NVLSP

NATIONAL VETERANS LEGAL SERVICES PROGRAM

Understanding Recent Changes to the VA's Rating of Musculoskeletal Disabilities

- General Info
- Musculoskeletal groups without changes
- Acute and Subacute Chronic Diseases
- Prosthetic Implants and Resurfacing
- Amputations: Upper Extremity
- Amputations: Lower Extremity
- Shoulder and Arm
- Spine
- Hip and Thigh
- Knee and Leg
- Ankle
- Foot
- Muscle Injuries

GENERAL INFO

BACKGROUND

- 38 C.F.R. §§ 4.40-4.71: principles and general rules for rating musculoskeletal system disabilities
- 38 C.F.R. § 4.71a: rating schedule for the musculoskeletal system
- 38 C.F.R. § 4.73: rating schedule for muscle injuries

BACKGROUND

- 2007: IOM found VA's rating schedule inadequate and outdated
- VA created musculoskeletal system workgroup
- Aug. 1, 2017: VA published proposed rule to change musculoskeletal system ratings
  - Purpose to remove obsolete DCs, modernize names of some DCs, revise descriptions and criteria, add new DCs
  - 2 month comment period
- Nov. 30, 2020: VA published final rule
- Feb. 7, 2021: Rule went into effect

BACKGROUND

- 4 DCs *added*:
  - 2 Musculoskeletal System
    - 5244 Traumatic paralysis, complete
    - 5269 Plantar fasciitis
  - 2 Muscle Injuries
    - 5330 Rhabdomyolysis, residuals of
    - 5331 Compartment syndrome
- 3 DCs *removed* from Musculoskeletal System
  - 5018 (Hydroarthrosis, intermittent)
  - 5020 (Synovitis)
  - 5022 (Periostitis)
- 31 DCs in Musculoskeletal *revised*

APPLICABILITY

- **New rules apply to all claims filed on or after 2/7/2021**
  - If Vet rated under old criteria, VA can only reduce rating under new criteria if disability has improved
    - 38 U.S.C. § 1155
  - If Vet's disability warrants reduction under old criteria, only then can VA apply new criteria, even if it would result in a greater reduction than under the old criteria
    - VA Gen. Coun. Prec. 19-92 (Sept. 29, 1992)

APPLICABILITY

- **If SC/IR claim filed prior to, but pending on 2/7/2021:**
  - VA must determine if new or old regs are more favorable
    - Manual M21-1, V.ii.4.A.6.j (change date Dec. 2, 2020)

POLL #1

For pending claims filed before 2/7/2021, if old rating criteria more favorable, when should old criteria apply?

A. Only before 2/7/2021

B. Before AND after 2/7/2021

C. Old criteria cannot apply

D. Not sure

ANSWER

B

- **For claims filed prior to Feb 7, 2021, but that were still pending on that date, if the old rating criteria is more favorable, the old criteria will be applied for the entire claim period, even on and after Feb. 7, 2021**
  - Manual M21-1, V.ii.4.A.6.m (change date Dec. 2, 2020)

POLL #2

For pending claims filed before 2/7/2021, if new rating criteria more favorable, can they apply to the period prior to 2/7/2021?

A. Yes

B. No

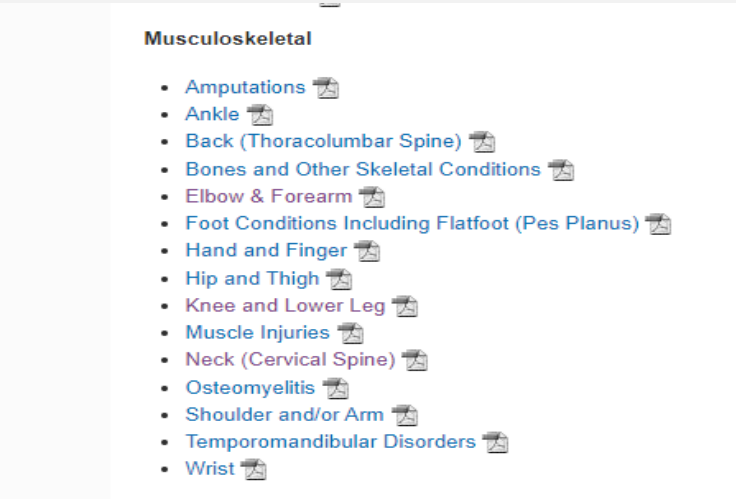
C. Maybe

ANSWER

- **The new rating criteria CANNOT be applied prior to 2/7/2021 – even if more favorable**

DISABILITY BENEFITS QUESTIONNAIRES

- Now 15 DBQs for musculoskeletal conditions
- ROM now documented by endpoint of type of motion (not by both start and end points)
- www.benefits.va.gov/compensation/dbq_publicdbqs.asp



DISABILITY BENEFITS QUESTIONNAIRES

- **New notes for examiners regarding reported flare-ups:**
  - The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings, or a general aversion to offering an estimate on issues not directly observed.
    - Based on holding in *Sharp v. Shulkin*, 29 Vet. App. 26 (2017)

DISABILITY BENEFITS QUESTIONNAIRES

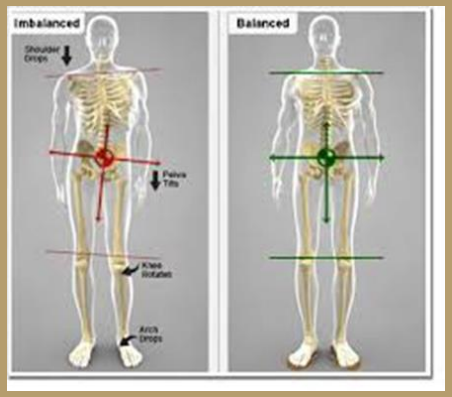
- If DBQ considers both extremities, they are now listed in a column layout

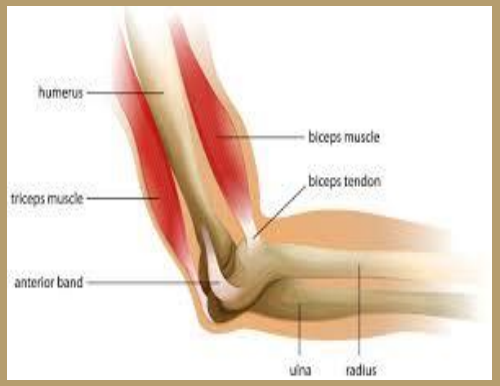
SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION (continued)

