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38 CFR Part 4

RIN 2900–AE41

Schedule for Rating Disabilities; Endocrine System Disabilities

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

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

DATES: This amendment is effective June 6, 1996.

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SUPPLEMENTARY INFORMATION: As part of the first comprehensive review of the rating schedule since 1945, VA published a proposal to amend 38 CFR 4.119, which addresses the endocrine system, in the Federal Register of January 22, 1993 (58 FR 5691–95). Interested persons were invited to submit written comments on or before March 23, 1993. We received comments from The American Legion, Disabled American Veterans, Veterans of Foreign Wars, Paralyzed Veterans of America, and VA employees.

There were a number of general comments. Two commenters requested that we establish more objective criteria, especially for thyroid disease, parathyroid disease, and diabetes mellitus. One of them noted that a substantial number of subjective descriptors remained. The other recommended that we remove ambiguous and undefined terms. One commenter said that the schedule should eliminate, as much as possible, the potential for inconsistency and error. Another suggested that removing comparative descriptions such as ''severe,'' ''moderate'', etc., would not disturb the remaining criteria and would result in more uniform rating decisions.

Although the commenters offered no specific alternatives for consideration, VA agrees that objective rating criteria help assure consistency of evaluations. With that in mind, we have revised the proposed criteria. In some cases we have simply removed subjective terms such as ''marked'', ''increasingly severe'', and ''pronounced'' when they did not substantively explain or clarify the evaluation criteria. In other cases, we have supplied objective definitions of terms. In still others, establishing more objective, consistent, and unambiguous criteria required more detailed modification of the proposed criteria, which will be discussed under the affected diagnostic codes.

One commenter, while agreeing with the removal of ambiguous words such as ''severe,'' urged that the rules not be made too concrete and thus sterile.

We believe that providing clear and objective criteria is the best way to assure that disabilities will be evaluated fairly and consistently. Judgment and flexibility are required in the evaluation process, since patients do not commonly present as textbook models of disease, and those evaluating disabilities always have the task of assessing which evaluation level best represents the overall picture. (See 38 CFR 4.7.)

One commenter stated that it would be helpful to have additional notes, such as the note under DC 7913 on the evaluation of the complications of diabetes mellitus, discussing pertinent clinical and nonclinical factors to be considered in assigning evaluations.

In general, we have retained or expanded upon such notes. Where it seemed more appropriate, we have incorporated the content of notes into the evaluation criteria. We have not added notes containing background material, such as general medical information that is available in standard textbooks, or other material that neither prescribes VA policy nor establishes procedures a rating board must follow, because such material is not appropriate in a regulation.

We have revised hyperthyroidism, DC 7900, in response to the comment suggesting more objectivity. The proposed criteria required ''severe tachycardia'' at the 100 percent level and ''tachycardia'' at all other levels. According to ''The Merck Manual'' (463, 16th ed. 1992), tachycardia is a heart rate greater than 100 beats per minute, but the medical literature does not define ''severe'' tachycardia. Using the word ''severe'' therefore imposed upon the rater the burden of subjectively determining its meaning, and we have removed ''severe'' at the 100 percent level. We have also made the criteria more objective by indicating that tachycardia means more than 100 beats per minute.

We proposed that the criteria for hyperthyroidism include ''marked sympathetic nervous system, cardiovascular, or gastrointestinal symptoms'' at the 100 percent level and ''marked emotional instability'' at the 60 percent level. In both cases, we have removed the indefinite word ''marked'' because it does not substantively explain or clarify the evaluation criteria, and the criteria are clear without it.

One commenter suggested that we specify the symptoms of the sympathetic nervous system proposed as criteria at the 100 percent level of evaluation under DC 7900.

VA does not concur. The sympathetic nervous system innervates thoracic, abdominal, and pelvic viscera as well as blood vessel walls. Therefore, exaggerated sympathetic nervous system activity can have widespread manifestations including, but not limited to, elevated blood pressure, increased cardiac output, increased metabolic rate, sweating, nervousness, weight loss, tachycardia, palpitations, increased frequency of bowel movements, and heat intolerance. Certain conditions, hyperthyroidism among them, are known as sympathomimetic conditions because they mimic the effects of increased activity of the sympathetic nervous system, although the sympathetic nervous system itself is normal. Since the particular signs and symptoms that might be exhibited vary widely from individual to individual, limiting the criteria at the 100 percent level to a few selected symptoms of the sympathetic nervous system would be inappropriate.

We proposed that increased pulse pressure be one of the criteria for the 60 percent and 30 percent levels of hyperthyroidism. One commenter questioned the use of pulse pressure as a criterion, stating that it is not a diagnostic marker and is not routinely recorded on an examination report.

Pulse pressure is the difference between the systolic and diastolic blood pressures, and it is readily available for anyone who has had a blood pressure recorded. Hyperthyroidism is one of a number of diseases that may produce an increased (or widened) pulse pressure, which results from an elevated systolic blood pressure and a lowered diastolic blood pressure. Because increased pulse pressure is a common sign of hyperthyroidism, it is an appropriate criterion to use in evaluating hyperthyroidism.

