nonunion of.
9917	Neoplasm, hard and soft tissue, benign.
9918	Neoplasm, hard and soft tissue, malignant.

[72 FR 12990, Mar. 20, 2007, as amended at 73 FR 54708, 54711, Sept. 23, 2008; 74 FR 18467, Apr. 23, 2009; 77 FR 6467, Feb. 8, 2012; 79 FR 45102, Aug. 4, 2014; 82 FR 36085, Aug. 3, 2017; 82 FR 50807, Nov. 2, 2017; 83 FR 15073, Apr. 9, 2018; 83 FR 15323, Apr. 10, 2018; 83 FR 32600, July 13, 2018; 83 FR 54258, Oct. 29, 2018; 84 FR 28234, June 18, 2019; 85 FR 76466, Nov. 30, 2020; 86 FR 8143, Feb. 4, 2021; 86 FR 54088, 54097, Sept. 30, 2021; 89 FR 19751, Mar. 20, 2024]

APPENDIX C TO PART 4—ALPHABETICAL INDEX OF DISABILITIES

	Diagnostic code No.
Alopecia areata	7831
Amebiasis	7321
Amputation:	
Arm:	
Complete amputation, upper extremity	5120
Above insertion of deltoid	5121
Below insertion of deltoid	5122
Digits, five of one hand	5126
Digits, four of one hand:	
Thumb, index, long and ring	5127
Thumb, index, long and little	5128
Thumb, index, ring and little	5129
Thumb, long, ring and little	5130
Index, long, ring and little	5131
Digits, three of one hand:.	
Thumb, index and long	5132
Thumb, index and ring	5133
Thumb, index and little	5134
Thumb, long and ring	5135
Thumb, long and little	5136
Thumb, ring and little	5137
Index, long and ring	5138
Index, long and little	5139
Index, ring and little	5140
Long, ring and little	5141
Digits, two of one hand:	
Thumb and index	5142
Thumb and long	5143
Thumb and ring	5144
Thumb and little	5145
Index and long	5146
Index and ring	5147
Index and little	5148
Long and ring	5149
Long and little	5150
Ring and little	5151
Single finger:	
Thumb	5152
Index finger	5153
Long finger	5154
Ring finger	5155
Little finger	5156
Forearm:	
Above insertion of pronator teres	5123
Below insertion of pronator teres	5124
Leg:	
With defective stump	5163
Not improvable by prosthesis controlled by natural knee action	5164
At lower level, permitting prosthesis	5165
Forefoot, proximal to metatarsal bones	5166
Toes, all, amputation of, without metatarsal loss or transmetatarsal, amputation of, with up to half of metatarsal loss	5170
Toe, great	5171
Toe, other than great, with removal metatarsal head	5172
Toes, three or more, without metatarsal involvement	5173
Thigh:	
Complete amputation, lower extremity	5160
Upper third	5161
Middle or lower thirds	5162
Amyotrophic lateral sclerosis	8017
Anatomical loss of:	
Both eyes	6061
One eye, with visual acuity of other eye:	
5/200 (1.5/60)	6063
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6064
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6065
20/40 (6/12)	6066
Both feet	5107
Both hands	5106
One hand and one foot	5108
One foot and loss of use of one hand	5105
One hand and loss of use of one foot	5104
Anemia:	