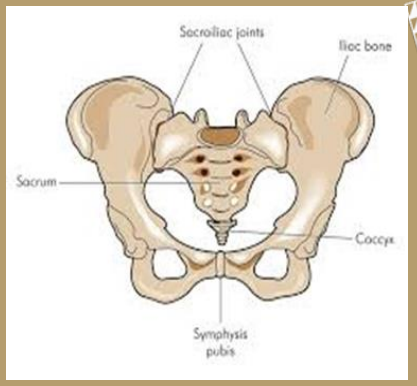
Right elbow	Left elbow
Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values:	Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values:
☐ Flexion endpoint (145 degrees) ____ degrees	☐ Flexion endpoint (145 degrees) ____
☐ Extension endpoint (0 degrees) ____ degrees	☐ Extension endpoint (0 degrees) ____
☐ Forearm supination endpoint (85 degrees) ____ degrees	☐ Forearm supination endpoint (85 degrees) ____
☐ Forearm pronation endpoint (80 degrees) ____ degrees	☐ Forearm pronation endpoint (80 degrees) ____
If noted on examination, which ROM exhibited pain? (select all that apply):	If noted on examination, which ROM exhibited pain? (select all that apply):
☐ Flexion ☐ Forearm supination ☐ Extension ☐ Forearm pronation	☐ Flexion ☐ Forearm supination ☐ Extension ☐ Forearm pronation
If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other, please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.	If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other, please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.
____ Flexion degree endpoint (if different than above)	____ Flexion degree endpoint (if different than above)
____ Extension degree endpoint (if different than above)	____ Extension degree endpoint (if different than above)
____ Forearm supination degree endpoint (if different than above)	____ Forearm supination degree endpoint (if different than above)
____ Forearm pronation degree endpoint (if different than above)	____ Forearm pronation degree endpoint (if different than above)

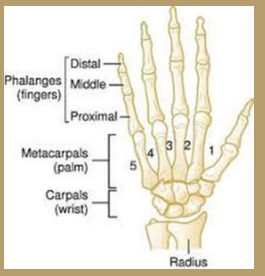
NOTE FOR THIS TRAINING

- Changes are *underlined and italicized* (unless DC is new)
- Changes then summarized after each DC

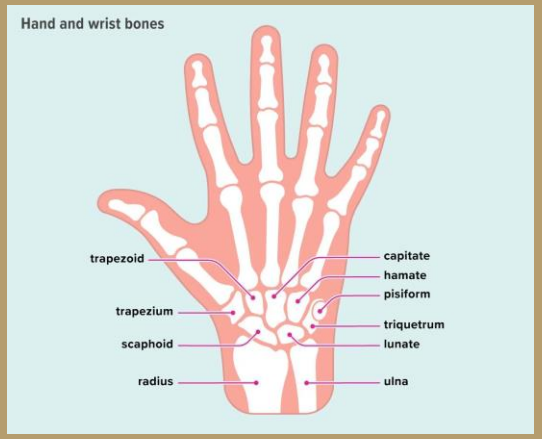


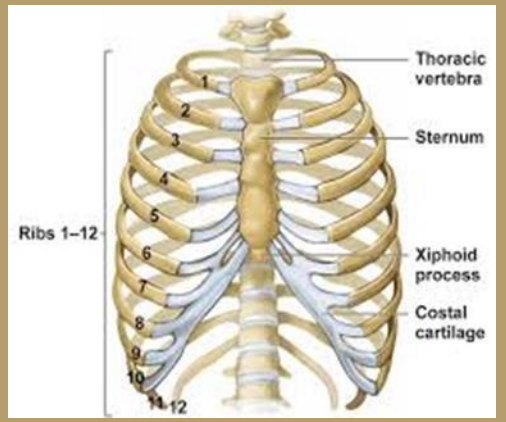






MUSCULOSKELETAL GROUPS WITHOUT CHANGES

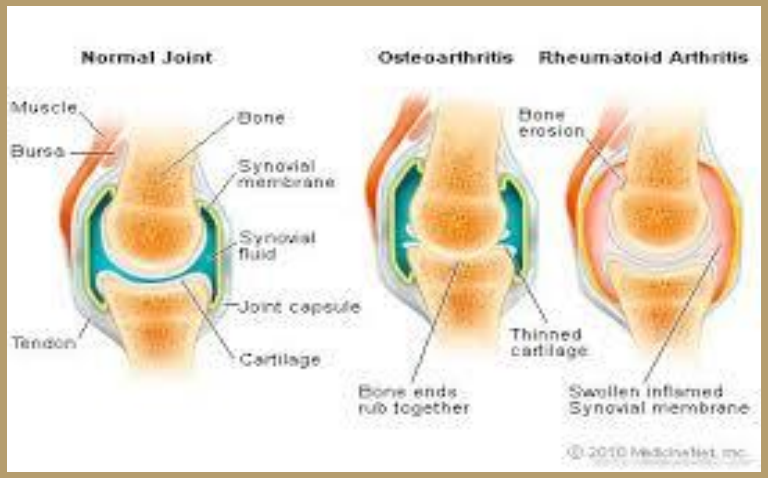




MUSCULOSKELETAL GROUPS WITHOUT CHANGES

- Elbow and Forearm (5205-5213)
- Wrist (5214-5215)
- Ankylosis or limitation of motion of single or multiple digits of the hand (5216-5230)
- Shortening of the Lower Extremity (5275)
- Skull (5296)
- Ribs (5297)
- Coccyx (5298)

ACUTE, SUBACUTE, OR CHRONIC DISEASES



ACUTE, SUBACUTE, OR CHRONIC DISEASES

- DCs in this category:
  - 5000-5025

- DCs with no changes
  - 5000 (Osteomyelitis)
  - 5004 – 5008 (Arthritis)
  - 5025 (Fibromyalgia)

ACUTE, SUBACUTE, OR CHRONIC DISEASES

- DCs with changes:
  - 5001
  - 5002
  - 5003
  - 5009-5017
  - 5019
  - 5021
  - 5023-5024

- DCs that have been deleted
  - DC 5018 (Hydrarthrosis, Intermittent)
  - DC 5020 (Synovitis)
  - DC 5022 (Periostitis)

DC 5001
BONES AND JOINTS, TUBERCULOSIS OF, ACTIVE OR INACTIVE

OLD RATING CRITERIA

- Active 100
- Inactive: See §§ 4.88b and 4.89

NEW RATING CRITERIA

- Active 100
- Inactive: See §§ *4.88c* and 4.89

- **Nonsubstantive!**
- **For inactive disease, directs raters to criteria for rating "inactive nonpulmonary tuberculosis" (§ 4.88c), rather than criteria for "infectious diseases/immune disorders/nutritional deficiencies" (§ 4.88b)**
  - **Residuals rated under the body system(s) affected**
- **Overdue correction—4.88b was redesignated as 4.88c in 1994, but VA never changed reference in DC 5001**

DC 5002

OLD RATING CRITERIA:

Arthritis Rheumatoid (Atrophic), as an active process

With constitutional manifestations associated with active joint involvement, totally incapacitating