One commenter suggested that tremor (one of several proposed criteria for hyperthyroidism at the 10 and 30

percent levels of evaluation) be evaluated as a secondary condition with a minimum evaluation of 20 percent, even for involvement of only one hand, because it is an employment handicap.

VA does not concur. There are several types of tremors, and it appears that the commenter may have based his suggestion on the observation of an individual with a tremor other than the type characteristic of hyperthyroidism. The tremor of hyperthyroidism is a fine tremor most noticeable in the outstretched hands. It is characterized as a physiologic tremor, i.e., one that is an exaggeration of the normal physiologic tremor that virtually everyone experiences at times (''Harrison's Principles of Internal Medicine'' 167 (Jean D. Wilson, M.D. et al. eds., 12th ed. 1991)), and is not severely disabling. Including tremor as one of the requirements at the 10 and 30 percent levels of evaluation for hyperthyroidism takes into account the type and severity of the characteristic hyperthyroid-induced tremor. In our judgment, the presence of such a tremor would not, in and of itself, warrant the 20 percent evaluation the commenter suggests.

One commenter suggested that emotional disorders and gastrointestinal and cardiovascular symptoms due to thyroid conditions (hyperthyroidism, DC 7900; toxic adenoma of thyroid gland, DC 7901; hypothyroidism, DC 7903) be evaluated separately rather than being part of the evaluation criteria for thyroid conditions.

Severe thyroid disease may produce distinct secondary conditions, including certain mental disorders, and such conditions can always be service-connected and separately evaluated (see 38 CFR 3.310(a)). Some secondary conditions, e.g., dementia under hypothyroidism (DC 7903), are specifically included in the evaluation criteria for the 60- or 100-percent levels of thyroid disease. This does not exclude the possibility of service-connecting and separately evaluating the secondary condition, but provides an alternative means of evaluation by allowing the secondary condition to be used to support the 60- or 100-percent evaluation level of thyroid disease. However, the same condition cannot be separately evaluated and concurrently used to evaluate the primary condition (DC's 7900, 7901, or 7903). (See 4.14 of this part.) This is comparable to the evaluation of diabetes mellitus (DC 7913), where compensable complications of diabetes may be either separately evaluated or used to support a 100-percent evaluation.

The request for separate evaluation of symptoms is a different issue. Because of the widespread effects of thyroid hormone, the symptoms of thyroid disease are diverse, reflecting effects on multiple body systems. However, the presence of such symptoms (e.g., gastrointestinal symptoms under hyperthyroidism (DC 7900)) can be an inherent part of thyroid disease and does not ordinarily indicate that a separate and distinct secondary condition is present. Unless they are clearly part of a distinct condition secondary to thyroid disease, the symptoms must be used in the overall evaluation criteria for the thyroid condition. The evaluation of secondary conditions is discussed in the preceding paragraph.

In the previous schedule, nontoxic adenoma of the thyroid (DC 7902) was evaluated on the basis of pressure symptoms or marked disfigurement. We proposed that it be evaluated at the 20 percent level if there is ''marked disfigurement of the head or neck.'' One commenter suggested that nontoxic adenoma of the thyroid be rated analogous to DC 7800 (scars, disfiguring, head, face, or neck).

We do not concur. Disfigurement from a nontoxic adenoma of the thyroid is not a skin phenomenon but an enlargement of the thyroid that produces an unsightly neck mass through sheer bulk. Factors that are used to evaluate skin conditions, such as discoloration and color contrast, are not appropriate for evaluating that type of disfigurement. In response to the general request for more objective criteria previously mentioned, we have removed the word ''marked'', leaving ''with disfigurement of the head or neck'' as the sole criterion for a 20 percent evaluation. In our judgment, any adenoma that is substantial enough to be disfiguring warrants a 20 percent evaluation. This does not represent a substantive change from the proposed criteria.

The proposed note under DC 7902 stated to rate as impairment of affected organ if a higher evaluation is warranted. For the sake of clarity, we have revised the note to state that if there are symptoms due to pressure on adjacent organs such as the trachea, larynx, or esophagus, nontoxic adenoma of the thyroid will be evaluated under the diagnostic code for disability of that organ, if doing so would result in a higher evaluation. This does not represent a substantive change from the proposed note.

We proposed to delete the zero percent level of evaluation for nontoxic adenoma (DC 7902) that was present in the previous schedule. However, to clarify that not all nontoxic adenomas are considered disfiguring, we have restored the zero percent level for those ''without disfigurement of the head or neck.'' This does not represent a substantive change.

For the sake of clarity, we have also removed the indefinite word ''severe'' before ''cold intolerance'' in the proposed criteria for a 100 percent evaluation for hypothyroidism (DC 7903) and revised the indefinite criterion ''slow pulse'' to the more precise medical term ''bradycardia'', which is defined as less than 60 beats per minute. We have also revised the requirement of ''mental symptoms'' to ''mental disturbance,'' since some of the possible manifestations are symptoms but others are distinct mental disorders. These are not substantive changes.

One commenter, stating that obesity is such a pervasive problem in American society that weight gain is not a true measure or mark of a specific disorder, felt that weight gain should not be included in the criteria for the 60 percent evaluation for hypothyroidism (DC 7903).