	Diagnostic code No.
Acquired hemolytic anemia	7723
Folic acid deficiency	7721
Iron deficiency anemia	7720
Pernicious anemia and Vitamin B_{12} deficiency anemia	7722
Aneurysm:	
Aortic: ascending, thoracic, abdominal	7110
Large artery	7111
Small artery	7118
Ankylosis:	
Ankle	5270
Digits, individual:	
Thumb	5224
Index finger	5225
Long finger	5226
Ring or little finger	5227
Elbow	5205
Hand	
Favorable:	
Five digits of one hand	5220
Four digits of one hand	5221
Three digits of one hand	5222
Two digits of one hand	5223
Unfavorable:	
Five digits of one hand	5216
Four digits of one hand	5217
Three digits of one hand	5218
Two digits of one hand	5219
Hip	5250
Knee	5256
Scapulohumeral articulation	5200
Subastragalar or tarsal joint	5272
Wrist	5214
Ankylosing spondylitis	5240
Aphakia	6029
Aphonia, organic	6519
Aplastic anemia	7716
Arteriosclerotic heart disease	7005
Arteriovenous fistula	7113
Arthritis:	
Degenerative, other than post-traumatic	5003
Gonorrheal	5004
Other specified forms (excluding gout)	5009
Pneumococcic	5005
Post-traumatic	5010
Multi-joint (except post-traumatic and gout)	5002
Streptococcic	5008
Syphilitic	5007
Typhoid	5006
Arthropathy	5009
Asbestosis	6833
Aspergillosis	6838
Asthma, bronchial	6602
Astragalectomy	5274
Atherosclerotic renal disease	7534
Athetosis	8107
Atrioventricular block	7015
Avitaminosis	6313
Bartonellosis	6306
Beriberi	6314
Bladder:	
Calculus in	7515
Diverticulum of	7545
Fistula in	7516
Injury of	7517
Neurogenic	7542
Blastomycosis	6836
Blindness: *see also* Vision and Anatomical Loss	
Both eyes, only light perception	6062
One eye, only light perception and other eye:	
5/200 (1.5/60)	6067
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6068
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6069
20/40 (6/12)	6070

	Diagnostic code No.
Bones:	
Neoplasm, benign	5015
Neoplasm, malignant, primary or secondary	5012
Shortening of the lower extremity	5275
Bradycardia (Bradyarrhythmia), symptomatic, requiring permanent pacemaker implantation	7009
Brain:	
Abscess	8020
Breast surgery	7626
Bronchiectasis	6601
Bronchitis	6600
Brucellosis	6316
Buerger's disease	7115
Bulbar palsy	8005
Bullous disorders	7815
Bursitis	5019
Campylobacter jejuni infection	6330
Cardiac:	
Pacemakers, implantable	7018
Transplantation	7019
Cardiomyopathy	7020
C-cell hyperplasia, thyroid	7919
Cataract:	
Senile and others	6028
Traumatic	6027
Cerebral arteriosclerosis	8046
Cervical strain	5237
Cervix disease or injury	7612
Chorea:	
Huntington's	8106
Sydenham's	8105
Chloracne	7829
Cholangitis, chronic	7314
Cholecystectomy (gallbladder removal), complications of (such as strictures and biliary leaks)	7318
Cholecystitis, chronic	7314
Cholelithiasis, chronic	7315
Choroiditis	6005
Chronic Fatigue Syndrome (CFS)	6354
Chronic lung abscess	6824
Chronic obstructive pulmonary disease	6604
Coccidioidomycosis	6835
Cold injury residuals	7122
Colitis, ulcerative	7323
Compartment syndrome	5331
Complete or incomplete pelvic organ prolapse due to injury or disease or surgical complications of pregnancy, including uterine or vaginal vault prolapse, cystocele, urethrocele, rectocele, enterocele, or combination	7621
Conjunctivitis:	
Trachomatous	6017
Other	6018
Coronary bypass surgery	7017
Coxiella burnetii infection (Q Fever)	6331
Cryptococcosis	6837
Cushing's syndrome	7907
Cutaneous manifestations of collagen-vascular diseases not listed elsewhere	7821
Cyclitis	6004
Cystitis, chronic	7512
Dacryocystitis	6031
Decompression illness	5011
Dermatitis or eczema	7806
Dermatophytosis	7813
Desquamative interstitial pneumonitis	6826
Diabetes:	
Insipidus	7909
Mellitus	7913
Diaphragm:	
Paralysis or paresis	6840
Rupture	5324
Diplopia	6090
Diplopia, limited muscle function, eye	6092
Disease:	
Addison's	7911
Buerger's	7115
Celiac	7355
Chronic obstructive pulmonary disease	6604