100

Less than criteria for 100% but with weight loss and anemia productive of severe impairment of health or severely incapacitating exacerbations occurring 4 or more times a year or a lesser number over prolonged periods

60

NEW RATING CRITERIA:

Multi-joint Arthritis (except post-traumatic and gout), 2 or more joints, as an active process

With constitutional manifestations associated with active joint involvement, totally incapacitating

100

Less than criteria for 100% but with weight loss and anemia productive of severe impairment of health or severely incapacitating exacerbations occurring 4 or more times a year or a lesser number over prolonged periods

60

DC 5002

Symptom combinations productive of definite impairment of health objectively supported by examination findings or incapacitating exacerbations occurring 3 or more times a year **40**

One or two exacerbations a year in a well-established diagnosis **20**

Symptom combinations productive of definite impairment of health objectively supported by examination findings or incapacitating exacerbations occurring 3 or more times a year **40**

One or two exacerbations a year in a well-established diagnosis **20**

DC 5002

For residuals such as limitation of motion or ankylosis, favorable or unfavorable, rate under the appropriate diagnostic codes for the specific joints involved. Where, however, the limitation of motion of the specific joint or joints involved is noncompensable under the codes a rating of 10 percent is for application for each such major joint or group of minor joints affected by limitation of motion, to be combined, not added under diagnostic code 5002. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion.

Note: The ratings for the active process will not be combined with the residual ratings for limitation of motion or ankylosis. Assign the higher evaluation.

Note (1): Examples of conditions rated using this diagnostic code include, but are not limited to, rheumatoid arthritis, psoriatic arthritis, and spondyloarthropathies.

Note (2): For chronic residuals, rate under diagnostic code 5003.

Note (3): The ratings for the active process will not be combined with the residual ratings for limitation of motion, ankylosis, or diagnostic code 5003. Instead, assign the higher evaluation.

DC 5002 CHANGES

- Purpose: to include a greater number of systemic arthritis processes that cause multisystem effects besides rheumatoid arthritis
- Name changed to: "Multi-joint Arthritis (except post-traumatic and gout), 2 or more joints, as an active process"
- Rating of residuals addressed in note 2, and to be rated under DC 5003
  - Prior language was similar to DC 5003
- Note 1 explains it applies to rheumatoid arthritis AND other types of arthritis (except post-traumatic and gout)
- Prior note is now essentially note 3

DC 5003

OLD RATING CRITERIA:

Arthritis, degenerative (hypertrophic or osteoarthritis)

NEW RATING CRITERIA:

Degenerative arthritis, other than post-traumatic

- **Nonsubstantive**
- **Renamed "degenerative arthritis, other than post-traumatic" to reflect current medical practice / nomenclature**

DC 5009

OLD RATING CRITERIA:

Arthritis, other types (specify)

With the types of arthritis, diagnostic codes 5004 through 5009, rate the disability as rheumatoid arthritis (5002)

NEW RATING CRITERIA:

Other specified forms of arthropathy (excluding gout)

Note (1): Other specified forms of arthropathy include, but are not limited to, Charcot neuropathic, hypertrophic, crystalline, and other autoimmune arthropathies.

Note (2): With the types of arthritis, diagnostic codes 5004 through 5009, rate the acute phase under diagnostic code 5002; rate any chronic residuals under diagnostic code 5003.

DC 5009 CHANGES

- Purpose: to capture other disease processes that cause joint injury, but are not captured within the rating schedule
- Nomenclature change to "Other Specified Forms Of Arthropathy (Excluding Gout)"
- Note 1 provides a non-exhaustive list of conditions that should be rated under this DC
- Note 2 essentially reflects prior rating criteria

DC 5010

OLD RATING CRITERIA:

Arthritis, due to trauma, substantiated by X-ray findings

- Rate as arthritis, degenerative

NEW RATING CRITERIA:

Post-Traumatic Arthritis

Rate as limitation of motion, dislocation, or other specified instability under the affected joint. If there are 2 or more joints affected, each rating shall be combined in accordance with § 4.25.

DC 5010 CHANGES

- **Name changed to distinguish between joint conditions arising from traumatic causes and those resulting from systemic processes**
  - Natural history and severity of disability differs between joint conditions stemming from these different causes
- **Criteria changed to give more accurate approach to rating joint injuries resulting from trauma**
  - Trauma a different event for each affected joint vs. systemic arthritis which affects joints the same way
  - Clarifies that ratings for separate joints combined under combined rating table
  - Disability no longer rated under DC 5003

DC 5011

OLD RATING CRITERIA:

Bones, caisson disease of

Rate as arthritis, cord involvement, or deafness, depending on the severity of disabling manifestations.

NEW RATING CRITERIA:

Decompression Illness

Rate manifestations under the appropriate diagnostic code within the affected body system, such as arthritis for musculoskeletal residuals; auditory system for vestibular residuals; respiratory system for pulmonary barotrauma residuals; and neurologic system for cerebrovascular accident residuals.

DC 5011 CHANGES

- **Name changed to "decompression illness" to reflect current terminology**
- **Criteria changed to provide more detailed instructions for rating non-arthritic manifestations, the most common of which are:**
  - **Vestibule-cochlear system**
    - hearing impairment, dizziness, vertigo
  - **Respiratory system**
    - obstructive lung disease, pulmonary blebs
  - **Neurologic system**
    - peripheral neuropathy, stroke, paralysis

FEDERAL REGISTER COMMENT AND RESPONSE

- **One commenter asked how DC 5011 would help evaluate a case of facial fractures, hearing loss, a collapsed sinus, eye injury, etc.**
  - VA noted that DC 5011 doesn't provide specific evaluation criteria; rather, it is a standalone DC to track decompression illness (AKA generalized barotrauma / the bends)
  - Residuals often involve other body systems; the criteria directs claims processors to evaluate residuals under the appropriate body system
  - Specific residuals will be evaluated under the most appropriate DC in accordance with the findings and disability present

DC 5012

OLD RATING CRITERIA:

Bones, new growths of, malignant

Note: The 100 percent rating will be continued for 1 year following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. At this point, if there has been no local recurrence or metastases, the rating will be made on residuals.

