Authority: 26 U.S.C. 7805 * * *

§ 1.6045–2T [Removed]

Par. 2. Section 1.6045–2T is removed.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 3. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

§ 602.101 [Amended]

Par. 4. Section 602.101(c) is amended by removing the entry for § 1.6045–2T from the table.

Cynthia E. Grigsby,

Chief, Regulations Unit, Assistant Chief Counsel (Corporate).

[FR Doc. 96–22592 Filed 9–4–96; 8:45 a.m.]

BILLING CODE 4830–01–M

DEPARTMENT OF JUSTICE

28 CFR Part 0

[DEA–136C]

Redelegation of Functions; Delegation of Authority to Drug Enforcement Administration Official

AGENCY: Department of Justice.

ACTION: Final rule.

SUMMARY: Under delegated authority, the Deputy Administrator of the Drug Enforcement Administration (DEA), Department of Justice, is amending the Appendix to Subpart R of the Justice Department regulations to make a technical correction to reflect a change in the position classification series for DEA Diversion Investigators.

EFFECTIVE DATE: September 5, 1996.

FOR FURTHER INFORMATION CONTACT: G. Thomas Gitchel, Chief, Liaison and Policy Section, Office of Diversion Control, Drug Enforcement Administration, Washington, D.C. 20537, Telephone (202) 307–7297.

SUPPLEMENTARY INFORMATION: On October 1, 1995, Drug Enforcement Administration Diversion Investigators were converted from the Office of Personnel Management position classification series 1810 to series 1801. Section 3(b) of the Appendix to Subpart R is being amended to reflect that change by removing the reference to series 1810 and replacing it with series 1801.

The Deputy Administrator certifies that this action will have no impact upon entities whose interests must be considered under the Regulatory Flexibility Act (5 U.S.C. 601). Pursuant to Executive Order 12866, this is not a significant regulatory action since it relates only to the organization of functions within DEA. Accordingly, it has not been reviewed by the Office of Management and Budget and does not require certification under Executive Order 12778. This action has been analyzed in accordance with Executive Order 12616. It has been determined that this matter has no federalism implications which would require preparation of a federalism assessment.

List of Subjects in 28 CFR Part 0

Authority Delegations (Government Agencies), Organizations and functions (Government Agencies).

For the reasons set forth above, and pursuant to the authority vested in the Deputy Administrator of the Drug Enforcement Administration by 28 CFR 0.100 and 0.104, and 21 U.S.C. 871, title 28 of the Code of Federal Regulations, part 0, appendix to subpart R, Redelegation of Functions, is amended as follows:

PART 0—ORGANIZATION OF THE DEPARTMENT OF JUSTICE

1. The authority citation for part 0 continues to read as follows:

Authority: 5 U.S.C. 301: 28 U.S.C. 509, 510, 515–519.

2. In the Appendix to subpart R, Section 3(b) remove the words ''series 1810'' and replace them with the words ''series 1801''.

Dated: August 28, 1996.

Stephen H. Greene,

Deputy Administrator.

[FR Doc. 96–22707 Filed 9–4–96; 8:45 am]

BILLING CODE 4410–09–M

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AE94

Schedule for Rating Disabilities; Respiratory System

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 Respiratory System. The intended effect of this action is to update the respiratory 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 October 7, 1996.

FOR FURTHER INFORMATION CONTACT: Caroll McBrine, M.D., Consultant, Regulations Staff (213A), Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington DC 20420, (202) 273–7210.

SUPPLEMENTARY INFORMATION: As part of its first comprehensive review of the rating schedule since 1945, VA published a proposal to amend 38 CFR 4.96 and 4.97, which address the respiratory system. The proposal was published in the Federal Register of January 19, 1993 (58 FR 4962–69). Interested persons were invited to submit written comments on or before March 22, 1993. We received comments from Paralyzed Veterans of America, Disabled American Veterans, Veterans of Foreign Wars, the American Legion, several VA employees, and one member of the general public.

One commenter suggested a need for a zero percent level for all conditions.

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 criteria for every condition. VA believes that it is useful to include a zero percent evaluation only if it is necessary to give the rating board clear and unambiguous instructions on rating where it might otherwise be unclear whether commonly occurring minor findings warrant a zero percent or higher evaluation.

One commenter suggested that the proposed revision would discriminate against veterans whose initial evaluations would be assigned under a new and deliberalized schedule.

Significant medical advances have occurred since the last comprehensive review of the rating schedule, and it is appropriate to take these advances into account in revising the rating schedule. Doing so is, in fact, one of the primary reasons for conducting this review. In our judgment, veterans will not be discriminated against by having their disabilities evaluated under criteria which reflect the effects of those medical advances. For veterans evaluated under the former criteria, Congress 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.

One commenter stated that rating schedule revisions appear to be based on optimum success in overcoming the effects of disease rather than average impairment.

VA disagrees. 38 U.S.C. 1155 directs that ''ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations.'' The word ''average,'' as used in the statute, refers to the ''usual or normal kind, amount, quantity, rate, etc.'' (''Webster's New World Dictionary,'' Third College Edition). To the extent possible, we have based our changes on average or usual or normal courses of disease and recovery.

The previous schedule provided a two-year period of total evaluation following the cessation of treatment for malignant neoplasms of the respiratory tract (DC 6819). As with malignant neoplasms in other revised sections of the rating schedule, we proposed that a 100-percent rating continue following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure, with a mandatory examination six months following cessation of treatment. Before any change in evaluation based upon the examination can be made, the provisions of § 3.105(e) must be implemented, and evaluation is made on residuals if there has been no metastasis or recurrence. We received a number of comments about that proposed change. One commenter said that six months is not a long enough convalescence.