	Diagnostic code No.
Crohn's	7326
Gallbladder and biliary tract, chronic	7314
Hodgkin's	7709
Inflammatory bowel	7326
Leprosy (Hansen's)	6302
Lyme	6319
Morton's	5279
Parasitic	6320
Disfigurement of, head, face or neck	7800
Dislocated:	
Cartilage, semilunar	5258
Lens, crystalline	6033
Disseminated intravascular coagulation	7540
Distomiasis, intestinal or hepatic	7324
Diverticulitis and diverticulosis	7327
Dysentery, bacillary	7322
Ectropion	6020
Embolism, brain	8007
Emphysema, pulmonary	6603
Encephalitis, epidemic, chronic	8000
Endocarditis	7001
Endometriosis	7629
Enteritis, chronic	7325
Enterocolitis, chronic	7326
Entropion	6021
Eosinophilic granuloma of lung	6828
Epilepsies:	
Diencephalic	8913
Grand mal	8910
Jacksonian and focal motor or sensory	8912
Petit mal	8911
Psychomotor	8914
Epiphora	6025
Erythema multiforme	7827
Erythroderma	7817
Erythromelalgia	7119
Esophagus:	
Barrett's	7207
Diverticulum	7205
Motility disorder	7204
Spasm	7204
Stricture	7203
Fallopian tube	7614
Female sexual arousal disorder (FSAD)	7632
Fever:	
Relapsing	6308
Rheumatic	6309
Fibrosis of lung, diffuse interstitial	6825
Fibromyalgia	5025
Fistula in ano	7335
Fistula:	
Rectovaginal	7624
Urethrovaginal	7625
Flatfoot, acquired	5276
Gastritis, chronic	7307
Gastroesophageal reflux disease	7206
Genu recurvatum	5263
Glaucoma:	
Congestive or inflammatory	6012
Simple, primary, noncongestive	6013
Glomerulonephritis	7536
Gout	5017
Graves' disease	7900
Hallux:	
Rigidus	5281
Valgus	5280
Hammer toe	5282
Heart valve replacement	7016
Hematologic:	
Essential thrombocythemia and primary myelofibrosis	7718
Immune thrombocytopenia	7705
Multiple myeloma	7712
Myelodysplastic syndromes	7725

	Diagnostic code No.
Solitary plasmacytoma	7724
Hematomyelia	8012
Hemorrhage:	
Brain	8009
Intra-ocular	6007
Hemorrhagic fevers, including dengue, yellow fever, and others	6329
Hemorrhoids	7336
Hepatitis C	7354
Hernia:	
Femoral, inguinal, umbilical, ventral, incisional, and other	7338
Hiatal and parasophageal	7346
Muscle	5326
Heterotopic ossification	5023
Hip:	
Flail joint	5254
Histoplasmosis	6834
HIV-Related Illness	6351
Hodgkin's disease	7709
Hodgkin's lymphoma	7709
Hydronephrosis	7509
Hyperaldosteronism	7917
Hyperhidrosis	7832
Hyperinfection syndrome or disseminated strongyloidiasis	6325
Hyperparathyroidism	7904
Hyperpituitarism	7916
Hypersensitivity	6831
Hypertensive:	
Heart disease	7007
Vascular disease	7101
Hyperthyroid heart disease	7008
Hyperthyroidism	7900
Hypoparathyroidism	7905
Hypothyroidism	7903
Impairment of:	
Humerus	5202
Clavicle or scapula	5203
Elbow	5209
Thigh	5253
Femur	5255
Knee, other	5257
Field vision	6080
Tibia and fibula	5262
Rectum & anus	7332
Ulna	5211
Implantable cardiac pacemakers	7018
Infections of the skin	7820
Injury:	
Bladder	7517
Breast	7631
Eye, unhealed	6009
Foot	5284
Gallbladder	7317
Lips	7201
Liver, residuals	7311
Mouth, soft tissue	7200
Muscle:	
Facial	5325
Group I Function: Upward rotation of scapula	5301
Group II Function: Depression of arm	5302
Group III Function: Elevation and abduction of arm	5303
Group IV Function: Stabilization of shoulder	5304
Group V Function: Elbow supination	5305
Group VI Function: Extension of elbow	5306
Group VII Function: Flexion of wrist and fingers	5307
Group VIII Function: Extension of wrist, fingers, thumb	5308
Group IX Function: Forearm muscles	5309
Group X Function: Movement of forefoot and toes	5310
Group XI Function: Propulsion of foot	5311
Group XII Function: Dorsiflexion	5312
Group XIII Function: Extension of hip and flexion of knee	5313
Group XIV Function: Extension of knee	5314
Group XV Function: Adduction of hip	5315
Group XVI Function: Flexion of hip	5316