NEW RATING CRITERIA:

Bones, neoplasm, malignant, primary or secondary

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

DC 5012 CHANGES

- Changes nonsubstantive
- Name changed to
  - Reflect current medical term for new growth – "neoplasm"
  - Ensure consistent and accurate evaluation of both primary *and secondary* neoplasms
- In note, addition of word "prescribed" before "therapeutic procedures" done to ensure that VA will only consider medically-directed therapy from someone licensed / qualified to prescribe treatment for malignancies

DCs 5013-5024

- DCs 5013-5024 are grouped together
  - Do not have individual rating criteria, but share a note
- There are 3 changes for this group of DCs
  - Deletion of DCs
  - Name changes
  - Change to the note

DCs 5013-5024 CHANGES

- **Removed DCs:**
  - 5018 (Hydroarthrosis, intermittent)
    - Sign of other disease found on physical exam
    - Underlying disease rated under own DC
  - 5020 (Synovitis)
    - Sign of other disease found on physical exam
    - Underlying disease rated under own DC
  - 5022 (Periostitis)
    - Nonspecific inflammatory process due to a number of diagnoses
    - Evaluation conducted under the primary diagnosis

DCs 5013-5024 CHANGES

- **Name changes:**

DC	OLD NAME	NEW NAME
5013	Osteoporosis, with Joint manifestations	Osteoporosis, residuals of
5014	Osteomalacia	Osteomalacia, residuals of

- **Reasons:**
  - Diseases themselves don't have disabling characteristics
  - VA rates *residuals* of these diseases, which ARE disabling

DCs 5013-5024 CHANGES

- **Name changes:**

DC	OLD NAME	NEW NAME
5015	Bones, new growths of, benign	Bones, neoplasms, benign

- **Reason:**
  - Reflects current medical term for new growth – "neoplasm"

DCs 5013-5024 CHANGES

- **Name changes:**

DC	OLD NAME	NEW NAME
5023	Myositis ossificans	Heterotopic ossification

- **Reason:**
  - Reflects current medical terminology

DCs 5013-5024 CHANGES

- **Name changes:**

DC	OLD NAME	NEW NAME
5024	Tenosynovitis	Tenosynovitis, tendinitis, tendinosis, or tendinopathy

- **Reasons:**
  - Newly-added conditions commonly seen in Vets and represent similar forms of disability
  - Assists VA raters in quickly identifying appropriate DC

DCs 5013-5024 CHANGES

Change to Note:

OLD RATING CRITERIA

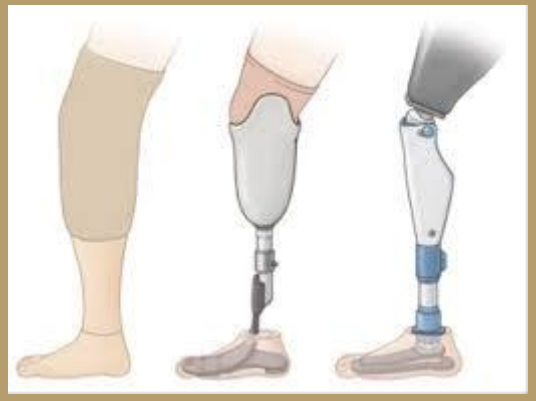
The diseases under diagnostic codes 5013 through 5024 will be rated on limitation of motion of affected parts, as arthritis, degenerative, except gout which will be rated under diagnostic code 5002.

NEW RATING CRITERIA

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

- **Removes limitation that gout only be evaluated under DC 5002**
  - Unnecessary due to changes to DC 5002
  - Now all conditions rated under DC 5003

PROSTHETIC IMPLANTS *& RESURFACING*



PROSTHETIC IMPLANTS

- DCs in this category:
  - 5051-5056
  - 5104-5111
- DCs with no changes:
  - 5051-5053 (Shoulder, elbow, and wrist replacement (prosthesis))
  - 5056 (Ankle replacement (prosthesis))
  - 5104-5111 (Combination of disabilities)
- DCs with changes:
  - Section name changed
  - Notes
  - 5054
  - 5055

OVERALL CHANGES

1. **Section name updated to add "and Resurfacing"**
   - Medical community has been employing joint resurfacing as a new treatment for some joints, particularly hip and knee
   - Similarities between joint resurfacing and prosthetic replacement
     - Take about the same time to perform
     - Recovery/rehab periods similar
   - Differences between joint resurfacing and prosthetic replacement
     - Resurfacing preserves more of the original anatomy
     - In most cases, resurfacing restores more of the original joint function
     - Less residual disability typically results from resurfacing

OVERALL CHANGES

1. **Section name updated to add "and Resurfacing" (cont.)**
   - Before change, VA did not compensate for disability associated with resurfacing, despite the similar impact on earning capacity as prosthetic replacement
   - VA revised DCs 5054 (hip replacement) and 5055 (knee replacement) to incorporate resurfacing
2. **Introductory notes added**
   - Some notes new
   - Other notes within prior section moved

INTRODUCTORY NOTES

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Note (1): When an evaluation is assigned for joint resurfacing or the prosthetic replacement of a joint under diagnostic codes 5051-5056, an additional rating under § 4.71a may not also be assigned for that joint, unless otherwise directed.

- Clarifies current practice and ensures consistent application by raters

Note (2): Only evaluate a revision procedure in the same manner as the original procedure under diagnostic codes 5051-5056 if all the original components are replaced.

Note (3): The term "prosthetic replacement" in diagnostic codes 5051-5053 and 5055-5056 means a total replacement of the named joint. However, in DC 5054, "prosthetic replacement" means a total replacement of the head of the femur or of the acetabulum.

INTRODUCTORY NOTES

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Note (4): The 100 percent rating for 1 year following implantation of prosthesis will commence after initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.

Note (5): The 100 percent rating for 4 months following implantation of prosthesis or resurfacing under DCs 5054 and 5055 will commence after the initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.

Note (6): Special monthly compensation is assignable during the 100 percent rating period the earliest date permanent use of crutches is established.

DC 5054

OLD RATING CRITERIA:

Hip replacement (prosthesis)

Prosthetic replacement of the head of the femur or of the acetabulum:

For 1 year following implantation of the prosthesis **100**

Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches **90**

NEW RATING CRITERIA:

Hip, *resurfacing or* replacement (prosthesis)

For 4 months following implantation of prosthesis *or resurfacing* **100**

Prosthetic replacement of the head of the femur or of the acetabulum:

Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches **90**

DC 5054

OLD RATING CRITERIA:

(continued)

Markedly severe residual weakness, pain or limitation of motion following implantation of prosthesis **70**

Moderately severe residuals of weakness, pain or limitation of motion **50**

Minimum rating **30**

NEW RATING CRITERIA

(continued)

Markedly severe residual weakness, pain or limitation of motion following implantation of prosthesis **70**

Moderately severe residuals of weakness, pain or limitation of motion **50**

Minimum *evaluation, total replacement only* **30**

Note: At the conclusion of the 100 percent evaluation period, evaluate resurfacing under diagnostic codes 5250 through 5255; there is no minimum evaluation for resurfacing.