VA does not concur. There are special characteristics of the weight gain associated with hypothyroidism that distinguish it from the weight gain seen in simple obesity. The weight gain in hypothyroidism is largely due to fluid retention, which appears as ascites, pleural effusion, edema of the extremities, or even edema of the nervous system (''Williams Textbook of Endocrinology'' 447–48 (Jean D. Wilson, M.D. and Daniel W. Foster, M.D. eds., 8th ed. 1992)). This type of weight gain is unlikely to be confused with obesity. For this reason, we believe that weight gain is appropriate as part of the overall criteria for the evaluation of hypothyroidism, and we have retained it among the criteria for the 60 percent level.

The previous schedule included ''sluggish mentality and other indications of myxedema'' in the criteria for the 30 percent evaluation level of hypothyroidism (DC 7903). We proposed to retain mental sluggishness as one of the criteria, but to delete the term myxedema. A commenter objected to the removal of myxedema, saying there is no basis for our contention that myxedema is seldom encountered.

The term myxedema is sometimes used loosely to refer to hypothyroidism in general, but in its stricter meaning, it is full-blown hypothyroidism with fluid retention. Hypothyroidism may present at any level of severity, including a subclinical form, and myxedema in the strict sense is found only in severe disease, when hypothyroidism is

untreated or has reached an advanced stage. We therefore replaced ''sluggish mentality with other indications of myxedema'' at the 30 percent level with less ambiguous criteria: fatigability, constipation, and mental sluggishness.

The previous schedule assigned hyperthyroidism (DC 7900) and hypothyroidism (DC 7903) minimum ten percent evaluations when continuous medication is required for control. We proposed to delete the minimum evaluations, and three commenters objected.

Upon further review, VA agrees that a ten percent evaluation is appropriate when continuous medication is required for control of these conditions because such treatment implies both the need for repeated medical evaluations and the possibility of side effects that may themselves require treatment. We have therefore restored the ten percent evaluation level under diagnostic codes 7900 and 7903 for those who require continuous medication. For the sake of consistency, we have also added a ten percent evaluation level under hyperparathyroidism (DC 7904) for those who require continuous medication. We have recast the note under hypoparathyroidism (DC 7905) establishing a minimum evaluation of ten percent when continuous medication is required as ten percent evaluation criteria. The change under DC 7905 is editorial in nature and does not represent any substantive change to the criteria as proposed.

''Decreased levels of circulating thyroid hormones (T4 and/or T3 by specific assays)'' was one of the criteria for a 100 percent evaluation for hypothyroidism (DC 7903) in the previous schedule. We proposed a change to ''undetectable levels of circulating thyroid hormones'' as one of the criteria for the 100 percent level. Two commenters felt that the proposed change made the criteria too stringent.

VA concurs. Therapy is instituted as soon as medical personnel learn that there are no detectable levels of hormone; the therapy produces a rapid reversion of hormone levels toward normal but leaves the clinical signs of disease to resolve more slowly. Although many endocrine conditions require laboratory confirmation of hormone levels for diagnosis, the hormone levels may not correlate with the severity of the clinical findings, and laboratory findings are therefore more useful for diagnosis than evaluation. For these reasons, we have removed: (1) ''undetectable levels of circulating thyroid hormones'' from the criteria for the 100 percent level of hypothyroidism (DC 7903), (2) ''decreased levels of circulating thyroid hormone'' from the 60 percent and 30 percent levels of hypothyroidism, (3) ''elevated levels of circulating thyroid hormones'' as a requirement for the 100 and 60 percent levels of hyperthyroidism (DC 7900), and (4) ''elevated blood and urine calcium levels'' as a requirement for the 100 and 60 percent levels of hyperparathyroidism (DC 7904).

One commenter suggested that we quantify weight loss by indicating a percentage below normal weight or similar objective measure rather than using the term ''marked weight loss'' for the 100 and 60 percent levels of hyperparathyroidism (DC 7904).

In addition to removing the references to laboratory findings, as discussed above, we have modified the criteria for hyperparathyroidism by removing ''marked weight loss'' from the criteria for the 100 and 60 percent levels. Since severe hyperparathyroidism may manifest itself through a variety of gastrointestinal symptoms, weight loss being only one (Williams, 1431), we have replaced the separate requirement for weight loss with the more flexible requirement for ''gastrointestinal symptoms (nausea, vomiting, anorexia, constipation, weight loss, or peptic ulcer)'' at the 100 and 60 percent levels. This change recognizes that gastrointestinal symptoms are part of an overall pattern of abnormalities, but that any individual symptom, such as a specified amount of weight loss, is not required for either level of severity. This offers more flexibility than the proposed requirement for marked weight loss.

We proposed that ocular disturbances be one of the criteria for both the 100 percent and 60 percent levels of evaluation for hypoparathyroidism (DC 7905). One commenter, while giving no reason, requested that ocular disturbances be removed as a criterion.

There are two distinct types of ocular disturbance that may occur in hypoparathyroidism—cataracts and papilledema (Williams, 1456–57; Harrison, 1915–16). Papilledema, if present, would be an indication of the increased intracranial pressure that sometimes occurs in hypoparathyroidism, but it is only one possible manifestation of increased intracranial pressure. Cataracts are unrelated to increased intracranial pressure. For the sake of making the criteria clearer and more objective, we have substituted ''cataract or evidence of increased intracranial pressure (such as papilledema)'' for ''ocular disturbances''.

One commenter mentioned hypoparathyroidism as another example of a condition where objective criteria should be employed in place of ambiguous terms.

Criteria we proposed for the 100 percent level of hypoparathyroidism, in addition to ocular disturbances, were: seizures or convulsions, muscular spasm (tetany), or marked neuromuscular excitability. Since muscular spasms and convulsions are themselves two specific manifestations of marked neuromuscular excitability, for more clarity and to eliminate redundancy, we have retained marked neuromuscular excitability as one of the criteria, giving its most common manifestations—convulsions, muscular spasms (tetany), and laryngeal stridor—in parentheses. By providing this list of conditions, we have made the meaning of ''marked'' definite enough that it substantively clarifies the degree of neuromuscular excitability needed to support a 100 percent evaluation.

For the 60 percent level of hypoparathyroidism, the proposed criteria were: marked neuromuscular excitability, ocular disturbances, and constipation or numbness and tingling of the extremities. We have revised the proposed criteria by providing three alternative sets of criteria: marked neuromuscular excitability, a combination of paresthesias (of arms, legs, or circumoral area) and cataract, or a combination of paresthesias and increased intracranial pressure. While this represents a substantive change, it responds to the general comment that we eliminate, as much as possible, the potential for inconsistency and error. The proposed criteria appeared to be more stringent at the 60 percent level than at the 100 percent level, and there also could have been confusion about which of the criteria listed were required and which were alternatives. The revision eliminates this confusion, affords more flexibility, and provides a clearer differentiation between the 100 and 60 percent levels.

We deleted the word ''marked'', modifying loss of muscle strength, at the 100 percent level of Cushing's syndrome (DC 7907). This is more objective because the rater does not now have to estimate whether a reported loss of muscle strength is ''marked.'' The change allows any reported loss of muscle strength to serve as one of the requirements at the 100 percent level.

We proposed to retain 100 and 60 percent levels of evaluation for Cushing's syndrome, as in the previous schedule. One commenter stated that the condition warrants additional levels of evaluation, especially when it is secondary to medication.

VA agrees. Although secondary Cushing's syndrome (due to steroid

therapy) has physical findings indistinguishable from primary Cushing's syndrome (Harrison, 1723), there is a wide range of severity depending on the dosage of steroids used, duration of therapy, etc. We have therefore added a 30 percent level of Cushing's syndrome for those with milder manifestations: striae, obesity, moon face, glucose intolerance, and vascular fragility.

The previous schedule required increased intracranial pressure, hypertension, genital decline and atrophy, hypotrichosis, hypoglycemia, obesity, and asthenia for a 100 percent evaluation of acromegaly (DC 7908). We proposed to revise the criteria by requiring increased intracranial pressure, arthropathy, glucose intolerance, hypertension, cardiomegaly, and visual impairment. One individual felt that represents a tightening of the requirements and recommended that cardiomegaly not be required at the 100 percent level.

Upon further consideration, VA has revised the proposed criteria for the 100 percent level. Cardiomegaly is present in 80 percent of acromegalics and may be part of the generalized organomegaly that is sometimes seen (Williams, 272). It is therefore seen commonly enough to be an appropriate criterion. Hypertension occurs in approximately 20–40 percent of acromegalics, and overactivity of the sympathetic nervous system has been suggested as a possible etiology. Hypertension and cardiomegaly are thus independent entities, with apparently different etiologies (although they may be associated when hypertension results in cardiomegaly). Because either may be a manifestation of acromegaly, instead of removing cardiomegaly, we have made cardiomegaly an alternative criterion to hypertension at the 100 percent level, rather than requiring both.

The previous schedule required intracranial pressure as one of the criteria for the 100 percent level of acromegaly, and symptoms of intracranial pressure in the optic region for the 60 percent level. We proposed to require both increased intracranial pressure and visual impairment for the 100 percent level. One commenter, noting that increased intracranial pressure specifically impairs peripheral vision, stated that ''visual impairment'' is too broad a term. He said we should distinguish visual field loss from central visual acuity loss and other visual deficits.

We agree. The term ''visual impairment'' can have many meanings, and not all types of visual impairment result from acromegaly. Those that do occur are the result of localized or generalized increased intracranial pressure because acromegaly is almost always due to a pituitary adenoma (Merck, 1064). There may, for example, be a visual field defect when the pituitary tumor presses on the optic chiasm. However, it is increased intracranial pressure from the tumor that is the underlying cause of any visual impairment that is present, and the increased pressure is at times manifested only by findings other than visual impairment. We have therefore revised the criteria by deleting the requirement for both increased intracranial pressure and visual impairment in favor of a more flexible, but also more specific, requirement for evidence of increased intracranial pressure ''such as visual field defect.'' This will allow other possible manifestations of increased intracranial pressure, such as papilledema, headaches, etc., to satisfy one of the requirements for a 100 percent level of evaluation and will exclude as criteria visual impairments that have no relationship to acromegaly.

In further response to the general request for more objective criteria, we have revised the proposed criteria for diabetes insipidus (DC 7909) by removing the subjective terms ''excessive thirst'' and ''severe polyuria'' wherever they occurred in favor of the more objective phrase ''polyuria with near-continuous thirst.'' We also revised the criteria for the 100 percent evaluation, which we proposed to be: ''excessive thirst and severe polyuria requiring parenteral hydration therapy, episodes of syncope, and low systolic and diastolic blood pressure'' to a requirement for ''polyuria with near-continuous thirst, and more than two documented episodes of dehydration requiring parenteral hydration in the past year.'' The excretion of large quantities of very dilute urine is the underlying abnormality in this condition, and this leads to dehydration and hypovolemia. Syncope and low blood pressure are not isolated separate signs but are common effects of dehydration, and these criteria therefore encompass both parenteral hydration therapy, used to treat dehydration, and two of the signs of dehydration (syncope and low blood pressure).

The proposed criteria for the 60 percent level included excessive thirst, polyuria, dehydration, serum osmolality greater than 295 mOsm/kg., and urine osmolality less than 38 mOsms/kg. We revised these to a requirement for one or two documented episodes of dehydration requiring parenteral hydration in the past year, in addition to the basic requirements of thirst and polyuria. Serum and urine osmolality levels are objective criteria, but osmolality levels were not proposed as criteria for the 20, 40, or 100 percent levels. The change in favor of specifying the number of episodes of dehydration provides criteria that are more parallel and comparable from one level to the next, and are objective enough that the additional laboratory tests are not needed to determine a 60 percent level of severity. Finally, we have changed the proposed requirement for the 40 percent level from ''polyuria, excessive thirst, and dehydration'' to ''polyuria with near-continuous thirst, and one or more episodes of dehydration in the past year not requiring parenteral hydration.''

We have also deleted the words ''increasingly,'' ''severe,'' ''pronounced,'' and ''marked'' wherever they occurred in the proposed evaluation criteria for Addison's disease (DC 7911). These words did not substantively explain or clarify the evaluation criteria, and the criteria are clear without them.

The proposed criteria for the 20 percent level of Addison's disease required either corticosteroid therapy or a combination of weakness and fatigability. In response to the commenter who said that the schedule should eliminate the potential for inconsistency, we have added alternative criteria for the 20 percent level that are parallel to the higher levels. These criteria require one or two crises or two to four episodes during the past year, which assures consistency of evaluation for those with fewer crises or episodes. For further clarity of the criteria, we added two notes under DC 7911 that define Addisonian ''crises'' and Addisonian ''episodes.''

In the previous schedule, under diabetes mellitus (DC 7913), regulation or careful regulation of activities (defined as avoidance of strenuous occupational and recreational activities) was one of the criteria at the 100 percent and 40 percent evaluation levels. We proposed ''regulation of activities,'' not further defined, as a criterion at the 100, 60, and 40 percent levels. One commenter felt that the proposed change in language made the meaning less clear.

We agree and have retained the definition used in the previous rating schedule, ''avoidance of strenuous occupational and recreational activities,'' and included it in the evaluation criteria for the 100 percent level.

The same commenter said that it is meaningless to include limitation of

activities as a factor in evaluating diabetes mellitus since information of this type is not provided in a VA examination.

VA disagrees. VA's Physician's Guide for Disability Evaluation Examinations is meant to insure that all necessary tests are performed and that all findings are provided for diagnosis and/or evaluation to meet the specific requirements of the Schedule for Rating Disabilities and related programs. It is available to VA and fee-basis examiners conducting examinations for VA disability benefits. The Guide will be revised to provide detailed guidelines for examinations reflecting the revised provisions of the rating schedule. It is incumbent upon the rating board to return to the examiner reports that lack information necessary to apply the provisions of the rating schedule (see § 4.2 of 38 CFR).

The proposed 100 percent level for diabetes mellitus required ''repeated'' episodes of ketoacidosis or hypoglycemic reactions requiring, among other things, ''frequent'' hospital or physician treatment. We received one comment requesting that we clearly define ''frequent treatment.''

We concur and have revised that portion of the criteria to require ''episodes of ketoacidosis or hypoglycemic reactions requiring at least three hospitalizations per year or weekly visits to a diabetic care provider.'' Similarly, for the 60 percent level we have changed the requirement from ''occasional'' episodes of ketoacidosis or hypoglycemic reactions to ''episodes of ketoacidosis or hypoglycemic reactions requiring one or two hospitalizations per year or twice a month visits to a diabetic care provider.'' The change from a requirement for physician treatment to a requirement for visits to a diabetic care provider reflects the fact that diabetics are usually under the care of a multidisciplinary diabetic team, and at any given visit may see a nurse practitioner, physician's assistant, etc.

The previous schedule required ''severe complications'' as one of the alternative criteria for the 100 percent level of diabetes mellitus (DC 7913). The proposed revision instead required ''severe complications such as retinopathy, nephropathy, arteriosclerosis, or neuropathy'' as one of the alternatives. For the 60 percent level the previous schedule required ''mild complications, such as pruritus ani, mild vascular deficiencies, or beginning diabetic ocular disturbances.'' The proposed revision required ''mild complications such as mild vascular deficiencies or beginning diabetic ocular disturbances.''

A commenter stated that the word ''severe,'' referring to complications at the 100 percent level of diabetes mellitus, is a subjective description that should be changed.

VA agrees. We have revised the language at both the 60 and 100 percent levels to make it more objective, consistent from level to level, and more precise. We have revised the 100 percent criteria to require complications that would be compensable if separately evaluated and the 60 percent criteria to require complications that would not be compensable if separately evaluated. This is also consistent with note (1), following DC 7913, that directs that compensable complications of diabetes mellitus are to be rated separately unless they support a 100 percent evaluation and that noncompensable complications are considered part of the diabetic process under DC 7913.

One commenter questioned whether a 10 percent evaluation included those with Type II (adult onset) diabetes without symptoms and not following a restricted diet.

The criterion we proposed for the 10 percent level, ''controlled by restricted diet only,'' refers to anyone with diabetes mellitus mild enough not to require insulin or oral hypoglycemics. For the sake of greater clarity, we have revised the requirement for zero percent to ''manageable by restricted diet only.'' This does not represent a substantive change.

A proposed note under diabetes mellitus (DC 7913) stated that when diabetes mellitus has been definitely diagnosed, a glucose tolerance test need not be ordered solely for rating purposes. A commenter said that the term ''definitely diagnosed'' is an entirely subjective descriptor.

To assure that there is no misunderstanding about the meaning, we have changed the term ''definitely diagnosed'' to ''conclusively diagnosed.'' The intent of the term ''conclusively diagnosed'' is to indicate those individuals who have a diagnosis of diabetes mellitus that has been established through the usual medical means, both clinical and laboratory, and to exclude those with insufficient evidence to support a clear diagnosis.

One commenter stated that the revision should address the basic concept of lost earnings due to time lost from work. He suggested no alternatives.

In our judgment, the evaluation criteria we have provided are clearly linked to lost earnings because they include such things as periods of hospitalization, episodes of incapacitating symptoms, muscular weakness, arthropathy, fatigability, etc., all of which may affect the ability to work. Furthermore, we have provided criteria for the 100 percent levels that indicate a degree of severity that would render the average person completely unable to work. Thus the proposed criteria do address the effects of time lost from work.

An additional general comment was that recently discharged veterans would be discriminated against by being evaluated under the revised rating schedule, which he said is ''deliberalized''.

VA disagrees. 38 U. S. C. gives the Secretary the authority to readjust the schedule of ratings from time to time in accordance with experience. The significant medical advances that have occurred since 1945 form part of the experience that must be taken into account in revising the rating schedule. In order to assure fair and consistent evaluations for veterans, the schedule must reflect actual residuals of disease or injuries, not what residuals might have been in the past. Furthermore, Congress foresaw that evaluations might change when the rating schedule is revised and amended 38 U.S.C. 1155 to prohibit a reduction in a veteran's disability rating because of a readjustment of the rating schedule unless an improvement in the disability has been shown.

The previous schedule had a 100 percent evaluation for one year following the cessation of treatment of malignancies. We proposed that the 100 percent evaluation continue indefinitely but that there be a mandatory VA examination six months following the cessation of treatment, with any change in evaluation based on that or any subsequent examination, to be implemented under the provisions of 38 CFR 3.105(e). Three commenters recommended that VA retain the evaluation criteria from the previous schedule.

We do not concur. An examination six months following the cessation of treatment affords sufficient time for convalescence and stabilization of residuals because the rule requires an examination, not a reduction, six months after the cessation of treatment. In fact, the rule precludes a reduction at that time because the process of re-evaluation does not begin until then.

First, there must be a VA examination six months after completion of treatment. If the results of that or any subsequent examination warrant a reduction in evaluation, the reduction will be implemented under the provisions of 38 CFR 3.105(e), which

require a 60 day notice before VA reduces an evaluation and an additional 60 day notice before the reduced evaluation takes effect. The revision not only requires a current examination to assure that all residuals are documented, but also offers the veteran more contemporaneous notice of any proposed action and expands the veteran's opportunity to present evidence showing that the proposed action should not be taken. In our judgment, this method will better ensure that actual side-effects and recuperation times are taken into account because they will be noted on the required VA exam.

Because of commenters' concerns, however, we have revised the note under this code so that it cannot be misinterpreted as requiring a reduction six months after treatment is terminated. We have also added to the note a direction to rate on residuals, if there has been no local recurrence or metastasis, in order to make these provisions consistent with those we provided for malignancies of the revised genitourinary system. This is not a substantive change, but has been made to provide further clarity, as well as internal consistency within the rating schedule.

One commenter said that VA exceeded its mandate by proposing the change in convalescence.

VA does not concur. VA's mandate arises from 38 U.S.C. 1155, which authorizes the Secretary to readjust the rating schedule from time to time in accordance with experience.

Another commenter objected to the change in convalescence, saying that the average person would require at least 12 months of convalescence for brain surgery.

VA does not agree. The convalescent periods adopted in this change represent, in our judgment, based on sound medical advice, neither the longest nor shortest periods that any individual patient might require for recovery, but the usual or normal periods during which a normal patient, under normal circumstances, would be expected to recover from a specific condition or surgical procedure. Furthermore, these convalescent periods represent the point at which the individual patient's condition is to be evaluated by examination, and do not preclude an extension of a total evaluation, if appropriate, based on the individual patient's condition.

Another commenter said that the proposed changes in convalescent periods appear to be purely economically based.

The myriad of advances in medicine that have occurred since 1945, such as early ambulation, better surgical techniques, new anesthetics, and better control of infectious diseases, have led to strikingly shorter periods of convalescence after both medical and surgical treatment. The revisions were proposed based on medical considerations; no cost studies or projections were conducted in conjunction with this review. Cost cutting was therefore not an issue.

One commenter stated that applying § 3.105(e) will cause significant problems from an administrative standpoint and will often significantly lengthen the periods for which a convalescent rate is paid.

VA believes that the changes in convalescence following treatment of malignancy where § 3.105(e) must be applied can be implemented without serious administrative problems. Similar changes are being made in each body system, and any procedural changes that may be necessary to implement the new process will be made as needed. We have included the implementation of the provisions of § 3.105(e) to assure that veterans are afforded due process before convalescent ratings are reduced, and if administrative delays do occur from time to time, they cannot operate to the disadvantage of veterans. Also, since § 3.105(e) applies only to reductions in ''compensation payments currently being made,'' it need not be applied in cases where a total evaluation will be assigned and reduced retroactively.

One commenter urged that VA provide zero percent evaluations for all diagnostic codes.

We do not agree. On October 6, 1993 VA revised its regulation addressing the issue of zero percent evaluations (38 CFR 4.31) to authorize assignment of a zero percent evaluation for any disability in the rating schedule when minimum requirements for a compensable evaluation are not met. In general, that regulatory provision precludes the need for zero percent evaluation criteria. We have retained zero percent evaluation criteria only when necessary to give the rater clear and unambiguous instructions on rating where it might otherwise be unclear whether commonly occurring minor findings warrant a compensable evaluation.

One commenter noted that veterans are receiving diagnoses of hyperlipidemia, elevated triglycerides, and elevated cholesterol, and the commenter asked that we address the handling of claims for these findings.

The diagnoses listed by the commenter are actually laboratory test results, and are not, in and of themselves, disabilities. They are, therefore, not appropriate entities for the rating schedule to address. In addition, they have no special relationship to the endocrine system.

We have made several additional changes based on our own review of the proposed regulation. For example, we edited the proposed note under malignant neoplasm (DC 7914) by modifying the sentence ''Any change in evaluation based upon that examination shall be subject to the provisions of § 3.105(e) of this chapter'' to ''Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.'' The change assures that the veteran will be given the notices described above regardless of when an examination leading to a proposed change in evaluation is done and is consistent with changes we have made in the revision of other portions of the rating schedule. This represents no substantive change.

The previous schedule had a note under DC 7900, hyperthyroidism, addressing the issue of evaluating hyperthyroid heart disease if disease of the heart predominates. We have expanded the note for clarity by adding ''if doing so would result in a higher evaluation than using the criteria above.''

We also made a nonsubstantive editorial change in the note following pheochromocytoma (DC 7918) from the proposal to rate hyperpituitarism, hyperaldosteronism and pheochromocytoma as malignant or benign neoplasm under DC 7914 or 7915, whichever is applicable, to a direction to evaluate those conditions under benign or malignant neoplasms as appropriate.

For the sake of greater clarity and ease of comparison, we rearranged the order of the criteria for diabetes mellitus (DC 7913) regarding need for insulin or an oral hypoglycemic agent, diet, and regulation of activities, putting them in the same order at all levels where they appear. This does not represent a substantive change.

We proposed that constipation be one of the criteria for the 60 percent level of hypoparathyroidism (DC 7905). However, because standard medical textbooks such as ''The Merck Manual'' and ''Williams Textbook of Endocrinology'' do not include it as a characteristic clinical manifestation of hypoparathyroidism, we have concluded that it is not appropriate as

part of VA's evaluation criteria, and we have, therefore, removed it.

We proposed that DC 7901 (thyroid gland, toxic adenoma of) be rated as DC 7900 (hyperthyroidism). For the convenience of rating specialists, we have instead repeated the rating criteria for DC 7900 under DC 7901. For the same reason, we have repeated the note under DC 7914, which explains evaluation of malignant neoplasms, under C-cell hyperplasia of the thyroid (DC 7919), rather than instructing to rate C-cell hyperplasia of the thyroid as malignant neoplasm, as we proposed. These changes reduce the risk of error because the necessary criteria are closely associated with the diagnostic code rather than on another page, and they also save time for the rating specialist. They do not represent substantive changes.

We have made additional nonsubstantive editorial changes in language by substituting ''evaluate'' for ''rate'' in several instances and by changing ''neoplasms'' to ''neoplasm'' in DC's 7914 and 7915, for internal consistency in the rating schedule.

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

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

This regulatory amendment has been reviewed by the Office of Management and Budget under the provisions of Executive Order 12866, Regulatory Planning and Review, dated September 30, 1993.

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

List of Subjects in 38 CFR Part 4

Disability benefits, Individuals with disabilities, Pensions, Veterans.

Approved: December 5, 1995.

Jesse Brown,

Secretary of Veterans Affairs.

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

PART 4—SCHEDULE FOR RATING DISABILITIES

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

Authority: 38 U.S.C. 1155.

Subpart B—Disability Ratings

2. Section 4.119 is revised to read as follows:

§ 4.119 Schedule of ratings—endocrine system.

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

	Rating
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, and enlarged sella turcica	30
7909 Diabetes insipidus	
Polyuria with near-continuous thirst, and more than two documented episodes of dehydration requiring parenteral hydration in the past year	100
Polyuria with near-continuous thirst, and one or two documented episodes of dehydration requiring parenteral hydration in the past year	60
Polyuria with near-continuous thirst, and one or more episodes of dehydration in the past year not requiring parenteral hydration	40
Polyuria with near-continuous thirst	20
7911 Addison's disease (Adrenal Cortical Hypofunction)	
Four or more crises during the past year	60
Three crises during the past year, or; five or more episodes during the past year	40
One or two crises during the past year, or; two to four episodes during the past year, or; weakness and fatigability, or; corticosteroid therapy required for control	20
NOTE (1): An Addisonian ''crisis'' consists of the rapid onset of peripheral vascular collapse (with acute hypotension and shock), with findings that may include: anorexia; nausea; vomiting; dehydration; profound weakness; pain in abdomen, legs, and back; fever; apathy, and depressed mentation with possible progression to coma, renal shutdown, and death.	
NOTE (2): An Addisonian ''episode,'' for VA purposes, is a less acute and less severe event than an Addisonian crisis and may consist of anorexia, nausea, vomiting, diarrhea, dehydration, weakness, malaise, orthostatic hypotension, or hypoglycemia, but no peripheral vascular collapse.	
NOTE (3): Tuberculous Addison's disease will be evaluated as active or inactive tuberculosis. If inactive, these evaluations are not to be combined with the graduated ratings of 50 percent or 30 percent for non-pulmonary tuberculosis specified under § 4.88b. Assign the higher rating.	
7912 Pluriglandular syndrome	
Evaluate according to major manifestations.	
7913 Diabetes mellitus	
Requiring more than one daily injection of insulin, restricted diet, and regulation of activities (avoidance of strenuous occupational and recreational activities) with episodes of ketoacidosis or hypoglycemic reactions requiring at least three hospitalizations per year or weekly visits to a diabetic care provider, plus either progressive loss of weight and strength or complications that would be compensable if separately evaluated	100
Requiring insulin, restricted diet, and regulation of activities with episodes of ketoacidosis or hypoglycemic reactions requiring one or two hospitalizations per year or twice a month visits to a diabetic care provider, plus complications that would not be compensable if separately evaluated	60
Requiring insulin, restricted diet, and regulation of activities	40
Requiring insulin and restricted diet, or; oral hypoglycemic agent and restricted diet	20
Manageable by restricted diet only	10
NOTE (1): Evaluate compensable complications of diabetes separately unless they are part of the criteria used to support a 100 percent evaluation. Noncompensable complications are considered part of the diabetic process under diagnostic code 7913.	
NOTE (2): When diabetes mellitus has been conclusively diagnosed, do not request a glucose tolerance test solely for rating purposes.	
7914 Neoplasm, malignant, any specified part of the endocrine system	100
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
7915 Neoplasm, benign, any specified part of the endocrine system rate as residuals of endocrine dysfunction.	
7916 Hyperpituitarism (prolactin secreting pituitary dysfunction)	
7917 Hyperaldosteronism (benign or malignant)	
7918 Pheochromocytoma (benign or malignant)	
NOTE: Evaluate diagnostic codes 7916, 7917, and 7918 as malignant or benign neoplasm as appropriate.	
7919 C-cell hyperplasia of the thyroid	100
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	

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Board of Veterans' Appeals

38 CFR Parts 19 and 20

RIN 2900–AH16

Appeals Regulations, Rules of Practice: Single Member and Panel Decisions; Reconsiderations; Order of Consideration

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the Appeals Regulations and Rules of Practice of the Board of Veterans'' Appeals. The amendments incorporate recent statutory changes (including provisions to allow matters to be decided by individual Board members), set forth procedures regarding reconsideration of decisions, change office names and designations due to administrative changes within the Board, and make other nonsubstantive changes.

DATES: Effective Date: This final rule is effective May 7, 1996.

Applicability Dates: The incorporation of statutory provisions and statutory interpretations contained in this final rule will be applied retroactively from the effective dates of the statutory provisions. For more information concerning the application of the provisions of this final rule, see the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Steven L. Keller, Chief Counsel, Board of Veterans' Appeals, Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420 (202–565–5978).

SUPPLEMENTARY INFORMATION: This document amends the Appeals Regulations, 38 CFR Part 19, and the Rules of Practice, 38 CFR Part 20, of the