	Diagnostic code No.
Group XVII Function: Extension of hip	5317
Group XVIII Function: Outward rotation of thigh	5318
Group XIX Function: Abdominal wall and lower thorax	5319
Group XX Function: Postural support of body	5320
Group XXI Function: Respiration	5321
Group XXII Function: Rotary and forward movements, head	5322
Group XXIII Function: Movements of head	5323
Pharynx	6521
Sacroiliac	5236
Spinal cord	6841
Stomach, residuals of	7310
Iritis	6003
Interstitial nephritis, including gouty nephropathy, disorders of calcium metabolism	7537
Intervertebral disc syndrome	5243
Intestine:	
Fistulous disease, external	7330
Large, resection of	7329
Small, resection of	7328
Irritable bowel syndrome (IBS)	7319
Keratinization, diseases of	7824
Keratitis	6001
Keratoconus	6035
Kidney:	
Abscess	7501
Cystic diseases	7533
Removal	7500
Transplant	7531
Tuberculosis	7505
Kyphoscoliosis, pectus excavatum / carinatum	6842
Lagophthalmos	6022
Laryngectomy	6518
Laryngitis:	
Tuberculous	6515
Chronic	6516
Larynx, stenosis of	6520
Leishmaniasis:	
American (New World)	7807
Old World	7808
Leprosy (Hansen's Disease)	6302
Leukemia:	
Chronic myelogenous leukemia (CML) (chronic myeloid leukemia or chronic granulocytic leukemia)	7719
Leukemia	7703
Limitation of extension:	
Forearm	5207
Leg	5261
Radius	5212
Supination and pronation	5213
Thigh	5251
Limitation of extension and flexion:	
Forearm	5208
Limitation of flexion:	
Forearm	5206
Leg	5260
Thigh	5252
Limitation of motion:	
Ankle	5271
Arm	5201
Index or long finger	5229
Ring or little finger	5230
Temporomandibular	9905
Thumb	5228
Wrist, limitation of motion	5215
Liver:	
Disease, chronic, without cirrhosis	7345
Transplant	7351
Cirrhosis	7312
Loss of:	
Auricle	6207
Condyloid process	9908
Coronoid process	9909
Eyebrows	6023
Eyelashes	6024
Eyelids	6032