DC 5054 CHANGES

- **Name change—DC now also contemplates resurfacing**
- **100% convalescence period reduced from 1 yr to 4 mos**
  - **Based on studies showing avg time to return to work 1.1 to 13.9 weeks for hip arthroplasty**
- **Following 100% convalescence period for *resurfacing*, rating based on hip and thigh limitation of motion, malunion, nonunion, etc. under DCs 5250-5255**
  - **Less of an expectation of residual disability with resurfacing**

DC 5055

OLD RATING CRITERIA:
Knee replacement (prosthesis)

Prosthetic replacement of the knee joint:

For 1 year following implantation of the prosthesis **100**

With chronic residuals consisting of severe painful motion or weakness in the affected extremity **60**

NEW RATING CRITERIA:
Knee, *resurfacing or* replacement (prosthesis)

For 4 months following implantation of prosthesis *or resurfacing* **100**

Prosthetic replacement of knee joint:

With chronic residuals consisting of severe painful motion or weakness in the affected extremity **60**

DC 5055

With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5256, 5261, or 5262.

Minimum rating 30

With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5256, 5261, or 5262.

Minimum evaluation, *total replacement only* 30

Note: At the conclusion of the 100 percent evaluation period, evaluate resurfacing under diagnostic codes 5256 through 5262; there is no minimum evaluation for resurfacing.

DC 5055 CHANGES

- Name change—DC now also contemplates resurfacing
- 100% convalescence period reduced from 1 yr to 4 mos
  - Based on studies showing avg time to return to work 8 to 12 weeks for knee arthroplasty
- Following 100% convalescence period for *resurfacing*, rating based on knee limitation of motion, instability, etc. under DCs 5256-5262
  - Less of an expectation of residual disability with resurfacing

FEDERAL REGISTER COMMENTS AND RESPONSES

- **Commenter proposed that the post-convalescence reduction for DCs 5054/5055 occur only after a mandatory exam**
  - VA rejected proposal due to the common nature of these medical procedures as well as the expected outcome and residuals, as supported by medical evidence
  - If Vet has worse than expected residuals or the need for more convalescence, Vet can submit claim (with pertinent treatment records) for increased rating or additional convalescence

FEDERAL REGISTER COMMENTS AND RESPONSES

- **Commenter proposed extending the convalescent period for DCs 5054/5055 whenever a revision procedure is performed**
  - VA stated that while a revision procedure may require additional time in the hospital, this typically amounts to a few days
  - While the recovery may be slower following a revision, VA was unaware of any published medical literature that quantifies this recovery in a manner sufficient to identify a unique and/or extended period of convalescence for purposes of the rating schedule

AMPUTATIONS: UPPER EXTREMITY

AMPUTATIONS: UPPER EXTREMITY

- DCs in this category:
  - 5120-5122 (Arm amputation)
  - 5123-5125 (Forearm amputation)
  - 5126-5151 (Multiple finger amputations)
  - 5152-5156 (Single finger amputations
- DCs with no changes:
  - 5121-5156
- DC with a change:
  - 5120

DC 5120
ARM, AMPUTATION OF

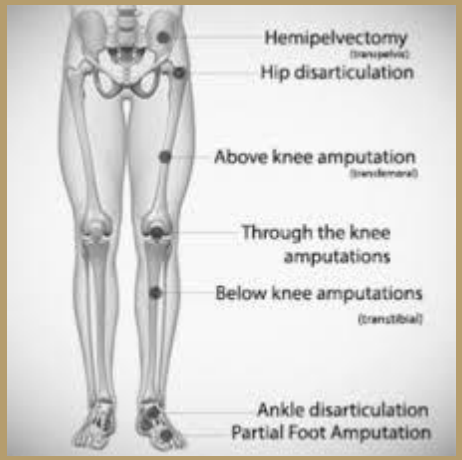
OLD RATING CRITERIA	
Disarticulation	
Disarticulation	90

NEW RATING CRITERIA	
Complete Amputation, Upper Extremity	
Forequarter amputation (involving complete removal of the humerus along with any portion of the scapula, clavicle, and/or ribs)	100
Disarticulation (involving complete removal of the humerus only)	90

DC 5120 CHANGES

- **Name changed to "complete amputation, upper extremity"**
  - More accurate description of the amputation level and site
- **Added a higher level of disability (100%)**
  - VA believed higher level of compensation warranted for forequarter amputation because it is a more extensive amputation than disarticulation and causes a more significant occupational impact

AMPUTATIONS: LOWER EXTREMITY



AMPUTATIONS: LOWER EXTREMITY

- DCs in this category:
  - 5160-5173
- DCs with no changes:
  - 5161 – 5167 (Amputation of thigh to amputation of foot)
  - 5171-5173 (Amputation of toes)
- DCs with changes:
  - 5160
  - 5170

DC 5160
THIGH, AMPUTATION OF

OLD RATING CRITERIA

Disarticulation, with loss of extrinsic pelvic girdle muscles **90**

NEW RATING CRITERIA

Complete amputation, lower extremity

Trans-pelvic amputation (involving complete removal of the femur and intrinsic pelvic musculature along with any portion of the pelvic bones) **100**

Disarticulation (involving complete removal of the femur and intrinsic pelvic musculature only) **90**

Note: Separately evaluate residuals involving other body systems (e.g., bowel impairment, bladder impairment) under the appropriate diagnostic code.

DC 5160 CHANGES

- **Name changed to "complete amputation, lower extremity"**
  - More accurate description of the amputation level and site
- **Added a higher level of disability (100%)**
  - VA believed higher level of compensation warranted for trans-pelvic amputation because it is a more extensive amputation than disarticulation and causes a more significant occupational impact
- **Note added to direct VA raters to separately evaluate residuals involving other body systems**

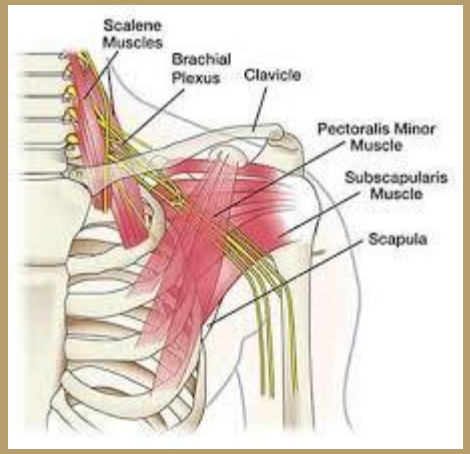
DC 5170

OLD RATING CRITERIA		NEW RATING CRITERIA	
Toes, all, amputation of, without metatarsal loss	30	Toes, all, amputation of, without metatarsal loss *or transmetatarsal, amputation of, with up to half of metatarsal loss*	30

Reasons:

- **These amputation levels cause similar disability and impairment of earning capacity**
- **Grouping them provides more efficient and timely delivery of benefits**

THE SHOULDER AND ARM



THE SHOULDER AND ARM

- DCs in this category:
  - 5200-5203
- DCs with no changes:
  - 5200 (Scapulohumeral articulation, ankylosis of)
  - 5203 (Clavicle or scapula, impairment of)
- DCs with changes:
  - 5201
  - 5202

DC 5201: ARM, LIMITATION OF MOTION OF

OLD RATING CRITERIA	Major/Minor
To 25° from side	40/30
Midway between side and shoulder level	30/20
At shoulder level	20/20

NEW RATING CRITERIA	Major/Minor
Flexion and/or abduction limited to 25° from side	40/30
Midway between side and shoulder level *(flexion and/or abduction limited to 45°)*	30/20
At shoulder level *(flexion and/or abduction limited to 90°)*	20/20

DC 5201 CHANGES

- **Changes meant to clarify, rather than alter, rating criteria**
  - Provides ROMs in terms of degrees to ensure VA raters consistently apply criteria
  - Clarifies that limitation of either flexion (lifting in front) or abduction (lifting from side) to listed degree will entitle Vet to rating

DC 5202: HUMERUS, OTHER IMPAIRMENT OF

OLD RATING CRITERIA	Major/Minor	NEW RATING CRITERIA	Major/Minor
Loss of head of (flail shoulder)	80/70	Loss of head of (flail shoulder)	80/70
Nonunion of (false flail joint)	60/50	Nonunion of (false flail joint)	60/50
Fibrous union of	50 40	Fibrous union of	50/40

DC 5202: HUMERUS, OTHER IMPAIRMENT OF

OLD RATING CRITERIA	Major/Minor
Recurrent dislocation of at scapulohumeral joint:	
With frequent episodes and guarding of all arm movements	30/20
With infrequent episodes, and guarding of movement only at shoulder level	20/20

NEW RATING CRITERIA	Major/Minor
Recurrent dislocation of at scapulohumeral joint:	
With frequent episodes and guarding of all arm movements	30/20
With infrequent episodes, and guarding of movement only at shoulder level *(flexion and/or abduction at 90 degrees)*	20/20

DC 5202: HUMERUS, OTHER IMPAIRMENT OF

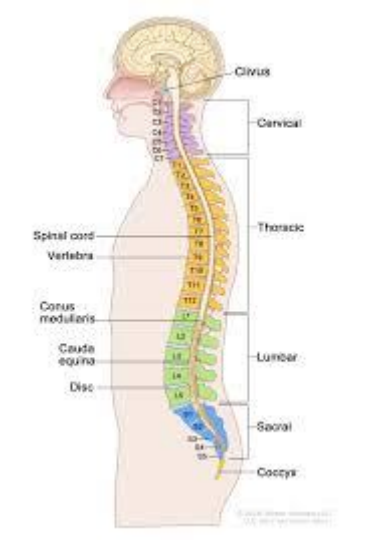
OLD RATING CRITERIA	Major/Minor
Malunion of:	
Marked Deformity	30/20
Moderate Deformity	20/20

NEW RATING CRITERIA	Major/Minor
Malunion of:	
Marked Deformity	30/20
Moderate Deformity	20/20

DC 5202 CHANGE

- **Change meant to clarify, rather than alter, rating criteria**
  - Provides ROM that qualifies as "shoulder level" in terms of degrees to ensure VA raters consistently apply criteria

THE SPINE



THE SPINE

- DCs in this category:
  - 5235-5243
- DCs with no changes:
  - 5235-5241 (Vertebral fracture or dislocation to spinal fusion)
- DCs with changes:
  - 5242
  - 5243
- New DC:
  - 5244

DC 5242

OLD NAME

Degenerative arthritis of the spine (see also diagnostic code 5003)

NEW NAME:

Degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome (also, see either DC 5003 or 5010)

DC 5242 CHANGES

- **Name changed to "degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome"**
  - Gives VA raters clear guidance when they encounter a imaging report that references DDD without mention of IVDS (also known as disc herniation)
- **Refers raters to DC 5010 (post-traumatic arthritis), in addition to DC 5003 (degenerative arthritis), as alternative means to rate**
  - Non-substantive

DC 5243: INTERVERTEBRAL DISC SYNDROME

OLD NAME	NEW INSTRUCTION ADDED
Intervertebral disc syndrome	Intervertebral disc syndrome: *Assign this diagnostic code only when there is disc herniation with compression and/or irritation of the adjacent nerve root; assign diagnostic code 5242 for all other diagnoses.*

DC 5243 CHANGES

- **Clarifies that use of DC 5243 is limited to when there is disc herniation with compression and/or irritation of the adjacent nerve root**
  - **Any other disc diagnoses should be rated under DC 5242**

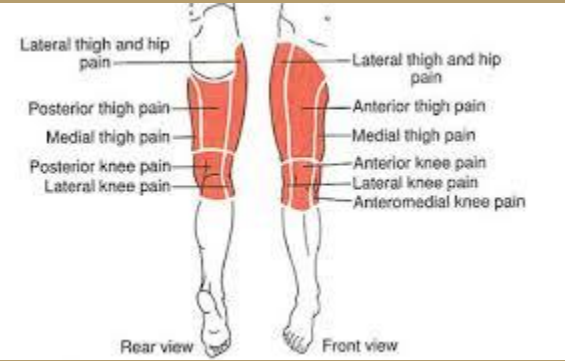
DC 5244

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

DC 5244

- Added because rating schedule previously didn't provide instructions for rating complete traumatic paralysis, but disability was not uncommon among Vets
- Directs ratings under DC 5110 (paraplegia) or both DC 5109 and 5110 (quadriplegia)
  - 5110 Loss of use of both feet: 100% + SMC
  - 5109 Loss of use of both hands: 100% + SMC
- Does not require impairment of anal and bladder sphincter control for paraplegia rating (only for SMC(o) based on paraplegia)

THE HIP AND THIGH



THE HIP AND THIGH

- **DCs in this category:**
  - 5250-5255
- **DCs with no changes:**
  - 5250-5254 (Hip ankylosis, LOM and impairment of thigh, hip flail joint)
- **DC with change:**
  - 5255

DC 5255: FEMUR, IMPAIRMENT OF

OLD RATING CRITERIA		NEW RATING CRITERIA	
Fracture of shaft or anatomical neck of:		Fracture of shaft or anatomical neck of:	
With nonunion, with loose motion (spiral or oblique fracture)	80	With nonunion, with loose motion (spiral or oblique fracture)	80
With nonunion, without loose motion, weightbearing preserved with aid of brace	60	With nonunion, without loose motion, weightbearing preserved with aid of brace	60
Fracture of surgical neck of, with false joint	60	Fracture of surgical neck of, with false joint	60

DC 5255: FEMUR, IMPAIRMENT OF

OLD RATING CRITERIA	
Malunion of:	
With marked knee or hip disability	30
With moderate knee or hip disability	20
With slight knee or hip disability	10

NEW RATING CRITERIA

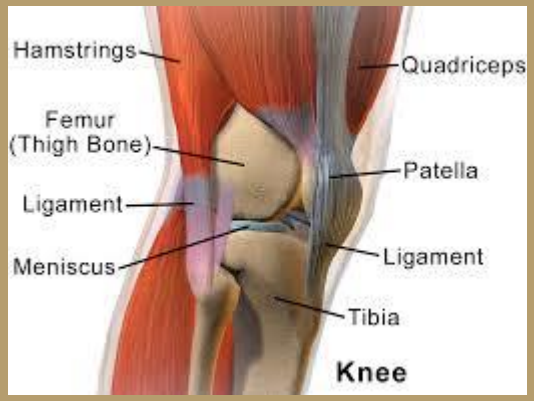
Malunion of:

Evaluate under diagnostic codes 5256, 5257, 5260, or 5261 for the knee, or 5250-5254 for the hip, whichever results in the highest evaluation.

DC 5255 CHANGES

- **Criteria for evaluating malunion of the femur changed**
  - **Old criteria were subjective and terminology vague, resulting in inconsistent ratings**
  - **DCs under which malunion now rated have objective criteria based on limitation of motion, instability, and other factors**
  - **Change meant to ensure VA raters consistently evaluate this disability**

THE KNEE AND LEG



THE KNEE AND LEG

- **DCs in this category:**
  - 5256-5263
- **DCs with no changes:**
  - 5256 (Knee, Ankylosis of)
  - 5258-5261 (Meniscus and LOM)
  - 5263 (Genu Recurvatum)
- **DCs with changes:**
  - 5257
  - 5262

DC 5257: KNEE, OTHER IMPAIRMENT OF

OLD RATING CRITERIA		NEW RATING CRITERIA	
Recurrent subluxation or lateral instability:		Recurrent subluxation or *instability:*	
Severe	30	*Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes both an assistive device (e.g., cane(s), crutch(es), walker) and bracing for ambulation*	30

DC 5257: KNEE, OTHER IMPAIRMENT OF

OLD RATING CRITERIA		NEW RATING CRITERIA	
Recurrent subluxation or lateral instability:		Recurrent subluxation or *instability:*	
		One of the following:	20
Moderate	20	a) *Sprain, incomplete ligament tear, or repaired complete ligament tear causing persistent instability, and a medical provider prescribes a brace and/or assistive device (e.g., cane(s), crutch(es), walker) for ambulation*	
		b) *Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes either an assistive device (e.g., cane(s), crutch(es), or a walker) or bracing for ambulation*	

DC 5257: KNEE, OTHER IMPAIRMENT OF

OLD RATING CRITERIA		NEW RATING CRITERIA	
Recurrent subluxation or lateral instability:		Recurrent subluxation or *instability*:	
Slight	10	*Sprain, incomplete ligament tear, or complete ligament tear (repaired, unrepaired, or failed repair) causing persistent instability, without a prescription from a medical provider for an assistive device (e.g., cane(s), crutch(es), walker) or bracing for ambulation*	10

DC 5257: KNEE, OTHER IMPAIRMENT OF

- **Patellar instability:**
  - A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription by a medical provider for a brace and either a cane or walker **30**
  - A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription by a medical provider for one of the following: a brace, cane, or walker **20**
  - A diagnosed condition involving the patellofemoral complex with recurrent instability (with or without history of surgical repair) that does not require a prescription from a medical provider for a brace, cane, or walker **10**

DC 5257: KNEE, OTHER IMPAIRMENT OF

- Note (1): For patellar instability, the patellofemoral complex consists of the quadriceps tendon, the patella, and the patellar tendon.

- Note (2): A surgical procedure that does not involve repair of one or more patellofemoral components that contribute to the underlying instability shall not qualify as surgical repair for patellar instability (including, but not limited to, arthroscopy to remove loose bodies and joint aspiration).

DC 5257 CHANGES

- "Lateral" removed from before "instability," so that DC covers other forms of knee instability or laxity
  - Reflects VA practice of rating any instability or laxity under this DC
- Patellar instability given its own criteria
- Note(2) specifies what constitutes surgical repair of patellar instability
  - Must involve actual anatomical structure repair
  - Excludes procedures not designed to repair instability or subluxation

DC 5257 CHANGES

- **Criteria:**
  - Incorporate functional loss elements
    - **Assistive devices, bracing**
  - Incorporate diagnostic elements
    - **Sprain, incomplete ligament tear, complete ligament tear**
  - Reflect current medical standards and, according to VA, serve as accurate proxies for functional loss of the magnitude that negatively impacts earnings
  - Are easily observed and measured

DC 5257 CHANGES

- **Reasons for changes**
  - Old criteria subjective and terminology vague, resulting in VA assigning inconsistent ratings
  - Severity of functional impairment can generally be determined by
    - **Presence or absence of anatomic abnormalities (damage to patellofemoral ligament complex, flake fractures, etc.), and**
    - **Whether conservative treatment prevents recurrent instability**

FEDERAL REGISTER COMMENTS AND RESPONSES

- **Commenter stated that the criteria for DC 5257 should include assistive devices and/or bracing whether prescribed by a provider or not**
  - VA stated that the requirement for provider-prescribed bracing, brace, and other assistive devices are commonly and readily available for purchase without prescription and the use of these devices without prescription does not always demonstrate the presence of a knee disability impairing earning capacity
  - A qualified medical professional's prescription, however, provides objective evidence of instability

DC 5262: TIBIA AND FIBULA, IMPAIRMENT OF

OLD RATING CRITERIA		NEW RATING CRITERIA	
Nonunion of, with loose motion, requiring brace	40	Nonunion of, with loose motion, requiring brace	40
Malunion of:		Malunion of:	
With marked knee or ankle disability	30	*Evaluate under diagnostic codes 5256, 5257, 5260, or 5261 for the knee, or 5270 or 5271 for the ankle, whichever results in the highest evaluation*	
With moderate knee or ankle disability	20		
With slight knee or ankle disability	10		

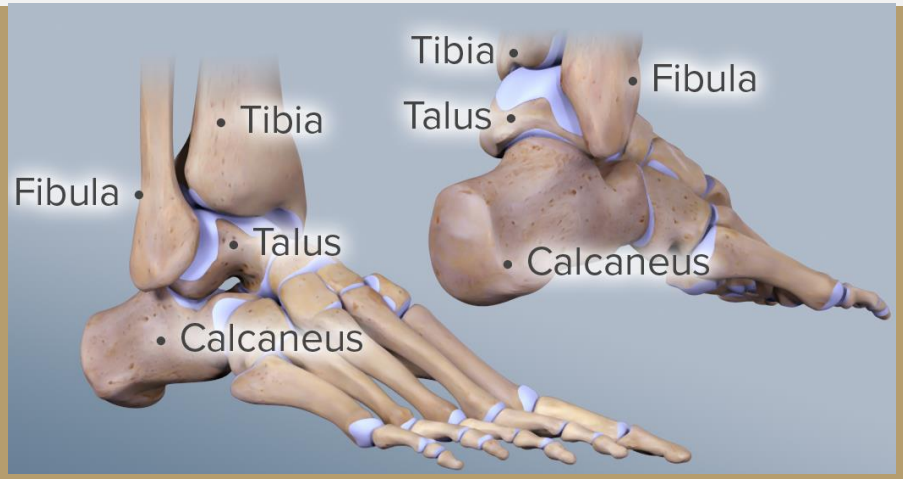
DC 5262: TIBIA AND FIBULA, IMPAIRMENT OF

- Medial tibial stress syndrome (MTSS) or shin splints:
  - Requiring treatment for no less than 12 consecutive months, and unresponsive to surgery and either shoe orthotics or other conservative treatment, both lower extremities — 30
  - Requiring treatment for no less than 12 consecutive months, and unresponsive to surgery and either shoe orthotics or other conservative treatment, one lower extremity — 20
  - Requiring treatment for no less than 12 consecutive months, and unresponsive to either shoe orthotics or other conservative treatment, one or both lower extremities — 10
  - Treatment less than 12 consecutive months, one or both lower extremities — 0

DC 5262 CHANGES

- **Malunion of tibia and fibula now rated under certain DCs for knee or ankle that have objective criteria**
  - Old criteria subjective and terminology vague, which resulted in inconsistent ratings
- **Updated to cover MTSS/shin splints**
  - Condition commonly claimed by Vets, but for which no DC specifically covered in past

THE ANKLE



THE ANKLE

- DCs in this category:
  - 5270-5274
- DCs with no changes:
  - 5270 (Ankle ankylosis)
  - 5272 (Subastragalar or tarsal joint ankylosis)
  - 5273 (Os calcis or astragalus malunion)
  - 5274 (Astragalectomy)
- DC with changes:
  - 5271

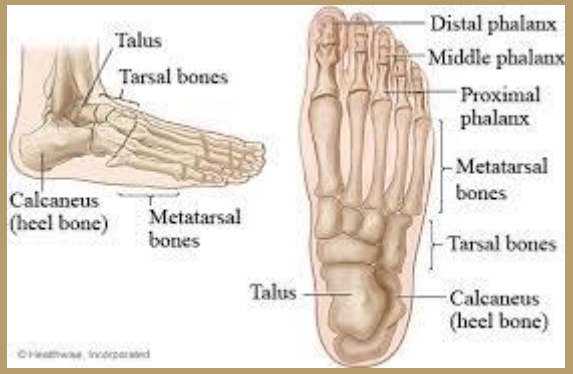
DC 5271: LIMITED MOTION OF THE ANKLE

OLD RATING CRITERIA		NEW RATING CRITERIA	
Marked	20	Marked *(less than 5 degrees dorsiflexion or less than 10 degrees plantar flexion)*	20
Moderate	10	Moderate *(less than 15 degrees dorsiflexion or less than 30 degrees plantar flexion)*	10

DC 5271 CHANGES

- Marked and moderate limitation of motion objectively defined to ensure consistent application of criteria by VA raters
  - Old criteria subjective and terminology vague, resulting in VA assigning inconsistent ratings
- Same standards were previously provided in Manual M21-1, so this change is simply clarification of prior VA policy

THE FOOT



THE FOOT

- **DCs in this category:**
  - 5269, 5276-5284
- **DCs with no changes:**
  - 5276-5284 (flatfoot, weak foot, claw foot, metatarsalgia, hallux valgus, hallux rigidus, hammer toe, malunion or nonunion of tarsal or metatarsal bones, other foot injuries)
- **New DC:**
  - 5269 – Plantar fasciitis

DC 5269 PLANTAR FASCIITIS

- 5269 Plantar fasciitis
  - No relief from both non-surgical and surgical treatment, bilateral 30
  - No relief from both non-surgical and surgical treatment, unilateral 20
  - Otherwise, unilateral or bilateral 10

- Note (1): With actual loss of use of the foot, rate 40 percent.
- Note (2): If a veteran has been recommended for surgical intervention, but is not a surgical candidate, evaluate under the 20 percent or 30 percent criteria, whichever is applicable.

DC 5269

- **Reasons for adding DC 5269:**
  - Disability common in Vets
  - Plantar fasciitis and its functional effects are very well defined
    - Characterized by heel pain due to inflammation
    - 90% of cases resolve with non-surgical treatment
    - Those who respond to treatment usually have no more than slight functional limitation, and that limitation is typically related to the treatment rather than the disability
- **Evaluation based on combination of extent of disability (bilateral vs. unilateral) and response to treatment**

MUSCLE INJURIES
38 C.F.R. § 4.73

MUSCLE INJURIES

- DCs in this category:
  - 5301-5331
- DCs with no changes:
  - 5301-5329 (shoulder girdle and arm, forearm and hand, foot and leg, pelvic girdle and thigh, torso and neck, miscellaneous)
- New DCs:
  - 5330
  - 5331
- Other change:
  - Note added to § 4.73 prior to DCs

PRELIMINARY NOTES

OLD NOTE

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

NEW NOTES

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

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

PRELIMINARY NOTES CHANGES

- Section 4.56 provides objective criteria for determining whether a muscle disability is slight, moderate, moderately severe, or severe
- Section 4.56 references DCs 5301 to 5323
- Before change, Section 4.73 did not cross-reference Section 4.56 or define levels of severity
- Will help ensure VA raters consider Section 4.56 when rating muscle injuries

RHABDOMYOLYSIS

- **A condition in which muscle tissue breaks down rapidly and releases muscle cell content into the blood, which can cause organ damage, particularly to the kidney**
  - *See* Centers for Disease Control and Prevention, *Rhabdomyolysis*, https://www.cdc.gov/niosh/topics/rhabdo/what.html
- **Addition of DC eliminates the need for analogous rating**

DC 5330

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

COMPARTMENT SYNDROME

- **A condition in which there is increased pressure within a group of muscles covered by a thin but firm membrane called a fascia, which causes the muscles to not get enough blood and die.**
  - *See* Cleveland Clinic, *Compartment Syndrome*, https://my.clevelandclinic.org/health/diseases/15315-compartment-syndrome
- **Addition of DC provides clear instructions for VA raters and eliminates the need for analogous rating**

DC 5331

- **5331 Compartment syndrome**
  - Rate each affected muscle group separately and combine in accordance with § 4.25.

QUESTIONS