We believe that an examination six months following the cessation of treatment affords sufficient time for convalescence and stabilization of residuals, particularly since the rule requires only an examination, not a reduction, at that time. 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 revised procedure, by requiring an examination, will not only assure that all residuals are documented, but also that the veteran receives timely notice of any proposed action and an expanded opportunity to present evidence showing that the proposed action should not be taken or should be mitigated. In our judgment, this method will better ensure that actual residual disabilities and recuperation times are taken into account because they will be documented on the required examination, and the veteran will have better opportunities to present evidence demonstrating the current level of disabilities.

We have revised the note under DC 6819 for the sake of clarity and consistency. We have 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 the revised provisions for malignancies of the genitourinary system. This is not a substantive change.

One commenter felt that applying § 3.105(e) will cause administrative problems and will significantly lengthen the period of a total evaluation when claims are received months or years after surgery. He felt that a retroactive increase to 100 percent simultaneously with the initiation of due process under § 3.105(e) to determine the extent of residual disability would be inconsistent.

Since § 3.105(e) applies only to reductions in ''compensation payments currently being made,'' it does not apply where a total evaluation is assigned and reduced retroactively.

When the proposed rule was published, we cited improvements in the administration of chemotherapy and radiation therapy as one reason for eliminating a fixed convalescent period. One commenter requested that we justify our statement that chemotherapy has improved.

While the first effective drugs for treating cancer were introduced in the mid and late 1940's, the results were disappointing because responses were incomplete and of short duration, and doses were limited by toxicity (''Cecil Textbook of Medicine'' 1118 (James B. Wyngaarden, M.D. et al. eds., 19th ed. 1992)). In 1945 there was only one drug known to be effective—nitrogen mustard. Today there are nearly 50 chemotherapeutic agents in use. The dose and frequency of administration of the newer agents often differ from those of earlier agents, and the actions of some of the newer agents are more targeted in their actions, so that side effects may be fewer and treatment shorter than before. In use since the 1960's, combination chemotherapy has also marked a turning point in the effective treatment of neoplastic disease (''Harrison's Principles of Internal Medicine'' 1587 (Jean D. Wilson, M.D. et al. eds., 12th ed. 1991)).

Another commenter stated that the proposed changes in convalescence should be justified by medical experts or text citations and that our medical consultants should be named.

As part of the process of reviewing the rating schedule, we contracted with an outside consultant, Abt Associates Incorporated, to submit recommendations for revisions to those portions of the rating schedule dealing with the respiratory system. We also received advice and suggestions from physicians in the Veterans Health Administration, and we consulted standard medical and surgical textbooks, including ''Harrison's Principles of Internal Medicine'' (Jean D. Wilson, M.D. et al. eds., 12th ed. 1991), ''Cecil Textbook of Medicine'' (James B. Wyngaarden, M.D. et al. eds., 19th ed. 1992), and ''The Merck Manual,'' (16th ed. 1992). The convalescent periods adopted in this change represent, in our judgment, based on sound medical advice, neither the longest nor the 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. For the unusual case where a longer convalescence is needed, the provisions of §§ 4.29 and 4.30 allow an extension of convalescence.

One commenter said that the reductions in the revision appear to be on a purely economic basis.

This review was carried out from a medical perspective. Its purpose is to ensure that the rating schedule uses current medical terminology and unambiguous criteria, and that it reflects medical advances which have occurred since the last review. Cost cutting was not an issue.

One commenter suggested that we revise the title of DC 6522, allergic rhinitis, to ''allergic or vasomotor rhinitis'' because both conditions exhibit the same manifestations and are at times indistinguishable.

We agree and have revised the title of DC 6522 accordingly.

Another commenter, without giving his reasons, suggested that we combine DC's 6510 through 6514 (the codes for chronic pansinusitis, ethmoid sinusitis, frontal sinusitis, maxillary sinusitis, and sphenoid sinusitis) into a single code for sinusitis.

Retaining a separate code for each of the sinuses will allow statistical tracking of disease of individual sinuses. Since the commenter gave no reason for suggesting the change, and no substantial advantage to either the veteran or the rating board is evident, we have kept separate codes.

One commenter felt that subjective descriptors like ''marked'' under DC's 6522 (allergic rhinitis), 6523 (chronic rhinitis), and 6516 (laryngitis), and ''abundant'' in DC 6601 (bronchiectasis) in the proposed revision should be eliminated for the sake of objectivity.

VA agrees, and we have revised the criteria accordingly. In some cases we have simply removed subjective terms such as ''marked'' and ''mild'' 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 and unambiguous criteria required greater modification of the proposed criteria, and these changes will be discussed under the affected diagnostic codes.

In the case of chronic laryngitis (DC 6516), removing ''marked'' and ''moderate'' required additional changes in the criteria to distinguish the 10- and 30-percent levels. We proposed a ten-percent evaluation for moderate hoarseness with inflammation of cords or mucous membrane and a thirty-percent evaluation for marked hoarseness with pathological changes such as inflammation of cords or mucous membrane, thickening or nodules of cords, or submucous infiltration. We have revised the requirements for a ten-percent evaluation to hoarseness with inflammation of cords or mucous membrane and for a thirty-percent evaluation to hoarseness with thickening or nodules of cords, polyps, submucous infiltration, or pre-malignant changes on biopsy. This clarifies the criteria for the given percentages.

For several conditions with nasal obstruction: septum, nasal, deviation of (DC 6502), allergic or vasomotor rhinitis (DC 6522), and bacterial rhinitis (DC 6523), we proposed a ten-percent evaluation if there is ''marked'' interference with breathing space. We replaced that subjective criterion with ''more than 50-percent obstruction of nasal passage on both sides or complete obstruction on one side'' for a ten-percent evaluation in all three conditions. This clarifies the criteria for the given percentages.