	Diagnostic code No.
Palate, hard	9911
Mandible:	
Including ramus, unilaterally or bilaterally	9902
Maxilla:	
More than half	9914
Less than half	9915
Nose, part of, or scars	6504
Skull, part of	5296
Smell, sense of	6275
Taste, sense of	6276
Teeth, loss of	9913
Tongue, loss of whole or part	7202
Loss of use of:	
Both feet	5110
Both hands	5109
Foot	5167
Hand	5125
One hand and one foot	5111
Lumbosacral strain	5237
Lupus:	
Erythematosus	6350
Erythematosus, discoid	7809
Lyme disease	6319
Lymphatic filariasis, to include elephantiasis	6305
Malaria	6304
Malignant melanoma	7833
Malunion:	
Mandible	9904
Os calcis or astragalus	5273
Maxilla, malunion or nonunion	9916
Maxilla or mandible, chronic osteomyelitis, osteonecrosis, or osteoradionecrosis of	9900
Melioidosis	6318
Meniere's syndrome	6205
Meningitis, cerebrospinal, epidemic	8019
Mental disorders:	
Anorexia nervosa	9520
Bipolar disorder	9432
Bulimia nervosa	9521
Chronic adjustment disorder	9440
Conversion disorder (functional neurological symptom disorder).	9424
Cyclothymic disorder	9431
Delirium	9300
Delusional disorder	9208
Depersonalization/derealization disorder	9417
Dissociative amnesia; dissociative identity disorder	9416
Generalized anxiety disorder	9400
Illness anxiety disorder	9425
Major depressive disorder	9434
Major or mild neurocognitive disorder due to Alzheimer's disease	9312
Major or mild neurocognitive disorder due to another medical condition or substance/medication-induced major or mild neurocognitive disorder	9326
Major or mild neurocognitive disorder due to HIV or other infections	9301
Major or mild neurocognitive disorder due to traumatic brain injury	9304
Major or mild vascular neurocognitive disorder	9305
Obsessive compulsive disorder	9404
Other specified and unspecified schizophrenia spectrum and other psychotic disorders	9210
Other specified anxiety disorder	9410
Other specified somatic symptom and related disorder	9422
Panic disorder and/or agoraphobia	9412
Persistent depressive disorder (dysthymia)	9433
Posttraumatic stress disorder	9411
Schizoaffective disorder	9211
Schizophrenia	9201
Somatic symptom disorder	9421
Specific phobia; social anxiety disorder (social phobia)	9403
Unspecified somatic symptom and related disorder	9423
Unspecified anxiety disorder	9413
Unspecified depressive disorder	9435
Unspecified neurocognitive disorder	9310
Metatarsalgia	5279
Migraine	8100
Morton's disease	5279
Mucormycosis	6839

	Diagnostic code No.
Multiple sclerosis	8018
Myasthenia gravis	8025
Myelitis	8010
Myocardial infarction	7006
Myositis	5021
Narcolepsy	8108
Neoplasms:	
Benign:	
Breast	7631
Digestive system	7344
Ear	6209
Endocrine	7915
Genitourinary	7529
Gynecological	7628
Hard and soft tissue	9917
Muscle	5328
Respiratory	6820
Skin	7819
Malignant:	
Breast	7630
Digestive system	7343
Ear	6208
Endocrine	7914
Genitourinary	7528
Gynecological	7627
Hard and soft tissue	9918
Muscle	5327
Respiratory	6819
Skin	7818
Nephritis, chronic	7502
Nephrolithiasis/Ureterolithiasis/Nephrocalcinosis	7508
Nephrosclerosis, arteriolar	7507
Neuralgia:	
Cranial Nerves	
Fifth (trigeminal)	8405
Seventh (facial)	8407
Ninth (glossopharyngeal)	8409
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 (radial)	8714
Median	8715
Ulnar	8716
Musculocutaneous	8717
Circumflex	8718
Long thoracic	8719
Sciatic	8720
External popliteal (common peroneal)	8721
Musculocutaneous (superficial peroneal)	8722
Anterior tibial (deep peroneal)	8723
Internal popliteal (tibial)	8724
Posterior tibial	8725
Anterior crural (femoral)	8726
Internal saphenous	8727
Obturator	8728
External cutaneous nerve of thigh	8729
Ilio-inguinal	8730
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
Optic	6026
Peripheral Nerves	
Upper radicular group	8610

	Diagnostic code No.
Middle radicular group	8611
Lower radicular group	8612
All radicular groups	8613
Musculospiral (radial)	8614
Median	8615
Ulnar	8616
Musculocutaneous	8617
Circumflex	8618
Long thoracic	8619
Sciatic	8620
External popliteal (common peroneal)	8621
Musculocutaneous (superficial peroneal)	8622
Anterior tibial (deep peroneal)	8623
Internal popliteal (tibial)	8624
Posterior tibial	8625
Anterior crural (femoral)	8626
Internal saphenous	8627
Obturator	8628
External cutaneous nerve of thigh	8629
Ilio-inguinal	8630
Neurogenic bladder	7542
New growths:	
Benign	
Bones	5015
Brain	8003
Eye, orbit, and adnexa	6015
Spinal cord	8022
Malignant	
Bones	5012
Brain	8002
Eye, orbit, and adnexa	6014
Spinal cord	8021
Nocardiosis	6823
Non-Hodgkin's lymphoma	7715
Nontuberculosis mycobacterium infection	6312
Nontyphoid salmonella infection	6333
Nonunion:	
Mandible, confirmed by diagnostic imaging studies	9903
Radius and ulna	5210
Nystagmus, central	6016
Osteitis deformans	5016
Osteomalacia, residuals of	5014
Osteomyelitis	5000
Osteoporosis, residuals of	5013
Otitis media:	
Externa	6210
Nonsuppurative	6201
Suppurative	6200
Otosclerosis	6202
Ovaries, atrophy of both	7620
Ovary:	
Disease or injury	7615
Removal	7619
Palsy, bulbar	8005
Pancreas:	
Chronic pancreatitis	7347
Post pancreatectomy syndrome	7357
Surgery, complications of	7303
Transplant	7352
Papillary necrosis	7538
Papulosquamous disorders	7822
Paralysis:	
Accommodation	6030
Agitans	8004
Complete, traumatic	5244
Paralysis, nerve:	
Cranial nerves	
Fifth (trigeminal)	8205
Seventh (facial)	8207
Ninth (glossopharyngeal)	8209
Tenth (pneumogastric, vagus)	8210
Eleventh (spinal accessory, external branch)	8211
Twelfth (hypoglossal)	8212

	Diagnostic code No.
Peripheral Nerves:	
Upper radicular group	8510
Middle radicular group	8511
Lower radicular group	8512
All radicular groups	8513
Musculospiral (radial)	8514
Median	8515
Ulnar	8516
Musculocutaneous	8517
Circumflex	8518
Long thoracic	8519
Sciatic	8520
External popliteal (common peroneal)	8521
Musculocutaneous (superficial peroneal)	8522
Anterior tibial nerve (deep peroneal)	8523
Internal popliteal (tibial)	8524
Posterior tibial nerve	8525
Anterior crural nerve (femoral)	8526
Internal saphenous	8527
Obturator	8528
External cutaneous nerve of thigh	8529
Ilio-inguinal	8530
Paramyoclonus multiplex	8104
Parasitic disease	6320
Pellagra	6315
Penis	
Erectile dysfunction	7522
Removal of glans	7521
Removal of half or more	7520
Pericardial adhesions	7003
Pericarditis	7002
Peripheral arterial disease	7114
Peripheral vestibular disorders	6204
Peritoneum, adhesions	7301
Peritonitis	7331
Pes cavus (Claw foot) acquired	5278
Pheochromocytoma	7918
Plague	6307
Plantar fasciitis	5269
Pleural effusion or fibrosis	6845
Pluriglandular syndrome	7912
Pneumoconiosis	6832
Pneumonitis & fibrosis:	
Drug-induced	6829
Radiation-induced	6830
Poliomyelitis, anterior	8011
Polycythemia vera	7704
Polyglandular syndrome	7912
Post-chiasmal disorders	6046
Postgastrectomy syndromes	7308
Post-phlebitic syndrome	7121
Post-surgical residual	6844
Progressive muscular atrophy	8023
Prostate gland injuries, infections, hypertrophy, postoperative residuals, bladder outlet obstruction	7527
Prostatitis, urethritis, epididymitis, orchitis (unilateral or bilateral), chronic only	7525
Prosthetic implants:	
Ankle replacement	5056
Elbow replacement	5052
Hip, resurfacing or replacement	5054
Knee, resurfacing or replacement	5055
Shoulder replacement	5051
Wrist replacement	5053
Pruritus ani (anal itching)	7337
Psoriasis	7816
Pterygium	6034
Ptosis	6019
Pulmonary:	
Alveolar proteinosis	6827
Vascular disease	6817
Pyelonephritis, chronic	7504
Raynaud's disease (primary Raynaud's)	7124
Raynaud's syndrome (secondary Raynaud's phenomenon, secondary Raynaud's)	7117
Rectum:	