In the general rating formula for sinusitis, the criteria included such subjective terms as ''severe symptoms,'' ''frequently incapacitating recurrences,'' and ''frequent severe headaches.'' We proposed a 100-percent evaluation for ''following radical surgery with chronic osteomyelitis, or; severe symptoms after repeated surgeries.'' We proposed a 30-percent evaluation for ''frequently incapacitating recurrences, and frequent severe headaches, and purulent discharge or crusting reflecting purulence.'' We proposed a ten-percent level for ''infrequent headaches with discharge or crusting or scabbing.'' We have revised these criteria by specifying the frequency of incapacitating or non-incapacitating episodes of sinusitis per year and the specific symptoms for the various levels. For example, we changed the criteria for a 30-percent evaluation to a requirement for 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. The change is to clarify the criteria.

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

We believe that providing clear and objective criteria is the best way to assure that disabilities will be evaluated fairly and consistently. At the same time we are aware that there must be some flexibility in application of the criteria because patients do not commonly present as textbook models of disease. Rating boards are required to assess all the evidence of record before determining a disability evaluation and must use their judgment in determining, for example, which level of evaluation is more appropriate when there is conflicting information. Therefore, no matter how objective the criteria, an element of judgment in their application remains.

We proposed criteria for bronchiectasis (DC 6601) that included ''severe'' hemoptysis, ''chronic'' antibiotic usage, and ''chronic recurrent'' pneumonia. One commenter said that the words ''severe,'' ''chronic,'' and ''chronic recurrent'' are not objective and that in fact they are unnecessary.

VA agrees. However, simply eliminating those adjectives would not have left appropriate criteria, so we have revised the criteria to make them more objective. We have specified the required duration of incapacitating episodes of infection or frequency of antibiotic usage for each level of severity of bronchiectasis. At the 60- and 30-percent levels, we also provided alternative objective criteria based on such symptoms as cough, purulent sputum, and weight loss. Our change is to clarify the criteria for the evaluation of bronchiectasis.

The previous schedule used a variety of symptoms, signs, and X-ray findings to evaluate pulmonary diseases. We proposed that many be evaluated, at least in part, on criteria based on the results of pulmonary function tests (PFT's). One commenter, concerned that a single set of PFT's on a given day might not accurately represent the veteran's usual condition, recommended that VA place greater emphasis on interpreting examination reports in light of all evidence of record and require that test results be reviewed by a pulmonary disease specialist or by the medical specialist on the rating board.

Rating boards are required by § 4.2 to evaluate all evidence of record before assigning an evaluation. It is highly unlikely that the results of a single set of PFT's would be the only available evidence on which to evaluate the level of severity of a pulmonary condition. Current clinical information, treatment records, previous examination reports, and other laboratory results are generally available for consideration. Rating boards seek medical consultation when they feel it is necessary. The medical consultant to the rating board is readily available for information and advice, and the rating board may request an examination by a pulmonary disease specialist when it feels it is needed. It would be both impractical and unnecessary to consult with a pulmonary disease specialist on every case in which PFT's have been conducted.

One commenter suggested that the criteria in the previous rating schedule for evaluating respiratory diseases be retained as a backup for cases where pulmonary function testing is not available.

The equipment for carrying out PFT's is widely available, but if an examining facility is not equipped for the tests, the examination will need to be conducted at another facility, as is the case with other specialized testing, such as for vision or hearing. VA therefore does not believe retention of the previous criteria as backup is necessary.

Another commenter stated that pulmonary function testing is contraindicated in certain instances for medical reasons, such as a history of spontaneous pneumothorax, a hole in the tympanic membrane, or a recent history of active tuberculosis, and that provisions are therefore needed for evaluating these conditions when PFT's cannot be done.

The Veterans Health Administration has advised us that the medical conditions listed by the commenter do not contraindicate pulmonary function testing. The major limiting factor in carrying out such testing is the inability of some patients to follow directions, as

might occur, for example, in individuals who are severely ill following a stroke. Even in such individuals, the new criteria allow assignment of a total evaluation for respiratory disease because there are a number of criteria warranting a 100-percent evaluation, including cor pulmonale, right ventricular hypertrophy, and respiratory failure, that can be assessed without the need for patient cooperation. As under the previous criteria, for a small number of patients with a less severe respiratory disease, an evaluation may have to be deferred until pulmonary function testing is feasible.

Machines that are used for disability testing purposes must meet the calibration standards of The American Thoracic Society, which are internationally accepted. This assures that the basis of evaluations will be the most accurate and consistent measurements possible.

We proposed a 100-percent level of evaluation for larynx, stenosis of, (DC 6520) if there is either a Forced Expiratory Volume in one second (FEV–1) of less than 40-percent predicted, or a permanent tracheostomy, and a 60-percent evaluation if there is an FEV–1 of 40- to 55-percent predicted. We proposed a 100-percent evaluation for chronic bronchitis (DC 6600), pulmonary emphysema (DC 6603), chronic obstructive pulmonary disease (DC 6604) and restrictive lung diseases if there is an FEV–1 of less than 40-percent predicted, a ratio of FEV–1 to Forced Vital Capacity (FVC) less than 40-percent, a DLCO less than 40-percent predicted, maximum exercise capacity less than 15 ml/kg/min oxygen consumption, cor pulmonale (right heart failure), right ventricular hypertrophy, pulmonary hypertension, episode(s) of acute respiratory failure, or a requirement for outpatient oxygen therapy. We proposed a 60-percent evaluation for the same group of conditions if there is an FEV–1 of 40- to 55-percent predicted, an FEV–1/FVC of 40- to 55-percent, a DLCO of 40- to 55-percent predicted, or maximum oxygen consumption of 15 to 20 ml/kg/min. We proposed a 100-percent evaluation for bronchial asthma (DC 6602) if there is an FEV–1 less than 40-percent predicted, an FEV–1/FVC less than 40-percent, more than one attack per week with episodes of respiratory failure, or daily use of systemic high dose corticosteroids or immuno-suppressive medication, and a 60-percent evaluation if there is an FEV–1 of 40- to 55-percent predicted, an FEV–1 of 40- to 55-percent, at least monthly visits to a physician for exacerbations, or intermittent courses of systemic corticosteroids.

One commenter said that the levels of reduction of pulmonary function for the 60- and 100-percent evaluation levels of DC's 6520, 6600, 6602, 6603, 6604, and 6844 (one of the restrictive lung conditions) that we proposed are extreme and do not represent average impairments.

VA disagrees. The criteria we have provided for a 100-percent evaluation for these conditions are consistent with the criteria used by the American Thoracic Society for its ''severely impaired (unable to meet the physical demands of most jobs)'' category. This is not more stringent than the requirement for ''dyspnea at rest'' or ''dyspnea on slight exertion,'' which were among the criteria for a 100-percent level of evaluation for many pulmonary conditions in the previous schedule. We also provided alternative requirements for a 100-percent evaluation, such as heart failure, that are consistent with criteria for this level in other sections of the rating schedule. The criteria we have provided for 60 percent are proportionately lower than those for the 100-percent level.

One commenter questioned what values will be assigned as normals in PFT's.

Normal values of PFT's, for VA purposes, are those that exceed the requirements for a 10-percent evaluation, and those levels are also consistent with the American Thoracic Society standards for normal values except in the case of the FEV–1/FVC ratio, where we include the 75- to 80-percent level in the criteria that warrant a ten-percent evaluation. Although the American Thoracic Society uses an evaluation of 75 percent as the normal level of the FEV–1/FVC ratio, two widely used medical textbooks use other normals: Cecil (374) uses ''80 percent,'' and Harrison (1035) uses ''approximately 75 to 80 percent.'' Therefore, our designation of over 80 percent as normal is consistent with current medical teaching.

The same commenter recommended that we specify that pulmonary function be tested before bronchodilatation in order to reflect ordinary conditions of life.

VA disagrees. The American Lung Association/American Thoracic Society Component Committee on Disability Criteria recommends testing for pulmonary function after optimum therapy. The results of such tests reflect the best possible functioning of an individual and are the figures used as the standard basis of comparison of pulmonary function. Using this standard testing method assures consistent evaluations.

One commenter stated that, while pulmonary function testing provides a very accurate picture of functional impairment of the respiratory system, compensation should be based on the limitation of earning capacity.

The determination of compensation based on limitation of earning capacity is not inconsistent with the use of objective PFT's. A major objective of the rating schedule revision is to provide criteria that are accurate, consistent, and unambiguous. The widespread use and acceptance of PFT's (American Thoracic Society, American Medical Association, etc.) indicates their value in assessing the severity of pulmonary diseases. Their usefulness lies in part in the fact that they correlate with the functional impairment that an individual experiences. The more severe the pulmonary disease, the more abnormal one or more PFT's are likely to be, and the more interference there is likely to be with occupational functioning. Using PFT's as a means of evaluation fulfills to as great an extent as is possible, the desire for evaluation criteria that allow accuracy and consistency and that are not ambiguous. The commenter offered no alternative suggestions for criteria to evaluate pulmonary disease.

One commenter felt that PFT's should be the exclusive basis for evaluating lung disorders because they are strictly objective.

VA disagrees. While we have used the results of pulmonary function tests as evaluation criteria when they are appropriate, they are not suitable for the evaluation of all lung conditions. Asthma, for example, is an episodic condition that may exhibit normal PFT's at most times despite significantly disabling disease, and it therefore requires other criteria for its evaluation, such as the need for a certain type or frequency of treatment.

One commenter, noting that we had proposed to assign most lung disorders (restrictive lung diseases, chronic bronchitis, asthma, emphysema, chronic obstructive pulmonary disease, and bronchiectasis) evaluation levels of 10, 30, 60, and 100 percent, but interstitial lung diseases levels of 0, 10, 40, 70, and 100 percent, said that it would be more logical and consistent to assign all lung conditions the same evaluation levels. Another commenter stated that lung conditions with similar impairments of lung functions should receive similar ratings. He suggested listing FEV–1, FVC, FEV–1/FVC, and DLCO under all lung diseases requiring PFT's, as recommended by the American

Thoracic Society and found in the AMA Guides.

Individual categories of pulmonary disorders often affect the results of one PFT more than another. Our non-VA panel of specialist consultants felt that FEV–1 and the ratio of FEV–1 to FVC are good indicators of the level of severity of many pulmonary diseases, but that the FVC and DLCO are more appropriate PFT's to evaluate interstitial diseases. The American Medical Association's ''Guides to the Evaluation of Permanent Impairment,'' Third Edition, Revised (1990), says that ''for interstitial lung disease, the FVC has proved to be a reliable and valid index of significant impairment,'' and it goes on to say that the DLCO is especially useful in detecting abnormalities that limit gas transference, such as emphysema or interstitial fibrosis of the lung parenchyma. A standard medical textbook (Cecil, 401), says that the ratio of FEV–1 to FVC may be normal or increased in interstitial disease. It is therefore not useful as a criterion to evaluate the severity of this type of disease. Our use of the proposed criteria is thus consistent with the effects of the various conditions on PFT's.

Regarding the comment about using the same evaluation levels for all lung disorders, VA agrees that there is no compelling reason to use evaluation levels for interstitial lung disease that differ from those used for the majority of other lung diseases. We have, therefore, for the sake of greater consistency, revised the criteria for interstitial lung disease by substituting 30- and 60-percent levels for the 40- and 70-percent levels. This required adjustments in the FVC and DLCO levels used as criteria, both because of the changed evaluation levels and to make them correspond with the PFT criteria for other pulmonary conditions. We also removed the zero-percent evaluation for consistency.

One commenter said that while an FEV–1 above 80 percent is considered normal in the proposed revision of the respiratory disease section of the rating schedule, the Veterans Health Administration's ''Physician's Guide for Disability Evaluation Examinations'' (a manual that gives guidance to examining physicians who do compensation and pension examinations) states that 83 percent is normal, and these figures are inconsistent.

The ''Physician's Guide'' 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 current version of the Guide (revised 1994), which is computerized and no longer available in printed form, does not provide lists of normal PFT results. The examining physician is required to obtain PFT's where the criteria call for them but need not interpret the results since the criteria themselves contain the actual figures that warrant various evaluations. As with any examination, 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 38 CFR 4.2).

We proposed notes under DC's 6600 (chronic bronchitis), 6603 (pulmonary emphysema), 6604 (chronic obstructive pulmonary disease) and under the general rating formula for restrictive lung diseases outlining the requirements for home oxygen. One commenter said that the requirements for home oxygen are too specific and should be flexible enough to allow for a physician's assessment that the patient needs oxygen. Another commenter said that the term ''home oxygen'' is confusing because many use oxygen away from home and the requirement for oxygen may be temporary, pending stabilization or during an acute illness.

VA agrees that the decision to use home oxygen should be a medical, not a rating, decision, and we have therefore deleted the note explaining the technical requirements for home oxygen. We proposed that ''meets requirements for home oxygen'' be one of the criteria for the 100-percent level of the conditions listed above, but the preferred current term for such treatment is ''outpatient oxygen therapy,'' and we have revised the language accordingly.

A commenter asked how VA will deal with results of PFT's from non-VA facilities that are at variance with VA test results.

This potential problem is not unique to the area of PFT's. Any laboratory test may show different results when performed on the same individual in the same facility at different times or when the same test is performed on the same individual at more than one facility. Rating boards are required to consider and reconcile all evidence of record, and at times they may seek additional testing or a medical opinion to help reconcile differences.

One commenter suggested we assign a minimum evaluation of 10 percent for any lung disorder if the patient must take daily medication.

VA disagrees. Because of the broad range of pulmonary conditions and medications used to treat them, a 10-percent evaluation would not necessarily be warranted in all cases on the basis of daily medication alone. For example, daily use of an expectorant or cough medicine would not necessarily be indicative of a condition warranting a ten-percent level of evaluation.

We proposed to add sarcoidosis (DC 6846) to the rating schedule with evaluation levels of 0, 30, and 60 percent. We received two comments about this change. One stated that while the criteria of pulmonary involvement with fever, weight loss, and night sweats requiring high dose systemic corticosteroids for control establish a 60-percent level of evaluation in the case of sarcoidosis, similar criteria (active infection with systemic symptoms such as fever, night sweats, weight loss, or hemoptysis) establish a 100-percent evaluation for bacterial infections of the lung (DC's 6822, 6823, and 6824). He felt that the criteria described should be considered totally disabling for both conditions.

VA agrees that some of the criteria we had proposed for the 60-percent level of sarcoidosis are more consistent with total disability. We have therefore revised the criteria for the 60-percent evaluation level and added a 100-percent evaluation level. We have made fever, night sweats, and weight loss part of the criteria for the 100-percent level and pulmonary disease requiring systemic high dose (therapeutic) steroids for control of the criterion for the 60-percent level. We also slightly revised the 30 percent criteria by adding ''maintenance'' in parentheses as a description of the steroid therapy and removed ''mild'' modifying symptoms because it is a subjective term, and whether maintenance or therapeutic doses of steroid are used makes a clearer differentiation of the level of severity.

The other commenter stated that it will be difficult to establish service connection for sarcoidosis on a presumptive basis if there is no ten-percent level, because presumptive service connection requires that a condition be manifest to a degree of ten percent or more within one year of discharge.

The evaluation levels we provide for various conditions are meant to reflect the ordinary levels of severity that may be seen in those conditions, and we do not provide ten-percent evaluation levels in order to aid presumptive service connection. The proposed evaluation criteria for sarcoidosis included 30- and 60-percent evaluation levels, and either of those levels would

establish presumptive service connection if present within one year of discharge. Sarcoidosis may also be evaluated under other criteria, however, as indicated in a note following the evaluation criteria. Therefore, a 10-percent level, as well as other levels of evaluation, may be assigned under DC 6600 (chronic bronchitis) based on the results of pulmonary function tests, or under skin disease, eye disease, etc., when there is extra-pulmonary involvement.

One commenter suggested that we add a diagnostic code and evaluation criteria for asbestosis. He suggested that we evaluate the condition based on its restrictive aspects, X-ray changes, and pleural changes.

VA agrees that asbestosis is a common enough disease in the veteran population to warrant its own diagnostic code. We have therefore removed asbestosis from the list of pneumoconioses in DC 6832 and have added asbestosis as DC 6833. It will be evaluated under the general rating formula for interstitial diseases, as recommended by our panel of consultants. The X-ray changes unique to asbestosis are not necessarily related to the degree of disability but are helpful in establishing the fact of asbestos exposure. They therefore relate more to the issue of service connection rather than to evaluation, and we have not made them part of the evaluation criteria. We have adjusted the numbering of the proposed diagnostic codes following asbestosis to accommodate the added condition. We have changed the proposed DC's for histoplasmosis of lung from 6833 to 6834, coccidioidomycosis from 6834 to 6835, blastomycosis from 6835 to 6836, cryptococcosis from 6836 to 6837, aspergillosis from 6837 to 6838, mucormycosis from 6838 to 6839, diaphragm paralysis or paresis from 6839 to 6840, spinal cord injury with respiratory insufficiency from 6840 to 6841, kyphoscoliosis, pectus excavatum, pectus carinatum from 6841 to 6842, traumatic chest wall defect, pneumothorax, hernia, etc., from 6842 to 6843, post-surgical residual from 6843 to 6844, chronic pleural effusion or fibrosis from 6844 to 6845, sarcoidosis from 6845 to 6846, and sleep apnea from 6846 to 6847.

One commenter asked why we have not proposed to rate the disfigurement and disability from radical neck surgery under respiratory disorders.

Radical neck surgery is not appropriate for inclusion in the respiratory system section of the rating schedule because it primarily results in loss of muscle tissue (of the neck), subcutaneous tissue, and lymph nodes. There is ordinarily no effect on the respiratory system from such surgery. Disability from this loss of tissue can be most appropriately evaluated under diagnostic codes in other sections, such as DC 5322 (Muscle Group XXII, muscles of the front of the neck) or DC 7800 (disfiguring scars of the head, face, or neck).

We proposed that injuries to the pharynx (DC 6521) have a single evaluation level of 50 percent based on the presence of stricture or obstruction of the pharynx or nasopharynx or on paralysis or absence of the soft palate. A commenter said that the resulting symptoms are severe enough to be considered 60-percent disabling, equivalent to complete organic aphonia (DC 6519) or stenosis of larynx (DC 6520), which have both 60- and 100-percent evaluation levels.

VA disagrees. The impairments from these three conditions differ because they are in different locations. The major effect of pharyngeal and palatal injuries is swallowing difficulty rather than respiratory difficulty, and any resulting speech impairment is not likely to approach the level of aphonia. (A 50-percent evaluation for these injuries is comparable to the 50-percent evaluation criteria in the digestive system for severe esophageal stricture, permitting passage of liquids only.) Laryngeal stenosis, on the other hand, causes both respiratory and speech impairment. However, if there is a case where the impairment from pharyngeal injury more closely resembles aphonia or the effects of laryngeal stenosis, an evaluation analogous to one of those conditions may be used instead (§ 4.20). In our judgment, the criteria and level of evaluation we have provided are appropriate for most pharyngeal injuries, and there are adequate provisions for evaluating those few that may be more severe.

Note (1) under the proposed general rating formula for inactive pulmonary tuberculosis stated that 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 under 38 U.S.C. 356 to notify the Adjudication Division in the event of failure to submit to examination or to follow prescribed treatment. A commenter said that the citation of 38 U.S.C. 356, repealed by Public Law 90–493, should be followed by a notation that it is to be found as footnote 1 to section 1156 of title 38, United States Code.

We agree and have revised the note accordingly.

One commenter felt that there is inequity in the evaluation criteria for laryngectomy and partial aphonia because if partial aphonia allows a person to whisper, the rating is 60 percent while if laryngectomy allows a person to whisper, the rating is 100 percent.

VA disagrees. Disability resulting from a laryngectomy is not comparable to partial aphonia with an intact larynx. In the case of laryngectomy, a significant organ has been removed which has functions beyond that of speech. The larynx acts as the sphincter guarding the gateway to the trachea, and a laryngectomy produces a serious compromise of the respiratory tract, requiring a permanent tracheostomy. Partial aphonia may result from any of several causes, including inflammatory and benign neoplastic conditions, but since they affect speech without affecting respiration, we have retained the evaluation criteria as proposed.

Another comment regarding total laryngectomy (DC 6518) and complete organic aphonia (DC 6519) was that there should be a footnote at these codes as a reminder to consider special monthly compensation (SMC), which may be awarded for complete organic aphonia under the provisions of 38 CFR 3.350.

In our judgment, the rating agency should refer directly to the complex and extensive regulations regarding special monthly compensation in § 3.350 whenever the question of special monthly compensation arises. However, in response to the comment, we have taken two steps to remind the rating board to consider the possibility of SMC. We added paragraph (c), ''Special monthly compensation,'' to § 4.96 requiring the rating board to refer to § 3.350 any time it evaluates a claim involving complete organic aphonia; and we placed footnotes at DC's 6518 and 6519, conditions which may be associated with complete organic aphonia, instructing rating boards to review for entitlement to SMC. While those conditions clearly call for review for entitlement to SMC, there are other conditions in this portion of the rating schedule where there might also be entitlement to SMC. The lack of a footnote does not relieve the rating board of the responsibility of recognizing additional circumstances where SMC might be warranted. We believe that the combination of the regulatory requirement contained in the note and the footnotes is the best method of making sure that potential entitlement to SMC is considered.

In view of the addition of paragraph (c) to § 4.96, we have changed the title

of this section to ''Special provisions regarding evaluation of respiratory conditions,'' which is more descriptive of its current contents.

The previous rating schedule had separate diagnostic codes and evaluations for pneumonectomy (60 percent under DC 6815) and lobectomy (50 percent if bilateral, and 30 percent if unilateral, under DC 6816). We proposed that all pulmonary post-surgical residuals, including lobectomy and pneumonectomy, be evaluated under DC 6843, post-surgical residual, as restrictive lung disease, based on the objective findings of PFT's. One commenter said this change is an arbitrary decrease because no advancement in medical science can change the degree of disability resulting from such surgery.

VA does not concur. Since there is an objective method to measure residual breathing impairment, it is more equitable to use that method so that evaluation of the residuals of any type of lung resection is made on the actual residuals found. The previous schedule did not provide evaluations for residuals more severe than the levels specified under those codes. It required, for example, that lobectomy be bilateral to qualify for a 50-percent level of impairment. Under the revised criteria, a veteran will be assigned an evaluation according to the level of disability reflected by the PFT's, whatever the extent of the surgery. This will assure that veterans with comparable residual pulmonary disabilities are consistently evaluated.

We proposed that chronic lung abscess (DC 6824) be evaluated under a general rating formula for bacterial infections of the lung and directed that post-surgical residuals and post-treatment fibrosis and scars be rated as chronic bronchitis (DC 6600). One commenter pointed out that there may be other types of residuals besides fibrosis and scars, such as thoracoplasty, lobectomy, or purulent pleurisy, and suggested that the residuals be rated as appropriate.

We agree, and have revised the statement under DC 6824 to read: ''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).''

The previous schedule called for a 100-percent rating for one year following the date of inactivity of active pulmonary tuberculosis (DC 6731). We proposed that once pulmonary tuberculosis becomes inactive, it be evaluated on the residual scar or fibrosis as chronic bronchitis (DC 6600). Three commenters objected to the change. One said that eliminating a period of convalescence when there is a new worldwide outbreak of tuberculosis is questionable, one said that the change is not justifiable, and one said that we should provide a period of readjustment because individuals have difficulty finding employment after release from treatment for tuberculosis.

On further consideration, VA agrees that some provision for readjustment is appropriate, and we have revised DC 6731 to require that a mandatory examination be requested immediately after notification that active tuberculosis has become inactive. Any change in evaluation will be carried out under the provisions of § 3.105(e). This will assure that a total evaluation will continue for at least several months, which will provide a period of readjustment, and will also assure that the extent of any residual impairment has been documented by examination.

The third commenter stated that the proposal to rate residual scar or fibrosis of inactive tuberculosis (DC 6731) as chronic bronchitis (DC 6600) is too restrictive because there may be other residuals.

We agree, and have revised the statement under DC 6731 to read: ''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.''

We proposed separate diagnostic codes for chronic bronchitis (DC 6600), pulmonary emphysema (DC 6603), and chronic obstructive pulmonary disease (DC 6604), with evaluation under identical criteria. One commenter suggested a single diagnostic code, ''chronic obstructive pulmonary disease (bronchitis or emphysema),'' for all of these conditions, since the proposed criteria are essentially identical.

VA disagrees. While pulmonary emphysema, chronic obstructive pulmonary disease (COPD), and chronic bronchitis often coexist and are sometimes hard to differentiate, they are not synonymous. COPD ordinarily refers to a combination of chronic obstructive bronchitis and emphysema (Cecil, 389), but the term is not always used precisely. Emphysema may be localized or generalized, and is not always categorized as COPD. Since an individual may receive a diagnosis of any of the three conditions, it is useful to have a separate diagnostic code for each entity for statistical purposes and to aid the rating board in selecting appropriate evaluation criteria.

We proposed to add spinal cord injury with respiratory insufficiency (DC 6840) as one of six restrictive lung diseases to be evaluated under a general rating formula. One commenter, without explaining how the conditions differ or offering an alternative for us to consider, suggested that spinal cord injury with respiratory insufficiency not be evaluated as a restrictive lung disease because ventilator dependency secondary to spinal cord injury is distinct from other lung diseases.

VA disagrees. The panel of non-VA specialists convened by a contract consultant included spinal cord injury with respiratory insufficiency among the restrictive pulmonary diseases. Cecil (377), in discussing restrictive pulmonary disease, includes those conditions that affect the chest wall or respiratory muscles. We have provided alternative criteria for restrictive lung disease at each evaluation level, and if any one of the criteria for a particular level is present, that level of evaluation can be assigned. A wide range of respiratory conditions with a predominantly restrictive effect can therefore be evaluated under our criteria, even though one condition might be reflected in an abnormality of one PFT more than another. As a result, our criteria are broad enough to encompass any likely functional impairment spinal cord injury with respiratory insufficiency may produce.

The previous rating schedule provided a one hundred-percent evaluation for six months following spontaneous pneumothorax (now DC 6843). We proposed to provide a convalescent period of three months following total pneumothorax. We received two comments objecting to this proposal. One commenter said that our statement in the preamble to the proposed revision that pneumothorax resolves sooner than six months is not supported by medical evidence, and the other said that decreasing the convalescent period may impede full recovery.

VA disagrees. ''The Merck Manual,'' (731, 16th ed. 1992), states that a small pneumothorax requires no special treatment and that the air is reabsorbed in a few days. It also says that full absorption of a larger airspace may take two to four weeks, a period which can be shortened by the use of a tube for drainage. Cecil (450), states that a small pneumothorax is reabsorbed in 7 to 14 days and that larger ones may be treated with a tube for 2 to 4 days if very large, under tension, or very symptomatic. A persistent or complicated pneumothorax

may require surgery, and in that case, the provisions of § 4.30(b)(2) allow the rating board to assign convalescence for up to a total of six months. Therefore, it is our judgment that three months of convalescence is adequate in the average case.

We received one comment on avoiding pyramiding, the prohibited practice of evaluating the same disability under various diagnoses (see 38 CFR 4.14). The commenter suggested that we direct that DC 6520, stenosis of larynx, not be combined with other codes in this section because the criterion for airflow obstruction due to stenosis of the larynx is similar to those for disease of bronchi or lungs.

Stenosis of the larynx may be evaluated on the basis of the results of pulmonary function tests, if there is respiratory impairment, or as aphonia, when interference with speech is the main impairment. Only in cases of laryngeal stenosis where respiratory impairment is the basis of evaluation would it be pyramiding to combine such an evaluation with the evaluation of another pulmonary condition. Therefore, a strict prohibition against combining evaluations for stenosis of the larynx with evaluations for pulmonary conditions is not warranted. The statement in § 4.96, paragraph (a), stipulating that when there is lung or pleural involvement, DC's 6819 and 6920 will not be combined with each other or with DC's 6600 through 6817 or 6822 through 6847 is sufficient to alert the rating board to possible problems of pyramiding when evaluating pulmonary conditions.

The same commenter additionally said that, to prevent pyramiding, VA should state that evaluations under DC's 6520 (stenosis of larynx), 6511, 6512, 6513, and 6514 (sinusitis in various locations) should not be combined with one another and likewise that evaluations under DC's 6522, 6523, and 6524 (rhinitis of various types) should not be combined with one another.

In VA's judgment, there is no need to specifically prohibit pyramiding of the various codes for sinusitis or rhinitis as the commenter suggests. The rating board is required in general by § 4.14 not to pyramid disabilities. The board must use its judgment as to whether a single evaluation encompasses all disability present or not. A specific prohibition might be useful if all conditions involved always had the same manifestations, but this is not true of either sinusitis or rhinitis.

The commenter went on to say that, alternatively, § 4.96 could be amended to state that it does not remove the prohibition against pyramiding that may apply to other diagnostic codes.

VA disagrees. Such an amendment is not necessary because § 4.14, which prohibits the practice of ''pyramiding,'' applies to the entire rating schedule, and all rating boards are required to follow it.

For further clarity, we have revised the criteria for pulmonary vascular disease, DC 6817. We proposed that the criterion for 30 percent be ''acute pulmonary embolism with residual symptoms,'' and we changed that language to ''symptomatic following resolution of acute pulmonary embolism.'' We proposed that the criterion at the zero-percent level be ''resolved pulmonary thromboembolism with no residual symptoms,'' and we changed that language to ''asymptomatic, following resolution of pulmonary thromboembolism.'' These do not represent substantive changes. Because pulmonary vascular disease may result in residuals other than those included in the proposed criteria, such as chronic pleural thickening, for the sake of completeness, we added a note under DC 6817 directing to evaluate other residuals under the most appropriate diagnostic code.

In the proposed regulation for chronic bronchitis (DC 6600), pulmonary emphysema (DC 6603), chronic obstructive pulmonary disease (DC 6604), and restrictive lung diseases, we inadvertently omitted an upper level of DLCO that would warrant a ten percent evaluation. We have corrected this oversight in the final regulation by making the DLCO requirement for the 10-percent evaluation ''66- to 80-percent predicted.''

An additional change we made for the sake of completeness was the addition of a note following DC 6504, nose, loss of part of, or scars, stating that this disability may alternatively be evaluated as DC 7800, disfiguring scars of the head, face, or neck.

We made minor editorial changes in language in several cases, such as changing ''rate'' to ''evaluate'' and ''applicable'' to ''appropriate'', but these are not substantive changes.

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: May 13, 1996.

Jesse Brown,

Secretary of Veterans Affairs.

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

PART 4—SCHEDULE FOR RATING DISABILITIES

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

Authority: 38 U.S.C. 1155.

Subpart B—Disability Ratings

2. In § 4.96, the section heading and paragraph (a) are revised, and paragraph (c) is added to read as follows:

§ 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.

* * * * *

(c) *Special monthly compensation.* When evaluating any claim involving complete organic aphonia, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate

conditions which potentially establish entitlement to special monthly compensation; however, there are other conditions in this section which under certain circumstances also establish entitlement to special monthly compensation.

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

3. Section 4.97 is revised to read as follows:

§ 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:	
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

	Rating
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
6702 Tuberculosis, pulmonary, chronic, moderately advanced, active	100
6703 Tuberculosis, pulmonary, chronic, minimal, active	100
6704 Tuberculosis, pulmonary, chronic, active, advancement unspecified	100
6721 Tuberculosis, pulmonary, chronic, far advanced, inactive.	
6722 Tuberculosis, pulmonary, chronic, moderately advanced, inactive.	
6723 Tuberculosis, pulmonary, chronic, minimal, inactive.	
6724 Tuberculosis, pulmonary, chronic, inactive, advancement unspecified.	
General Rating Formula for Inactive Pulmonary Tuberculosis: For two years after date of inactivity, following active tuberculosis, which was clinically identified during service or subsequently	100
Thereafter for four years, or in any event, to six years after date of inactivity	50
Thereafter, for five years, or to eleven years after date of inactivity	30
Following far advanced lesions diagnosed at any time while the disease process was active, minimum	30
Following moderately advanced lesions, provided there is continued disability, emphysema, dyspnea on exertion, impairment of health, etc	20
Otherwise	0
Note (1): The 100-percent rating under codes 6701 through 6724 is not subject to a requirement of precedent hospital treatment. It will be reduced to 50 percent for failure to submit to examination or to follow prescribed treatment upon report to that effect from the medical authorities. When a veteran is placed on the 100-percent rating for inactive tuberculosis, the medical authorities will be appropriately notified of the fact, and of the necessity, as given in footnote 1 to 38 U.S.C. 1156 (and formerly in 38 U.S.C. 356, which has been repealed by Public Law 90–493), to notify the Adjudication Division in the event of failure to submit to examination or to follow treatment.	

	Rating
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.	
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

	Rating
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
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.

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