	Diagnostic code No.
Rectum & anus, stricture	7333
Prolapse	7334
Removal:	
Cartilage, semilunar	5259
Coccyx	5298
Gall bladder	7318
Kidney	7500
Penis glans	7521
Penis half or more	7520
Ribs	5297
Testis	7524
Ovary	7619
Uterus	7618
Uterus and both ovaries	7617
Renal:	
Amyloid disease	7539
Disease caused by viral infection such as HIV, Hepatitis B, and Hepatitis C	7544
Disease, chronic	7530
Involvement in diabetes mellitus type I or II	7541
Tubular disorders	7532
Resection of intestine:	
Large	7329
Small	7328
Retina detachment of	6008
Retinal dystrophy (including retinitis pigmentosa, wet or dry macular degeneration, early-onset macular degeneration, rod and/or cone dystrophy)	6042
Retinopathy, diabetic	6040
Retinopathy or maculopathy not otherwise specified	6006
Rhabdomyolysis, residuals of	5330
Rhinitis:	
Allergic or vasomotor	6522
Bacterial	6523
Granulomatous	6524
Rickettsial, ehrlichia, and anaplasma Infections	6317
Sarcoidosis	6846
Scarring alopecia	7830
Scars:	
Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck	7800
Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck that are associated with underlying soft tissue damage	7801
Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck that are not associated with underlying soft tissue damage	7802
Retina	6011
Scars, other; and other effects of scars evaluated under diagnostic codes 7800, 7801, 7802, or 7804	7805
Unstable or painful	7804
Schistosomiasis	6326
Shigella infections	6334
Sinusitis:	
Ethmoid	6511
Frontal	6512
Maxillary	6513
Pansinusitis	6510
Sphenoid	6514
Sleep Apnea Syndrome	6847
Soft tissue sarcoma:	
Muscle, fat, or fibrous connected	5329
Neurogenic origin	8540
Vascular origin	7123
Spine:	
Degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome	5242
Spinal fusion	5241
Spinal stenosis	5238
Spleen, injury of, healed	7707
Splenectomy	7706
Spondylolisthesis or segmental instability, spine	5239
Stomach:	
Postgastrectomy syndrome	7308
Stenosis of	7309
Surgery, complications of	7303
Supraventricular tachycardia	7010
Symblepharon	6091
Syndromes:	

	Diagnostic code No.
Chronic Fatigue Syndrome (CFS)	6354
Cushing's	7907
Gastrointestinal dysmotility	7356
Meniere's	6205
Postgastrectomy	7308
Post pancreatectomy	7357
Raynaud's	7117
Sleep Apnea	6847
Syphilis	6310
Syphilis:	
Cerebrospinal	8013
Meningovascular	8014
Syphilitic heart disease	7004
Syringomyelia	8024
Tabes dorsalis	8015
Tarsal or metatarsal bones	5283
Tenosynovitis, tendinitis, tendinosis or tendinopathy	5024
Testis:	
Atrophy, complete	7523
Removal	7524
Thrombocytopenia	7705
Thrombosis, brain	8008
Thyroid gland:.	
Nontoxic thyroid enlargement	7902
Toxic thyroid enlargement	7901
Thyroiditis	7906
Tic, convulsive	8103
Tinnitus, recurrent	6260
Toxic nephropathy	7535
Traumatic brain injury residuals	8045
Traumatic chest wall defect	6843
Tuberculosis:	
Adenitis	7710
Bones and joints	5001
Eye	6010
Kidney	7505
Luposa (lupus vulgaris)	7811
Miliary	6311
Pleurisy, active or inactive	6732
Pulmonary:	
Active, far advanced	6701
Active, moderately advanced	6702
Active, minimal	6703
Active, advancement unspecified	6704
Active, chronic	6730
Inactive, chronic	6731
Inactive, far advanced	6721
Inactive, moderately advanced	6722
Inactive, minimal	6723
Inactive, advancement unspecified	6724
Tuberculosis luposa (lupus vulgaris)	7811
Tympanic membrane	6211
Ulcer, peptic	7304
Ureter, stricture of	7511
Urethra.	
Fistula	7519
Stricture	7518
Urticaria, chronic.	7825
Uterus:	
And both ovaries, removal	7617
Disease or injury	7613
Prolapse	7621
Removal	7618
Uveitis	6000
Vagina, disease or injury	7611
Vagotomy	7348
Valvular heart disease	7000
Varicocele/Hydrocele	7543
Varicose veins	7120
Vasculitis, primary cutaneous	7826
Ventricular arrhythmia	7011
Vertebral fracture or dislocation	5235
Vibriosis (Cholera, Non-cholera)	6300

	Diagnostic code No.
Visceral Leishmaniasis	6301
Visceroptosis	7342
Vision: *see also* Blindness and Loss of	
One eye 5/200 (1.5/60), with visual acuity of other eye:	
5/200 (1.5/60)	6071
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6072
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6073
20/40 (6/12)	6074
One eye 10/200 (3/60), with visual acuity of other eye:	
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6075
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6076
20/40 (6/12)	6077
One eye 15/200 (4.5/60), with visual acuity of other eye:	
15/200 (4.5/60) or 20/200 (6/60)	6075
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6076
20/40 (6/12)	6077
One eye 20/200 (6/60), with visual acuity of other eye:	
20/200 (6/60)	6075
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6076
20/40 (6/12)	6077
One eye 20/100 (6/30), with visual acuity of other eye: and other eye:	
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6078
20/40 (6/12)	6079
One eye 20/70 (6/21), with visual acuity of other eye:	
20/70 (6/21) or 20/50 (6/15)	6078
20/40 (6/12)	6079
One eye 20/50 (6/15), with visual acuity of other eye:	
20/50 (6/15)	6078
20/40 (6/12)	6079
Each eye 20/40 (6/12)	6079
Vitiligo	7823
Vulva or clitoris, disease or injury of	7610
Weak foot	5277
West Nile virus infection	6335

[72 FR 13003, Mar. 20, 2007, as amended at 73 FR 54708, 54712, Sept. 23, 2008; 73 FR 69554, Nov. 19, 2008; 74 FR 18467, Apr. 23, 2009; 77 FR 6467, Feb. 8, 2012; 79 FR 45103, Aug. 4, 2014; 82 FR 36085, Aug. 3, 2017; 82 FR 50807, Nov. 2, 2017; 83 FR 15073, Apr. 9, 2018; 83 FR 15323, Apr. 10, 2018; 83 FR 32601, July 13, 2018; 83 FR 54259, Oct. 29, 2018; 84 FR 28234, June 18, 2019; 85 FR 76467, Nov. 30, 2020; 85 FR 85523, Dec. 29, 2020; 86 FR 8143, Feb. 4, 2021; 86 FR 54088, 54097, Sept. 30, 2021; 89 FR 19752, Mar. 20, 2024]

PART 5—ADMINISTRATIVE PROCEDURES:GUIDANCE DOCUMENTS

Sec.

AUTHORITY: 38 U.S.C. 501; E.O. 12866, 58 FR 51735, 3 CFR, 1993 Comp., p. 638.

SOURCE: 85 FR 72570, Nov. 13, 2020, unless otherwise noted.

§ 5.0 Purpose.

This part provides the Department of Veterans Affairs' (VA's) processes and procedures for issuing and managing guidance documents.

[86 FR 30184, June 7, 2021]

§ 5.10 Definitions relating to guidance documents.

The following definitions apply to §§ 5.0 through 5.25.

Guidance document means an agency statement of general applicability (*i.e.*, it applies to more than just one person, event, or transaction), that is intended to have a future effect on the behavior or actions of regulated parties (to include non-VA actors), and that sets forth a policy on a statutory, regulatory, or technical issue, or an interpretation of a statute or regulation. A guidance document does not include the following: