No. 20-1321

United States Court of Appeals for the Federal Circuit

NATIONAL ORGANIZATION OF VETERANS' ADVOCATES, INC.; PETER CIANCHETTA; MICHAEL REGIS; ANDREW TANGEN,

Petitioners,

v.

ROBERT L. WILKIE, SECRETARY OF VETERANS AFFAIRS,

Respondent.

AMENDED PETITION FOR REVIEW

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I. INTRODUCTION

Petitioners the National Organization of Veterans' Advocates, Inc. (NOVA), Peter Cianchetta, Michael Regis, and Andrew Tangen hereby petition this Court pursuant to 38 U.S.C. § 502 and Federal Circuit Rule 15(f) to review three final rules adopted by the Department of Veterans Affairs (VA). First, Petitioners challenge VA created the first final rule when it added what is now Section III.iv.4.A.6.a of the Adjudication Procedures Manual M21-1 (Manual), entitled "Evaluations for Knee Replacement." That final rule—referred to here as the "Knee Replacement Rule"— was promulgated on November 21, 2016 and is attached as Exhibit A.[1] Second, Petitioners challenge *Agency Interpretation of Prosthetic Replacement of a Joint*, 80 Fed. Reg. 42,040 (July 16, 2015), referred to here as the "2015 Knee Replacement Guidance" and attached as Exhibit B. Third, Petitioners challenge Section III.iv.4.A.6.d of the Manual, entitled "Handling Joint Stability Findings." That final rule—referred to here as the "Knee Joint Stability Rule"—was promulgated on April 13, 2018 and is attached as Exhibit C.

[1] The current Section III.iv.4.A.6.a was added to the Manual as Section III.iv.4.A.3.e. It became Section III.iv.4.A.6.a on April 13, 2018.

II. JURISDICTION

This Court has jurisdiction over this petition for review pursuant to 38 U.S.C. § 502. Section 502 provides this Court with exclusive jurisdiction to review direct challenges to actions taken by the VA "to which section 552(a)(1) or 553 of title 5 (or both) refers." *Id.*; *see, e.g.*, *Military Order of the Purple Heart of the USA v. Sec'y of Veterans Affairs*, 580 F.3d 1293, 1296 (Fed. Cir. 2009). The final rules at issue here fall within the scope of that jurisdictional grant because they qualify as both (1) "substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency," 5 U.S.C. § 552(a)(1)(D), and (2) "interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice," *id.* § 553(b)(3)(A). In addition, the 2015 Knee Replacement Guidance qualifies as an "amendment[]" to 38 C.F.R. § 4.71a—a VA regulation covered by 5 U.S.C. § 552(a)(1)(D)—under 5 U.S.C. § 552(a)(1)(E).

The Knee Replacement Rule, the 2015 Knee Replacement Guidance, and the Knee Joint Stability Rule qualify as interpretive rules for purposes of Section 502 and its cross-references noted above, because

they interpret statutes, regulations, and/or judicial decisions. *See, e.g.*, *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 96-97 (2015); *Procopio v. Sec'y of Veterans Affairs*, 943 F.3d 1376, 1380 (Fed. Cir. 2019); James T. O'Reilly, *Administrative Rulemaking* § 3:26 (2020 ed., Westlaw). For that reason, Petitioners' challenges to the Knee Replacement Rule and the Knee Joint Stability Rule implicate *Disabled American Veterans v. Secretary of Veterans Affairs* (*DAV*), 859 F.3d 1072, 1075-78 (Fed. Cir. 2017), where this Court held that it lacks Section 502 jurisdiction to review VA interpretive rules if VA chooses to promulgate such rules through publication in the Manual.

Petitioners believe the *DAV* jurisdictional ruling is mistaken, largely for the reasons set forth by the petitioner in *Gray v. Wilkie*, 139 S. Ct. 2764 (2019).[2] NOVA has accordingly filed, and this Court has

[2] In *Gray*, this Court applied *DAV* to reject the petitioner's challenge to a revision to the Manual implementing the Agent Orange Act and VA regulations. *See Gray v. Sec'y of Veterans Affairs*, 875 F.3d 1102, 1105, 1108 (Fed. Cir. 2017) (applying *DAV* and dismissing for lack of jurisdiction). After this Court denied Gray's petition for rehearing over three dissents, *see Gray v. Sec'y of Veterans Affairs*, 884 F.3d 1379, 1382 (Fed. Cir. 2018) (Dyk, J., joined by Newman and Wallach, JJ., dissenting from the denial of rehearing en banc), the Supreme Court granted his subsequent petition for certiorari asking the Court to overturn *DAV*'s jurisdictional holding, *Gray v. Wilkie*, 139 S. Ct. 451 (2018). After the

granted, a petition for initial hearing en banc under Federal Rule of Appellate Procedure 35 and Federal Circuit Rule 35 asking this Court to overrule *DAV* and confirm that Section 502 authorizes challenges to Manual revisions such as those at issue here. Mr. Cianchetta, Mr. Regis, and Mr. Tangen adopt and fully join NOVA's existing briefing and argument.

III. TIMELINESS

This petition for review is timely under 28 U.S.C. § 2401(a), which establishes a six-year statute of limitations governing "every civil action" brought against the United States. *See Preminger v. Sec'y of Veterans Affairs* (*Preminger I*), 517 F.3d 1299, 1307 (Fed. Cir. 2008) (holding that Section 2401(a)'s statute of limitations governs challenges to VA agency action under Section 502). As noted, the Knee Replacement Rule was promulgated on November 21, 2016; the 2015 Knee Replacement

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petitioner and the Government filed their opening merits briefs, however, the case was dismissed as moot because the underlying Manual revision being challenged was effectively deemed unlawful by this Court's en banc ruling in *Procopio v. Wilkie*, 913 F.3d 1371 (Fed. Cir. 2019). The Supreme Court subsequently granted the petitioner's request to vacate this Court's *Gray* decision under *United States v. Munsingwear, Inc.*, 340 U.S. 36 (1950). *See Gray*, 139 S. Ct. at 2764.

Guidance was promulgated on July 16, 2015; and the Knee Joint Stability Rule was promulgated on April 13, 2018.

This case is not timely under Federal Circuit Rule 15(f)(1), which requires that "[a] petition for judicial review of an action of the Secretary of the Department of Veterans Affairs under 38 U.S.C. § 502 must be filed with the clerk of court within sixty (60) days after issuance of the action challenged in the petition."[3] But Rule 15(f)(1)'s 60-day limitations period impermissibly conflicts with the six-year statute of limitations made applicable to Section 502 civil actions by Section 2401(a). *See Preminger I*, 517 F.3d at 1307. This Court has noted—but never resolved—the conflict between the deadlines set forth in Rule 15(f)(1) and Section 2401(a). *See Brown v. Sec'y of Veterans Affairs*, 124 F.3d 227, 1997 WL 488930, at *2 (Fed. Cir. 1997) (unpublished). And the Court has regularly applied both time limits in different cases. *See, e.g.*, *Preminger I*, 517 F.3d at 1307-08 (applying Section 2401(a)'s six-year statute of limitations); *Preminger v. Sec'y of Veterans Affairs* (*Preminger II*), 632

[3] Effective July 1, 2020, the Court's 60-day limitations period was moved to Federal Circuit Rule 15(f)(1) from its previous placement in Federal Circuit Rule 47.12(a).

F.3d 1345, 1352-53 (Fed. Cir. 2011) (applying the Court's 60-day limitations period).

Petitioners believe Rule 15(f)(1)'s 60-day limitations period is invalid because it conflicts with Section 2401(a)'s six-year statute of limitations. *See* 28 U.S.C. § 2071(a) (providing that local rules promulgated by the federal courts "shall be consistent with Acts of Congress"); *see also Willy v. Coastal Corp.*, 503 U.S. 131, 135 (1992) ("[F]ederal courts, in adopting rules, [are] not free to extend or restrict the jurisdiction conferred by a statute."); *cf.* 28 U.S.C. § 2072(a). The Court has granted NOVA's request that the en banc Court resolve the conflict. ECF No. 50 at 3. Again, Mr. Cianchetta, Mr. Regis, and Mr. Tangen adopt and fully join NOVA's existing briefing and argument.

IV. PARTIES ADVERSELY AFFECTED

Petitioners are adversely affected by the challenged rules. Evidence of their standing, in the form of sworn declarations, has been submitted to the Court in connection with NOVA's supplemental briefing, ECF No. 89.

A. NOVA

NOVA is adversely affected by the final rules and has standing to bring this challenge. To establish associational standing, an association must demonstrate that "(a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Disabled Am. Veterans v. Gober* (*Gober*), 234 F.3d 682, 689 (Fed. Cir. 2000) (quoting *Hunt v. Wash. State Apple Advert. Comm'n*, 432 U.S. 333, 343 (1977)). Petitioner satisfies all three requirements, for essentially the same reasons this Court expressly held that NOVA had standing in *Gober*. NOVA has further explained why it has standing in its supplemental briefing to the Court. *See* ECF Nos. 89 and 96; *see also* Rauber Decl. (ECF No. 89).

First, many of NOVA's members would themselves have standing. Many of NOVA's members are veterans, and those members "are personally affected by the [Knee Replacement Rule and Knee Joint Stability Rule] for the same reason that members of the [other veterans' organizations] are personally affected by the rules"—they will be directly

harmed when they bring their own claims for benefits. *Gober*, 234 F.3d at 689; *see* NOVA Supp. Br. 3, 5, 7-12 (ECF No. 89).

Second, this petition for review is germane to NOVA's purpose. NOVA is a not-for-profit national organization of attorneys and other qualified members who act as advocates for disabled veterans. As this Court has recognized, NOVA's "purpose" is to provide "'representation for all persons seeking benefits through the federal veteran's benefits system, and in particular those seeking judicial review of denials of veterans' benefits.'" 234 F.3d at 689 (citation omitted); *see Mission Statement*, Nat'l Org. of Veterans' Advocates, Inc., https://www.vetadvocates.org/cpages/mission-statement-2 (last visited October 15, 2020). The adverse impact of these final rules looms large for veterans represented by NOVA who are seeking VA benefits, including veterans who are among NOVA's members. *See Gober*, 234 F.3d at 689-90; *see* NOVA Supp. Br. 4, 12-13 (ECF No. 89).

Third, the challenges to the final rules do not require the participation of NOVA's individual members. This petition for review presents a pure question of law: whether VA's promulgation of each rule was legally valid under the standards set forth in the Administrative

Procedure Act (APA). The resolution of that question does not require any individualized proof. *See Hunt*, 432 U.S. at 344; *E. Paralyzed Veterans Ass'n, Inc. v. Sec'y of Veterans Affairs*, 257 F.3d 1352, 1356 (Fed. Cir. 2001); NOVA Supp. Br. 13 (ECF No. 89).

B. Peter Cianchetta

Mr. Cianchetta is a member of NOVA. Cianchetta Decl. ¶ 2 (ECF No. 89). He sustained an injury to his right knee while serving in the Air Force. *Id.* ¶ 4. He has since undergone multiple knee surgeries. *Id.* ¶ 5. As a result of his knee injuries and those surgeries, Mr. Cianchetta was advised in November 2018 that he needed a partial knee replacement. *Id.* In October 2019, he was referred and scheduled to have that surgery in April 2020, but the surgery was ultimately delayed until September 2020 in part because of the COVID-19 pandemic. *Id.* ¶¶ 5-6.

On September 16, 2020, Mr. Cianchetta filed a claim seeking benefits for a knee replacement under DC 5055. *Id.* ¶ 7. Yet, under VA's interpretation of DC 5055 embodied in the Knee Replacement Rule (and, before that, in the 2015 Knee Replacement Guidance), he is "categorically exclude[d]" from receiving those benefits because he received only a *partial* knee replacement. *Id.* ¶ 8. Thus, absent that interpretation, Mr.

Cianchetta would "be able to obtain a disability rating under DC 5055 for [his] partial knee replacement." *Id.* ¶ 9.

C. Michael Regis

Mr. Regis is a member of NOVA. Regis Decl. ¶ 2 (ECF No. 89). He injured both of his knees while serving in the Air Force. *Id.* ¶ 4. In 2016, he was diagnosed with knee instability in both knees. *Id.* ¶ 5. In February 2020, the Board of Veterans' Appeals remanded Mr. Regis's claim to the VA regional office. *Id.* ¶ 6. The claim is currently pending and seeks (among other things) knee instability ratings under DC 5257—which is governed by the Knee Joint Stability Rule—for both knees. *Id.* ¶ 7. If the Knee Joint Stability Rule—which "is prone to measurement errors and undercompensates veterans . . . for the actual, functional loss [they] have suffered"—is deemed invalid, Mr. Regis "will directly benefit" because he will more likely to obtain separate and more favorable knee disability ratings under DC 5257. *Id.* ¶¶ 8-9.

D. Andrew Tangen

Mr. Tangen is a member of NOVA. Tangen Decl. ¶ 2 (ECF No. 89). He injured both of his knees while serving in the Navy in Afghanistan, conducting small boat operations in support of Counter Piracy, and

boarding ships in a non-compliant setting in support of Counter Piracy and Counter Narcotics Operations. *Id.* ¶¶ 3-4. He has been receiving disability benefits for instability in both knees under DC 5257, which is governed by the Knee Joint Stability Rule, since at least September 21, 2018. *Id.* ¶ 5. If the Knee Joint Stability Rule—which "prescribes a restrictive framework for VA regional office adjudicators to use in assigning disability ratings under DC 5257 based on measurements of joint translation"—is invalidated, Mr. Tangen "will be able to seek and obtain a more favorable disability rating under DC 5257." *Id.* ¶¶ 5-6.

V. FINAL RULES THAT REQUIRE THIS COURT'S REVIEW

Petitioners petition for review of three final rules promulgated by VA addressing disability benefits for knee disabilities. The Knee Replacement Rule added what is now Manual § III.iv.4.A.6.a, which addresses the treatment of partial knee replacements under Diagnostic Code (DC) 5055. *See* 38 C.F.R. § 4.71a. The 2015 Knee Replacement Guidance, published at 80 Fed. Reg. 42,040, also addresses the treatment of partial knee replacements under DC 5055. The Knee Joint Stability Rule added Manual § III.iv.4.A.6.d, which addresses the rating schedule for knee instability under DC 5257. *See id.*

The final rules make it more difficult for veterans with knee disabilities to obtain the benefits to which they are entitled under law. The final rules limit the circumstances in which higher disability ratings may be assigned. And because the amount of benefits the VA will award is tied to those ratings, both final rules limit the benefits VA will award disabled veterans. Petitioners hereby ask this Court to set aside the final rules as "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

A. The Knee Replacement Rule and the 2015 Knee Replacement Guidance

The Knee Replacement Rule, Manual § III.iv.4.A.6.a, is unlawful because it denies certain disability ratings to veterans who obtain partial knee replacements, in direct violation of VA regulations and this Court's decision in *Hudgens v. McDonald*, 823 F.3d 630 (Fed. Cir. 2016).

DC 5055 assigns disability ratings for a "[k]nee replacement." 38 C.F.R. § 4.71a. In *Hudgens*, this Court held that DC 5055 covers both full *and* partial knee replacements. 823 F.3d at 639. In doing so, the Court definitively rejected VA's interpretation of DC 5055 to cover only total knee replacements. *Id.* at 637-38. VA had advanced that interpretation in the 2015 Knee Replacement Guidance—an

"interpretive rule" issued while the case was pending. 80 Fed. Reg. at 42,041 . This Court rejected the 2015 Knee Replacement Guidance as a convenient "*post hoc* rationalization" that is inconsistent with (1) DC 5055's text; (2) the pro-veteran canon of construction recognized in *Brown v. Gardner*, 513 U.S. 115, 117-18 (1994); and (3) VA's longstanding interpretation of DC 5055 as applying to both total and partial knee replacements. *Hudgens*, 823 F.3d at 637-39.

Shortly after *Hudgens* was issued, VA defied this Court's ruling by promulgating the Knee Replacement Rule. The Rule explains that its purpose is to address "the court decision in *Hudgens v. McDonald*." Manual § III.iv.4.A.6.a. It indicates that for claims filed before July 16, 2015—the date that the 2015 Knee Replacement Guidance was published—partial knee replacements *are* covered by DC 5055. But despite *Hudgens*, the Rule nonetheless instructs VA adjudicators to apply the 2015 Knee Replacement Guidance to claims filed after that date: "If a claim for evaluation of a partial knee replacement was . . . filed and decided on or after July 16, 2015, . . . [t]hen . . . do not assign an evaluation under 38 C.F.R. 4.71a, DC 5055." Manual § III.iv.4.A.6.a.

The Rule thereby purports to interpret *Hudgens* to apply only to claims filed before VA issued the 2015 Knee Replacement Guidance.

Notably, the Rule does not identify any part of this Court's decision in *Hudgens* as providing that temporal limitation or otherwise allowing VA to apply its flawed interpretation of DC 5055 to claims filed after the 2015 Knee Replacement Guidance. To the contrary, *Hudgens* conclusively interpreted DC 5055 to cover both full *and* partial knee replacements. 823 F.3d at 637 ("[T]he regulation does not expressly state that the only prosthetic implants covered are those for full knee replacements."). That decision addressed—and rejected—the narrower construction VA had promulgated in the 2015 Knee Replacement Guidance. *Id.* at 638-39. *Hudgens* bars VA from applying that Guidance to *any* veteran, regardless of when his or her claim is filed.

Petitioners ask this Court to set aside the Knee Replacement Rule as unlawful for two primary reasons. First, the Rule's interpretation of *Hudgens* as applying only to claims filed before July 16, 2015, is plainly erroneous. Second, the Rule is arbitrary, capricious, and unlawful because—as *Hudgens* itself made clear—it rests on a misinterpretation

of the plain language of DC 5055 and is unduly harsh to disabled veterans.

Petitioners also ask this Court to review the 2015 Knee Replacement Guidance, 80 Fed. Reg. 42,040. The 2015 Knee Replacement Guidance is unlawful for the same reasons expressed by the Court in *Hudgens*.

B. The Knee Joint Stability Rule

The Knee Joint Stability Rule, Manual § III.iv.4.A.6.d, is unlawful because it is prone to measurement errors and undercompensates veterans for the actual, functional loss they have suffered.

DC 5257 assigns different disability ratings to different knee injuries depending on the extent to which the injury hampers the stability of the affected knee. 38 C.F.R. § 4.71a. Specifically, it assigns a 10 percent disability rating for "Slight" instability, a 20 percent disability rating for "Moderate" instability, and a 30 percent disability rating for "Severe" instability. *Id.*

In recent years, VA has concluded that this rating schedule is too vague, subjective, and imprecise. In 2017, it therefore published a notice of proposed rulemaking in the Federal Register stating that it was

planning to issue a "substantive" rule amending DC 5257 to make the schedule more "objective." *Schedule for Rating Disabilities; Musculoskeletal System and Muscle Injuries*, 82 Fed. Reg. 35,719, 35,720, 35,722-23 (proposed Aug. 1, 2017).

VA's proposed "substantive" rule would have replaced the terms "Slight," "Moderate," and "Severe" with specific medical criteria. One of those criteria was the "grade" of knee instability, which would have been assigned on the basis of the measurement of joint translation—that is, the amount of movement that occurs within the joint. *Id.* at 35,723; *see generally* Prashant Komdeur et al., *Dynamic Knee Motion in Anterior Cruciate Impairment: A Report and Case Study*, 15 Baylor U. Med. Ctr. Proc. 257 (July 2002), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1276620/pdf/bumc0015-0257.pdf. Grade 1 instability would have required 0-5 mm of joint translation, grade 2 instability would have required 6-10 mm of joint translation, and grade 3 instability would have required 11 mm or greater of joint translation. 82 Fed. Reg. at 35,723. Along with the other specified medial criteria, the grade of joint instability would have dictated the disability rating assigned.

VA received a dozen comments in response to the proposed rulemaking, almost all of which were unfavorable. As relevant here, multiple commenters complained that the measurement-based schedule for grading knee instability was too subjective, insofar as creates an excessive risk of subjectivity and error because the instability measurement is affected by the amount of pressure applied by the physician. They also complained that the new schedule focused too narrowly on a rigid measurement, and thus would not account for the actual, functional loss suffered by veterans.[4]

VA never formally adopted the proposed rule or responded to the comments it received, and it appears to have essentially abandoned the proposed rulemaking. Instead, VA simply incorporated an adjusted version of the measurement-based grading schedule directly into its Manual, in the form of the Knee Joint Stability Rule. *See* Manual § III.iv.4.A.6.d. Just like the abandoned proposed regulation, the Knee

[4] *See, e.g.*, Paralyzed Veterans of America, Comment Letter on Proposed Rule Schedule for Rating Disabilities; Musculoskeletal System and Muscle Injuries (Oct. 2, 2017), https://www.regulations.gov/document?D=VA-2017-VBA-0016-0014; Jay Kyler, Comment Letter on Proposed Rule Schedule for Rating Disabilities; Musculoskeletal System and Muscle Injuries (Oct. 2, 2017), https://www.regulations.gov/document?D=VA-2017-VBA-0016-0009.

Joint Stability Rule requires VA officials to assign a disability rating for knee instability on the basis of the measurement of joint translation: 0-5 mm of joint translation receives a 10 percent "slight" disability, 5-10 mm of joint translation receives a 20 percent "moderate" disability rating, and 10 mm or greater of joint translation receives a 30 percent "severe" disability rating.

Petitioners petition the Federal Circuit to set aside the Knee Joint Stability Rule as arbitrary, capricious and unlawful. The Rule is subjective, does not account for the functional loss veterans may suffer, and is unduly harsh to disabled veterans. The measurement-based schedule for rating knee instability is subject to error because of how that measurement is taken. Different doctors will apply different levels of pressure, and different veterans with comparable knee instability will therefore receive different disability ratings. Relatedly, the measurement-based schedule for grading knee instability ignores the large number of unmeasurable impairments and limitations that can and often do attend knee instability, some of which were expressly contemplated in the proposed rule itself. *See* 82 Fed. Reg. at 35,723 (contemplating "operative intervention" and whether "ambulation

requires both bracing and an assistive device"). In these and other ways, the Rule undercompensates veteran for their actual losses and impairments.

VI. CONCLUSION

For all of these reasons, Petitioners are adversely affected by the unlawful final rules challenged above, and respectfully petition this Court for review.

Dated: October 16, 2020

Respectfully submitted,

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EXHIBIT A

Key Changes

Changes Included in This Revision

The table below describes the changes included in this revision of Veterans Benefits Manual M21-1, Part III, "General Claims Process," Subpart iv, "General Rating Process."

Notes:

- Unless otherwise noted, the term "claims folder" refers to the official, numbered, Department of Veterans Affairs (VA) repository – whether paper or electronic – for all documentation relating to claims that a Veteran and/or his/her survivors file with VA.
- Minor editorial changes have also been made to
  – add references
  – reassign alphabetical designations to individual blocks, where necessary, to account for new and/or deleted blocks within a topic, and
  – bring the document into conformance with M21-1 standards.

Reason(s) for Notable Change	Citation
To add a new Block e on knee replacements discussing the court decision in *Hudgens v. McDonald*.	M21-1, Part III, Subpart iv, Chapter 4, Section A, Topic 3, Block e (III.iv.4.A.3.e)

Rescissions

None

Authority

By Direction of the Under Secretary for Benefits

Signature

Beth Murphy, Director
Compensation Service

Distribution

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Section A. Musculoskeletal Conditions

Overview

In This Section This section contains the following topics:

Topic	Topic Name
1	Evaluating Joint Conditions, Painful Motion, and Functional Loss
2	Evaluating Musculoskeletal Disabilities of the Upper Extremities
3	Evaluating Musculoskeletal Disabilities of Spine and Lower Extremities
4	Congenital Musculoskeletal Conditions
5	Rheumatoid Arthritis (RA)
6	Degenerative Arthritis
7	Limitation of Motion (LOM) in Arthritis Cases
8	Examples of Rating Decisions for LOM in Arthritis Cases
9	Osteomyelitis
10	Examples of the Proper Rating Procedure for Osteomyelitis
11	Muscle Injuries
12	Miscellaneous Musculoskeletal Considerations

1. Evaluating Joint Conditions, Painful Motion, and Functional Loss

Introduction

This topic contains information on evaluating joint conditions, painful motion, and functional loss, including

- assigning multiple LOM evaluations for a joint
- assigning a noncompensable evaluation when schedular 0-percent criteria are not specified
- considering pain when assigning multiple LOM evaluations for a joint
- example of compensable limitation of two joint motions
- example of compensable limitation of one motion with pain in another motion
- example of noncompensable limitation of two motions with pain
- considering functional loss due to pain when evaluating joint conditions
- establishing the minimum compensable evaluation under 38 CFR 4.59
- assessing medical evidence for functional loss due to pain
- entering *DeLuca* and *Mitchell* data in Evaluation Builder
- example of evaluating a joint with full range of motion (ROM) and functional loss due to pain
- example of evaluating a joint with LOM and functional loss due to pain
- inappropriate situations for using functional loss to evaluate musculoskeletal conditions
- example of evaluating joints with arthritis by x-ray evidence only with other joint(s) affected by non-arthritic condition, and
- definition of
  – major joints
  – minor joints, and
  – minor joint groups.

Change Date

October 27, 2016

a. Assigning Multiple LOM Evaluations for a Joint

In VAOPGCPREC 9-2004 Office of General Counsel (OGC) held that separate evaluations under 38 CFR 4.71a, Diagnostic Code (DC) 5260, (limitation of knee flexion) and 38 CFR 4.71a, DC 5261, (limitation of knee extension) can be assigned without pyramiding. Despite the fact that knee flexion and extension both occur in the same plane of motion, limitation of flexion (bending the knee) and limitation of extension (straightening the knee) represent distinct disabilities.

Important:

- The same principle and handling apply ***only*** to
  – qualifying elbow and forearm movement DCs, flexion (38 CFR 4.71a, DC 5206), extension (38 CFR 4.71a, DC 5207), and impairment of either

supination or pronation (38 CFR 4.71a, DC 5213), and
– qualifying hip movement DCs, extension (38 CFR 4.71a, DC 5251), flexion (38 CFR 4.71a, DC 5252), and abduction, adduction or rotation (38 CFR 4.71a, DC 5253).
- Always ensure that multiple evaluations do not violate the amputation rule in 38 CFR 4.68.

Note: The Federal Circuit has definitively ruled that multiple evaluations for the shoulder under 38 CFR 4.71a, DC 5201, are not permitted. In *Yonek v. Shinseki*, 22 F.3d 1355 (Fed. Cir. 2013) the court held that a Veteran is entitled to a single rating under 38 CFR 4.71a, DC 5201, even though a shoulder disability results in limitation of motion (LOM) in both flexion (raising the arm in front of the body) and abduction (raising the arm away from the side of the body).

References: For more information on
- pyramiding of evaluations, see
  – 38 CFR 4.14, and
  – *Esteban v. Brown*, 6 Vet.App. 259 (1994)
- painful motion in multiple evaluations for joint LOM, see M21-1, Part III, Subpart iv, 4.A.1.c
- assignment of separate evaluations for disabilities of the elbow, forearm, and wrist, see M21-1, Part III, Subpart iv, 4.A.2.c, and
- examples of actual LOM of two knee motions, see M21-1, Part III, Subpart iv, 4.A.1.d.

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b. Assigning a Noncompensable Evaluation When Schedular 0-Percent Criteria Are Not Specified

For those joint motions where the 0-percent evaluation criteria is not defined by regulation, any LOM for that specific movement will be assigned a separate noncompensable disability evaluation. The motions include

- 38 CFR 4.71a, DC 5207, limitation of extension of the elbow
- 38 CFR 4.71a, DC 5213, impairment of supination and pronation of the forearm
- 38 CFR 4.71a, DC 5251, limitation of extension of the hip
- 38 CFR 4.71a, DC 5252, limitation of flexion of the hip, and
- 38 CFR 4.71a, DC 5253, impairment of rotation, adduction, or abduction of the hip.

Example: A Department of Veterans Affairs (VA) examination shows a Veteran has flexion of the hip limited to 60 degrees. 38 CFR 4.71a, DC 5252 does not define the criteria for assignment of a 0-percent disability evaluation. Normal range of motion (ROM) for flexion of the hip is 125 degrees. Since there is limited flexion, but not to the extent that the criteria for the schedular 10-percent evaluation is met, and because there is no defined schedular 0-percent evaluation criteria, a 0-percent evaluation is warranted for limited flexion of the hip under 38 CFR 4.71a, DC 5252.

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c. Considering Pain When Assigning Multiple LOM Evaluations for a Joint

When considering the role of pain in evaluations for multiple motions of a single joint, the following guidelines apply.

- When more than one qualifying joint motion is actually limited to a compensable degree and there is painful but otherwise noncompensable limitation of the complementary movement(s), ***only one compensable evaluation can be assigned***.
  – *Mitchell v. Shinseki*, 25 Vet.App. 32 (2011) reinforced that painful motion is the equivalent of limited motion only based on the specific language and structure of 38 CFR 4.71a, DC 5003, not for the purpose of 38 CFR 4.71a, DC 5260, and 38 CFR 4.71a, 5261. For arthritis, if one motion is actually compensable under its 52XX-series DC, then a 10-percent evaluation under 38 CFR 4.71a, DC 5003, is not available and the complementary motion cannot be treated as limited at the point where it is painful.
  – 38 CFR 4.59 does not permit separate compensable evaluations for each painful joint *motion*. It only provides that VA policy is to recognize actually painful motion as entitled to at least the minimum compensable evaluation for the *joint*.
- When each qualifying joint motion is painful but motion is not actually limited to a compensable degree under its applicable 52XX-series DC, ***only one compensable evaluation can be assigned***.
  – Assigning multiple compensable evaluations for pain is pyramiding.
  – A joint affected by arthritis established by x-ray may be evaluated as 10-percent disabling under 38 CFR 4.71a, DC 5003.
  – For common joint conditions that are not evaluated under the arthritis criteria such as a knee strain or chondromalacia patella, a 10-percent evaluation can be assigned for the joint based on pain on motion under 38 CFR 4.59. Do not apply instructions from Note (1) under 38 CFR 4.71a, DC 5003, for non-arthritic conditions, since the instructions are strictly limited to arthritic conditions. See example in M21-1, Part III, Subpart iv, 4.A.1.n.

References: For more information on

- pyramiding of evaluations, see
  – 38 CFR 4.14, and
  – *Esteban v. Brown*, 6 Vet.App. 259 (1994)
- assigning multiple evaluations for a single joint, see M21-1, Part III, Subpart iv, 4.A.1.a, and
- examples of evaluations for which one or both joint motions are not actually limited to a compensable degree but there is painful motion, see M21-1, Part III, Subpart iv, 4.A.1.e and f.

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d. Example 1: Compensable Limitation of Two Joint

Situation: Evaluation of chronic knee strain with the following examination findings

Motions

- Flexion is limited to 45 degrees.
- Extension is limited by 10 degrees.
- There is no pain on motion.
- There is no additional limitation of flexion or extension on additional repetitions or during flare-ups.

Result: Assign a 10-percent evaluation under 38 CFR 4.71a, DC 5260, and a separate 10-percent evaluation under 38 CFR 4.71a, DC 5261.

Explanation: Each disability (limitation of flexion and limitation of extension) warrants a separate evaluation and the evaluations are for distinct disability.

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e. Example 2: Compensable Limitation of One Motion With Pain in Another Motion

Situation: Evaluation of knee tenosynovitis with the following examination findings

- Flexion is limited to 45 degrees with pain at that point and no additional loss with repetitive motion.
- Extension is full to the 0-degree position, but active extension was limited by pain to 5 degrees.

Result: Assign a 10-percent evaluation under 38 CFR 4.71a, DC 5260 and a noncompensable evaluation under 38 CFR 4.71a, DC 5261.

Explanation:

- Flexion is compensable under 38 CFR 4.71a, DC 5260, but extension remains limited to a noncompensable degree under 38 CFR 4.71a, DC 5261.
- Under *Mitchell v. Shinseki*, 25 Vet.App. 32 (2011), the painful extension could only be considered limited for the purpose of whether a 10-percent evaluation can be assigned for the joint under 38 CFR 4.71a, DC 5003, which is not applicable in this example because a compensable evaluation was already assigned for flexion under 38 CFR 4.71a, DC 5260.
- 38 CFR 4.59 does not support a separate compensable evaluation for painful extension. The regulation states that the intention of the rating schedule is to recognize actually painful joints due to healed injury as entitled to at least the minimum compensable evaluation for the joint, not for each painful movement.
- If the fact pattern involved chondromalacia patella or a knee strain rather than tenosynovitis the result would be the same.

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f. Example 3: Noncompensable Limitation of Two Motions With Pain

Situation: Evaluation of knee arthritis shown on x-ray with the following examination findings.

- Flexion is limited to 135 degrees with pain at that point.
- Extension is full to the 0-degree position with pain at that point.
- There is no additional loss of flexion or extension on repetitive motion.

Result: Assign one 10-percent evaluation for the knee under 38 CFR 4.71a, DC 5003.

Explanation:

- There is limitation of major joint motion to a noncompensable degree under 38 CFR 4.71a, DC 5260, and 38 CFR 4.71a, DC 5261, x-ray evidence of arthritis and satisfactory evidence of painful motion. Painful motion is limited motion for the purpose of applying 38 CFR 4.71a, DC 5003. Therefore, a 10-percent evaluation is warranted for the joint.
- Assigning two compensable evaluations, each for pain, would be pyramiding.
- Neither 38 CFR 4.71a, DC 5003, nor 38 CFR 4.59 permits separate 10-percent evaluations for painful flexion and extension; they provide for a 10-percent evaluation for a joint.
- If the fact pattern involved chondromalacia patella or a knee strain rather than arthritis you would still assign a 10-percent evaluation, not separate evaluations. However, the authority would be 38 CFR 4.59 and you should use 38 CFR 4.71a, DC 5260, rather than 38 CFR 4.71a, DC 5003.

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g. Considering Functional Loss Due to Pain When Evaluating Joint Conditions

Functional loss due to pain is a factor in the evaluation of musculoskeletal conditions under any DC that involves LOM. Consider the following factors when evaluating functional loss due to pain.

Notes:

- Painful motion of a joint is indicative of disability and warrants at least the minimum compensable evaluation for the joint.
  - The pain may be caused by the actual joint, connective tissues, nerves, or muscles.
  - The medical nature of the particular disability determines whether the DC is based on LOM.
  - Pain on palpation is not the same as painful motion of a joint and does not warrant assignment of a compensable evaluation under 38 CFR 4.59 for painful motion. However, pain on palpation of the joint may be considered in determining the evaluation to be assigned for the joint.
- Pain on weight bearing or nonweight-bearing is not the same as painful motion of a joint, and does not warrant assignment of a compensable evaluation under 38 CFR 4.59 for painful motion. Medical evidence must demonstrate actual painful motion to warrant a compensable evaluation under 38 CFR 4.59.
- When pain results in loss of motion of a joint, the joint should be evaluated based on the additional loss of motion.
  - For joint conditions where multiple evaluations are possible due to LOM in different motions, assignment of an additional separate evaluation for LOM due to pain of a joint requires that the limitation must at least meet the level of the minimum schedular evaluation for the affected joint.
  - For painful motion to be the basis for a higher evaluation than the one

based solely on actual LOM, the pain must actually limit motion at the corresponding compensable level.
– When pain results in additional functional loss during flare-ups or upon repeated use over a period of time, evaluate the joint based on the resulting LOM.

References: For more information on
- functional loss, see
  – 38 CFR 4.40
  – *DeLuca v. Brown*, 8 Vet.App. 202 (1995), and
  – *Mitchell v. Shinseki*, 25 Vet.App. 32 (2011)
- disability of the joints, see 38 CFR 4.45
- painful motion, see 38 CFR 4.59, and
- multiple evaluations for musculoskeletal disability, see
  – VAOPGCPREC 9-98, and
  – VAOPGCPREC 9-2004.

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h. Establishing the Minimum Compensable Evaluation Under 38 CFR 4.59

When applying the provisions of 38 CFR 4.59, assign at least the minimum compensable rating for the joint specified *under the appropriate DC* for the joint involved.

Example 1: Assume a shoulder strain with forward elevation and abduction limited to 145 degrees with acceptable evidence of pain while performing each motion, starting at 140 degrees. Assign a 20-percent evaluation under 38 CFR 4.71a, DC 5201. Under 38 CFR 4.59 there is actually painful motion and joint or periarticular pathology (a strain). Therefore the intention of the rating schedule is that the decision maker will assign the minimum compensable evaluation provided under the DC appropriate to the disability at issue. The lowest specified compensable evaluation for shoulder motion under the DC is 20 percent.

Example 2: Assume the same facts as in Example 1, but the diagnosis is traumatic arthritis of the shoulder based on x-rays. Assign a 20-percent evaluation under 38 CFR 4.71a, DC 5010-5201 with application of 38 CFR 4.59. The ROM does not meet the criteria for a 20-percent evaluation under 38 CFR 4.71a, DC 5201 because arm motion is not limited at shoulder height. However, pursuant to 38 CFR 4.59 there is actually painful motion and joint or periarticular pathology (arthritis). Therefore the intention of the rating schedule is that the decision maker will assign the minimum compensable evaluation provided under the DC appropriate to the disability at issue. The lowest specified compensable evaluation for shoulder motion under 38 CFR 4.71a, DC 5201 is 20 percent.

Although the diagnosis was traumatic arthritis, using 38 CFR 4.71a, DC 5010-5201 is more advantageous to the Veteran. However in some cases a 10-percent evaluation under the arthritis criteria may be appropriate. See Example 3.

Example 3: Assume the same facts as in Example 2 except that there was no pain on motion. There was a minor amount of swelling of the shoulder. Assign a 10-percent evaluation under 38 CFR 4.71a, DC 5010. There is x-ray evidence of traumatic arthritis and motion that is noncompensable under the applicable DC. There is no evidence of painful motion so 38 CFR 4.59 is not applicable. Ratings for traumatic arthritis under 38 CFR 4.71a, DC 5010 are rated using the criteria of 38 CFR 4.71a, DC 5003, which requires that LOM be "objectively confirmed" by findings such as swelling, spasm, or satisfactory evidence of painful motion. In this case there was objective evidence supporting the LOM – namely the minor swelling of the shoulder.

Example 4: For a claimant with residuals of right ring finger fracture resulting in painful motion of the ring finger, the appropriate DC for the joint involved would be 38 CFR 4.71a, DC 5230, and as this DC only provides for a noncompensable rating, 38 CFR 4.59 does not entitle a claimant to a compensable rating.

Important: This guidance resulted from the decision in *Sowers v. McDonald*, 27 Vet.App. 472 (2016). Therefore this guidance applies to claims pending on or after May 23, 2016.

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i. Assessing Medical Evidence for Functional Loss Due to Pain

Medical evidence used to evaluate functional impairment due to pain must account for painful motion, pain on use, and pain during flare-ups or with repeated use over a period of time.

As a part of the assessment conducted in accordance with *DeLuca v. Brown*, 8 Vet.App. 202 (1995), the medical evidence must

- clearly indicate the exact degree of movement at which pain limits motion in the affected joint, and
- include the findings of at least three repetitions of ROM.

Per *Mitchell v. Shinseki*, 25 Vet.App. 32 (2011), when pain is associated with movement, an examiner must opine or the medical evidence must show whether pain could significantly limit functional ability

- during flare-ups, or
- when the joint is used repeatedly over a period of time, and
- if there is functional impairment found during flare-ups or with repeated use over a period of time, the examiner must provide, if feasible, the degree of additional LOM due to pain on use or during flare-ups.

Important: If the examiner is unable to provide any of the above findings, he or she must

- indicate that he/she cannot determine, without resort to mere speculation, whether any of these factors cause additional functional loss, and
- provide the rationale for this opinion.

Note: Per *Jones (M.) v. Shinseki*, 23 Vet.App. 382 (2010), the VA may only

accept a medical examiner's conclusion that an opinion would be speculative if

- the examiner has explained the basis for such an opinion, identifying what facts cannot be determined, or
- the basis for the opinion is otherwise apparent in VA's review of the evidence.

Reference: For more information on evaluating functional impairment due to pain, see M21-1, Part III, Subpart iv, 4.A.1.g.

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j. Entering *DeLuca* and *Mitchell* Data in the Evaluation Builder

The findings of De*Luca* repetitive ROM testing or the functional loss expressed in the *Mitchell* opinion will be used to evaluate the functional impairment of a joint due to pain.

- Only the most advantageous finding will be utilized to evaluate the joint condition.
- Do not "add" the LOM on *DeLuca* exam to the LOM expressed in a *Mitchell* opinion.

Note: For purposes of data entry in the Evaluation Builder tool, if evaluating a joint where data fields are present for only initial ROM and for *DeLuca* (but not for *Mitchell*), enter either the *DeLuca* or the *Mitchell* data in the *DeLuca* field, whichever results in the higher disability evaluation.

Examples: For examples of how to evaluate functional loss due to pain, refer to M21-1, Part III, Subpart iv, 4.A.1.k-l.

Reference: For more information on the *Deluca* and *Mitchell* cases, see M21-1, Part III, Subpart iv, 4.A.1.i.

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k. Example of Evaluating a Joint with Full ROM and Functional Loss Due to Pain

Situation: Evaluation of a knee condition with normal initial ROM and additional functional loss indicated on *DeLuca* and *Mitchell* assessments.

- Examination reveals normal ROM for extension of the knee, but pain on motion is present.
- In applying the *DeLuca* repetitive use test, the examiner determines that after repetitive use extension of the knee is additionally limited, and the post-test ROM is to 10 degrees due to pain.
- The examiner provides a *Mitchell* assessment that during flare-ups the extension of the knee would be additionally limited to 15 degrees due to pain.

Result: Assign one 20-percent disability evaluation under 38 CFR 4.71a, DC 5261 for limited extension of the knee.

Explanation: 15-degree limitation of extension, expressed in the *Mitchell* opinion, is the most advantageous assessment of functional loss for extension

of the knee in this scenario. Therefore, the knee will be evaluated based on extension limited to 15 degrees, resulting in a 20-percent evaluation under 38 CFR 4.71a, DC 5261.

Reference: For more information on the *Deluca* and *Mitchell* cases, see M21-1, Part III, Subpart iv, 4.A.1.i.

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l. Example of Evaluating a Joint With LOM and Functional Loss Due to Pain

Situation: Evaluation of a knee condition with limited initial ROM and additional functional loss indicated on *DeLuca* and *Mitchell* assessments.

- Flexion of the knee is limited to 70 degrees with pain on motion during initial examination.
- In applying the *DeLuca* repetitive use test, the examiner determines that after repetitive use flexion of the knee is additionally limited, and the post-test ROM is 50 degrees as a result of pain with repetitive use.
- The examiner provides a *Mitchell* assessment that during flare-ups the estimated ROM for flexion of the knee would be 30 degrees due to pain.

Result: Assign one 20-percent disability evaluation under 38 CFR 4.71a, DC 5260 for limited flexion of the knee.

Explanation: Flexion of the knee would be assessed at 30 degrees, as the ROM estimated in the *Mitchell* assessment is the most advantageous representation of the Veteran's limitation of flexion.

Reference: For more information on the *Deluca* and *Mitchell* cases, see M21-1, Part III, Subpart iv, 4.A.1.i.

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m. Inappropriate Situations for Using Functional Loss to Evaluate Musculoskeletal Conditions

Functional loss as discussed in 38 CFR 4.40, 38 CFR 4.45, and 38 CFR 4.59 is not used to evaluate musculoskeletal conditions that do not involve ROM findings.

Example: An evaluation under 38 CFR 4.71a, DC 5257 for lateral knee instability does not involve ROM findings. Therefore, the functional loss provisions are inapplicable.

A finding of crepitus/joint crepitation alone is not sufficient to assign a compensable evaluation for a joint under 38 CFR 4.59.

The regulation alludes to crepitus (a clinical sign of a crackling or grating feeling or sound in a joint) as indicative of a point of contact that is diseased but crepitus is not synonymous with painful motion, which is required for the application of 38 CFR 4.59.

Reference: For additional information on the historical application of 38 CFR 4.40, and 38 CFR 4.45 to evaluations for intervertebral disc syndrome **(**IVDS), refer to VAOPGCPREC 36-1997.

n. Example of Evaluating Joints with Arthritis by X-Ray Evidence Only with Other Joint(s) Affected by Non-arthritic Condition

Example: Veteran is rated 10 percent for bilateral arthritis of the elbows confirmed by x-ray evidence, without limited or painful motion or incapacitating exacerbations. Veteran subsequently files a claim for service connection (SC) for chondromalacia of the right knee and is awarded a 20-percent evaluation based on VA examination, which revealed limitation of flexion of the right knee to 30 degrees.

Analysis: A 10-percent evaluation for bilateral arthritis of the elbows and a separate 20-percent evaluation for right knee chondromalacia is justified. In this case, the rating does not violate Note (1) under 38 CFR 4.71a, DC 5003, because the knee condition is not an arthritic condition.

Reference: For additional information on ratings not permissible under Note (1) under 38 CFR 4.71a, DC 5003, see M21-1, Part III, Subpart iv, 4.A.8.d.

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o. Definition: Major Joints

The term ***major joint*** means

- a shoulder
- an elbow
- a wrist
- a hip
- a knee, or
- an ankle.

Reference: For more information on major joints, see 38 CFR 4.45(f).

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p. Definition: Minor Joints

The term ***minor joint*** means

- an interphalangeal joint (of the hand or foot)
- a metacarpal joint (hand)
- a metatarsal joint (foot)
- a carpal joint (hand)
- a tarsal joint (foot)
- cervical vertebrae
- dorsal vertebrae
- lumbar vertebrae
- the lumbosacral articulation, or
- a sacroiliac joint.

References: For more information on

- the definition of a minor joint, see 38 CFR 4.45(f)
- the definition of minor joint groups, see M21-1, Part III, Subpart iv, 4.A.1.q
- the joints of the hand see M21-1, Part III, Subpart iv, 4.A.2.f, and
- identifying the digits of the foot, see M21-1, Part III, Subpart iv, 4.A.3.~~o~~p.

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q. Definition: Minor Joint Groups

A ***minor joint group*** means

- multiple involvements of the interphalangeal, metacarpal and carpal joints of the same upper extremity, namely, combinations of
  – distal interphalangeal (DIP) joints
  – proximal interphalangeal (PIP) joints
  – metacarpophalangeal (MCP) joints, and/or
  – carpometacarpal (CMC) joints
- multiple involvements of the interphalangeal, metatarsal and tarsal joints of the same lower extremity, namely, combinations of
  – interphalangeal (IP) joints
  – metatarsophalangeal (MTP) joints, and/or
  – transverse tarsal joints
- the cervical vertebrae
- the dorsal (thoracic) vertebrae
- the lumbar vertebrae or
- the lumbosacral articulation together with both sacroiliac joints.

References: For more information on

- the definition of minor joint groups, see 38 CFR 4.45(f)
- evaluations for LOM, painful motion and arthritis of the fingers, see M21-1, Part III, Subpart iv, 4.A.2.n
- arthritis and pain on motion or use of the toes, see M21-1, Part III, Subpart iv, 4.A.3.~~r~~t and u, and
- arthritis where a compensable evaluation cannot be assigned under another DC, see M21-1, Part III, Subpart iv, 4.A.7.b.

2. Evaluating Musculoskeletal Disabilities of the Upper Extremities

Introduction

This topic contains information on evaluating musculoskeletal disabilities of the upper extremities, including

- considering separate evaluations for disabilities of the shoulder and arm
- example of separate evaluations for disabilities of the shoulder and arm
- assigning separate evaluations for disabilities of the elbow, forearm, and wrist
- example of separate evaluations for multiple disabilities of the elbow, forearm, and wrist
- considering impairment of supination and pronation of the forearm
- identifying digits of the hand
- anatomy of the hand
- anatomical position of the hand and fingers
- range of motion of the index, long, ring, and little fingers
- rating Dupuytren's contracture of the hand
- evaluating amputations of multiple fingers
- evaluating amputations of single fingers
- evaluating ankylosis of one or more fingers, and
- compensable evaluations for LOM, painful motion, and arthritis of the fingers.

Change Date

September 23, 2016

a. Considering Separate Evaluations for Disabilities of the Shoulder and Arm

Separate evaluations may be given for disabilities of the shoulder and arm under 38 CFR 4.71a DCs 5201, 5202, or 5203 if the manifestations represent separate and distinct symptomatology that are neither duplicative nor overlapping.

Reference: For additional information concerning separate and distinct symptomatology, refer to

- 38 CFR 4.14, and
- *Esteban v. Brown*, 6 Vet.App. 259 (1994).

b. Example of Separate Evaluations for Disabilities of the Shoulder and Arm

Situation: A Veteran was involved in an automobile accident that resulted in multiple injuries to the upper extremities. The Veteran sustained the following injuries

- a humeral fracture resulting in restriction of arm motion at shoulder level, and

- a clavicular fracture resulting in malunion of the clavicle.

Result:
- assign a 20-percent evaluation for the impairment of the humerus under 38 CFR 4.71a, DC 5202-5201, and
- assign a separate 10-percent evaluation for malunion of the clavicle under 38 CFR 4.71a, DC 5203.

Notes:
- The hyphenated evaluation DC is assigned under 38 CFR 4.71a, DC 5202-5201 because the humerus impairment affects ROM.
- The separate evaluation for the clavicle disability is warranted because this disability does not affect ROM.

Exception: Multiple evaluations cannot be assigned under 38 CFR 4.71a, DC 5201 for limited flexion and abduction of the shoulder.

Reference: For additional information on evaluating shoulder conditions, see *Yonek v. Shinseki*, 22 F.3d 1355 (Fed. Cir. 2013).

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c. Assigning Separate Evaluations for Disabilities of the Elbow, Forearm, and Wrist

Impairments of the elbow, forearm, and wrist will be assigned separate disability evaluations. The motions of these joints are all viewed as clinically separate and distinct. Assign separate evaluations for impairment under the following DCs.

- elbow flexion under 38 CFR 4.71a, DC 5206
- elbow extension under 38 CFR 4.71a, DC 5207
- forearm supination and pronation under 38 CFR 4.71a, DC 5213, and
- wrist flexion or ankylosis under 38 CFR 4.71a, DC 5214 or 38 CFR 4.71a, DC 5215.

Reference: For additional information on assigning separate evaluations for elbow motion, see M21-1, Part III, Subpart iv. 4.A.1.a.

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d. Example of Separate Evaluations for Disabilities of the Elbow, Forearm, and Wrist

Situation: A Veteran sustained multiple injuries to the right upper extremity in a vehicle rollover accident. The following impairments are due to the service-connected (SC) injuries:

- elbow flexion limited to 90 degrees
- elbow extension limited to 45 degrees
- full ROM on supination and pronation with painful supination, and
- full ROM of the wrist with pain on dorsiflexion.

Result: Assign the following disability evaluations
- 20 percent for limited elbow flexion under 38 CFR 4.71a, DC 5206
- 10 percent for limited elbow extension under 38 CFR 4.71a, DC 5207

- 10 percent for painful forearm supination under 38 CFR 4.71a, DC 5213, and
- 10 percent for painful wrist motion under 38 CFR 4.71a, DC 5215.

Explanation:
- Compensable LOM of elbow flexion and extension is present. Separate evaluations are warranted for elbow flexion and extension.
- Motion of the forearm is separate and distinct from elbow motion. Therefore, a separate evaluation is warranted for painful supination.
- Motion of the wrist is separate and distinct from forearm motion. Therefore, a separate evaluation is warranted for painful motion of the wrist.

Note: If elbow flexion is limited to 100 degrees and elbow extension is limited to 45 degrees, assign a single 20-percent disability evaluation under 38 CFR 4.71a, DC 5208.

References: For more information on
- separate evaluations for motion of a single joint, see
  – VAOPGCPREC 9-2004, and
  – M21-1, Part III, Subpart iv, 4.A.1.a
- separate evaluations for the elbow, forearm, and wrist, see M21-1, Part III, Subpart iv, 4.A.2.c
- evaluating painful motion of a joint, see
  – 38 CFR 4.59, and
  – M21-1, Part III, Subpart iv, 4.A.1.c, and
- considering impairment of supination and pronation of the forearm, see M21-1, Part III, Subpart iv, 4.A.2.e.

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e. Considering Impairment of Supination and Pronation of the Forearm

When preparing rating decisions involving impairment of supination and pronation of the forearm, consider the following facts:

- Full pronation is the position of the hand flat on a table.
- Full supination is the position of the hand palm up.
- When examining limitation of pronation, the
  – arc is from full supination to full pronation, and
  – middle of the arc is the position of the hand, palm vertical to the table.

Assign the lowest, 20-percent evaluation when pronation cannot be accomplished through more than the first three-quarters of the arc from full supination.

Do *not* assign a compensable evaluation for both limitation of pronation and limitation of supination of the same extremity.

Reference: For more information on painful motion, see
- 38 CFR 4.59, and
- M21-1, Part III, Subpart iv, 4.A.1.c.

f. Identifying Digits of the Hand

Follow the guidelines listed below to accurately specify the injured digits of the hand.

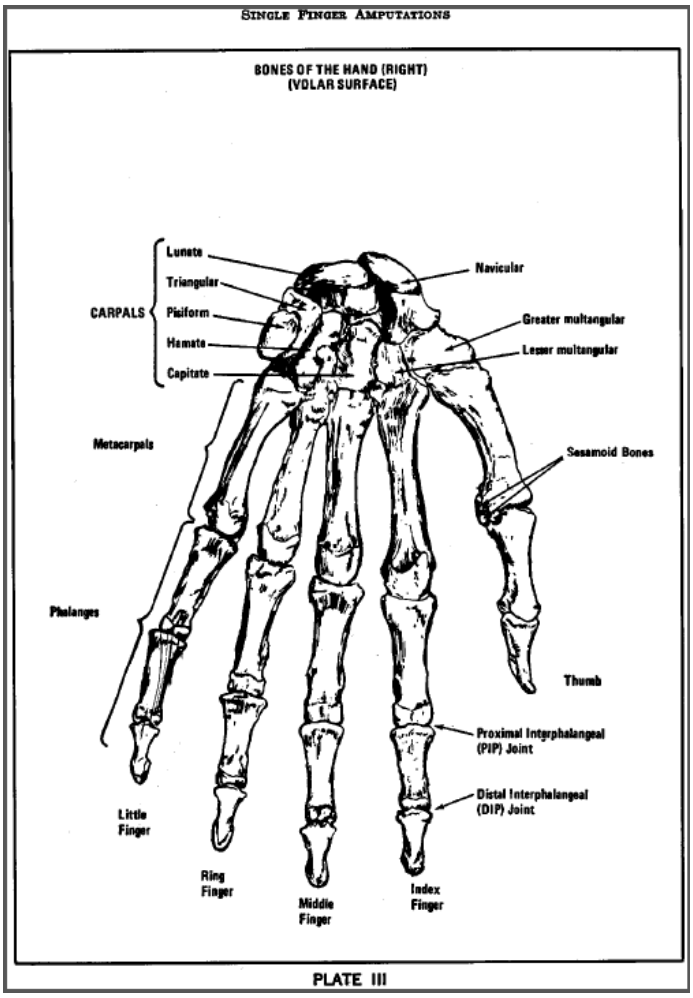
- The digits of the hand are identified as
  – thumb
  – index
  – long
  – ring, or
  – little.
- Do not use numerical designations for either the fingers or the joints of the fingers.
- Each digit, except the thumb, includes three phalanges
  – the proximal phalanx (closest to the wrist)
  – the middle phalanx, and
  – the distal phalanx (closest to the tip of the finger).
- The joint between the proximal and middle phalanges is called the ***proximal interphalangeal*** or ***PIP*** joint.
- The joint between the middle and distal phalanges is called the ***distal interphalangeal*** or ***DIP*** joint.
- The thumb has only two phalanges, the proximal phalanx and the distal phalanx. Therefore, each thumb has only a single joint, called the ***interphalangeal*** or ***IP*** joint.
- The joints connecting the phalanges in the hands to the metacarpals are the ***metacarpophalangeal*** or ***MCP*** joints.
- Designate either right or left for the digits of the hand.

Note: If the location of the injury is unclear, obtain x-rays to clarify the exact point of injury.

References: For
- more information on determining dominant handedness, see 38 CFR 4.69, and
- an exhibit of the anatomy of the hand, see M21-1, Part III, Subpart iv, 4.A.2.g.

g. Anatomy of the Hand

The following image is a reproduction of Plate III following 38 CFR 4.71a, DC 5156. It illustrates the bones of the hand, as well as the PIP and DIP joints.



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h. Anatomical Position of the Hand and Fingers

The normal anatomical position of the hand (called the position of function of the hand in the rating schedule) and fingers is with the

- wrist dorsiflexed 20 to 30 degrees
- MCP and PIP joints flexed to 30 degrees, and
- thumb abducted and rotated so that the thumb pad faces the finger pads.

Reference: For more information on the normal anatomical position of the hand and fingers, see note (1) preceding 38 CFR 4.71a, DC 5216.

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i. Range of Motion of the Index, Long, Ring, and Little

For the index, long, ring, and little fingers, zero degrees of flexion represents the fingers fully extended, making a straight line with the rest of the hand.

For these digits, the

Fingers

- MCP joint has a range of zero to 90 degrees of flexion
- PIP joint has a range of zero to 100 degrees of flexion, and
- DIP joint has a range of zero to 70 or 80 degrees of flexion.

Reference: For more information on the range of motion of the index, long, ring, and little fingers, see note (1) preceding 38 CFR 4.71a, DC 5216.

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j. Rating Dupuytren's Contracture of the Hand

The rating schedule does not specifically list Dupuytren's contracture as a disease entity; therefore, assign an evaluation on the basis of limitation of finger movement.

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k. Evaluating Amputations of Multiple Fingers

The evaluation levels for amputations of multiple fingers are contained in 38 CFR 4.71a, DC 5126 to 5151.

Consider and apply the following principles as applicable when evaluating amputations of multiple fingers:

- Amputations other than at the PIP joints or through the proximal phalanges will be rated as ankylosis of the fingers.
  - Amputations at distal joints, or through distal phalanges (other than negligible losses) will be rated as favorable ankylosis of the fingers.
  - Amputation through middle phalanges will be rated as unfavorable ankylosis of the fingers.
- If there is amputation or resection of metacarpal bones (where more than one-half the bone is lost) in multiple fingers injuries add (not combine) 10 percent to the specified evaluation for the finger amputations subject to the amputation rule (at the forearm level).
- When an evaluation is assigned under 38 CFR 4.71a, DC 5126 to 5130 there will also be entitlement to special monthly compensation.
- Loss of use of the hand exists when no effective function remains other than that which would be equally well served by an amputation stump with a suitable prosthetic appliance.

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l. Evaluating Amputations of Single Fingers

The rating schedule provisions for amputations of single fingers are at 38 CFR 4.71a, DC 5152 to 5156.

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m. Evaluating Ankylosis of One or More Fingers

The rating schedule provisions for ankyloses of one or more fingers are at 38 CFR 4.71a, DC 5216 to 5227.

When considering an evaluation for ankylosis of the index, long, ring or little finger, evaluate as:

- *favorable ankylosis* if ***either*** the MCP ***or*** PIP joint is ankylosed, ***and*** there is

a gap of two inches (5.1 cm.) ***or less*** between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible

- *unfavorable ankylosis* if
  - ***either*** the MCP ***or*** PIP joint is ankylosed, ***and*** there is a gap of ***more than*** two inches (5.1 cm.) between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible, ***or***
  - ***both*** the MCP ***and*** PIP joints of a digit are ankylosed (even if each joint is individually fixed in a favorable position), ***or***
- *amputation without metacarpal resection at the PIP joint or proximal thereto* (38 CFR 4.71a, DC 5153 to 5156) if both the MCP and PIP joints of a digit are ankylosed, *and* either is in extension or full flexion, *or* there is rotation or angulation of a bone.

When considering an evaluation for ankylosis of the thumb, evaluate as:

- *favorable ankylosis* if ***either*** the carpometacarpal ***or*** IP joint is ankylosed, ***and*** there is a gap of two inches (5.1 cm.) ***or less*** between the thumb pad and fingers with the thumb attempting to oppose the fingers
- *unfavorable ankylosis* if
  - ***either*** the carpometacarpal ***or*** IP joint is ankylosed, ***and*** there is a gap of ***more than*** two inches (5.1 cm.) between the thumbpad and the fingers, with the thumb attempting to oppose the fingers, ***or***
  - ***both*** the capometacarpal ***and*** IP joints are ankylosed (even if each joint is individually fixed in a favorable position), ***or***
- *amputation at the carpometacarpal joint or joint or through proximal phalange* (38 CFR 4.71a, DC 5152) if both the carpometacarpal and IP joints are ankylosed, *and* either is in extension or full flexion, *or* there is rotation or angulation of a bone.

Note: Only joints in the position specified in M21-1, Part III, Subpart iv, 4.A.1.h-i are considered in a favorable position.

Reference: For more information on evaluation of ankylosis of the fingers, see the notes prior to 38 CFR 4.71a, DC 5216.

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n. Compensable Evaluations for LOM, Painful Motion and Arthritis of the Fingers

When considering evaluations for the fingers based on LOM or painful motion, a compensable evaluation can be assigned for any of the following:

- LOM of the thumb as specified in 38 CFR 4.71a, DC 5228.
- LOM of the index or long finger as specified in 38 CFR 4.71a, DC 5229.
- X-ray evidence of arthritis or other condition rated under the criteria of 38 CFR 4.71a, DC 5003, affecting a *group* of minor joints of the fingers of *one* hand. There must be
  - noncompensable LOM in more than one of the joints comprising the group of affected minor joints, *and*
  - findings such as swelling, muscle spasm or satisfactory evidence of

painful motion in the affected minor joints of the joint group.

- Painful noncompensable motion of two or three of the fingers listed in the first two bullets above (thumb, index finger, long finger) of the same hand due to joint or periarticular pathology pursuant to 38 CFR 4.59.
- X-ray-*only* evidence of arthritis (where there is no LOM) under the criteria of 38 CFR 4.71a, DC 5003, affecting *two or more groups* of minor joints – namely the fingers of *both* hands or a group of minor joints in one hand in combination with another group of minor joints.

With regard to the third and fourth bullets above

- The Federal Circuit held in *Spicer v. Shinseki*, 752 F.3d 1367 (Fed. Cir. 2014) that the minor joint *group* of IP joints of a hand is compensably disabled *only when two or more* joints in the group are affected by LOM.
- The Court of Appeals for Veterans Claims held in *Sowers v. McDonald*, 27 Vet.App. 472 (2016) that *where the DC does not provide for a compensable evaluation, 38 CFR 4.59 does not require that a compensable evaluation be assigned*.
- Only the thumb, index finger and long finger DCs specify a compensable evaluation. Therefore 38 CFR 4.59 can only potentially apply to those fingers and at least two of the fingers must be involved in order to find that a group of minor joints is affected by noncompensable but painful motion due to joint or periarticular pathology.

References: For more information on

- identifying the digits of the hand and the finger joints, see M21-1, Part III, Subpart iv, 4.A.2.f
- anatomy of the hand, see M21-1, Part III, Subpart iv, 4.A.2.g
- the definition of minor joint, see M21-1, Part III, Subpart iv, 4.A.1.p
- the definition of a group of minor joints, see M21-1, Part III, Subpart iv, 4.A.1.q
- range of motion of the index, long, ring and little fingers, see M21-1, Part III, Subpart iv, 4.A.2.i
- assigning evaluations under 38 CFR 4.71a, DC 5003 when a compensable rating based on LOM cannot be assigned under another DC, see M21-1, Part III, Subpart iv, 4.A.7.b, and
- inability to use 38 CFR 4.59 to establish a minimum compensable evaluation for a fracture of a single ring finger, see M21-1, Part III, Subpart iv, 4.A.1.h.

3. Evaluating Musculoskeletal Disabilities of the Spine and Lower Extremities

Introduction

This topic contains information on evaluating musculoskeletal disabilities of the spine and lower extremities, including

- evaluating manifestations of spine diseases and injuries
- definition of incapacitating episode of IVDS
- example of evaluating IVDS
- evaluating ankylosing spondylitis
- evaluations for knee replacement
- evaluating noncompensable knee conditions
- definition of lateral instability of the knee
- separate evaluations for knee instability and LOM
- separate evaluations – LOM and meniscus disabilities
- separate evaluations, knee instability and meniscus disabilities
- separate evaluations – genu recurvatum
- evaluating shin splint
- moderate and marked LOM of the ankle
- considering ankle instability
- evaluating plantar fasciitis
- identifying the digits of the foot
- definition of metatarsalgia or Morton's disease
- evaluating metatarsalgia or Morton's disease
- pyramiding of metatarsalgia and either plantar fasciitis or pes planus
- evaluating arthritis of the minor joints of the toes
- pain on motion or use of the toes, and
- considering toe injuries under 38 CFR 4.71a, DC 5884.

Change Date

~~September 23, 2016~~November 21, 2016

a. Evaluating Manifestations of Spine Diseases and Injuries

Evaluate diseases and injuries of the spine based on the criteria listed in the 38 CFR 4.71a, General Rating Formula for Diseases and Injuries of the Spine (General Rating Formula). Under this criteria, evaluate conditions based on chronic orthopedic manifestations (for example, painful muscle spasm or LOM) and any associated neurological manifestations (for example, footdrop, muscle atrophy, or sensory loss) by assigning separate evaluations for the orthopedic and neurological manifestations.

Evaluate IVDS under 38 CFR 4.71a, DC 5243, either based on the General Rating Formula or the Formula for Rating IVDS Based on Incapacitating Episodes (Incapacitating Episode Formula), whichever formula results in the higher evaluation when all disabilities are combined under 38 CFR 4.25.

Variations of diagnostic terminology exist for IVDS. When used in the clinical setting, the following terminology is consistent with the general designation of IVDS:

- slipped or herniated disc
- ruptured disc
- prolapsed disc
- bulging or protruded disc
- degenerative disc disease
- sciatica
- discogenic pain syndrome
- herniated nucleus pulposus, and
- pinched nerve.

Notes:

- When an SC thoracolumbar disability is present and objective neurological abnormalities or radiculopathy are diagnosed but the medical evidence does not identify a specific nerve root, rate the lower extremity radiculopathy under the sciatic nerve, 38 CFR 4.124a, DC 8520.
- If an evaluation is assigned based on incapacitating episodes, a separate evaluation may not be assigned for LOM, radiculopathy, or any other associated objective neurological abnormality as it would constitute pyramiding.
- Apply the previous provisions of 38 CFR 3.157 (b) (prior to March 24, 2015) when determining the effective date for neurological abnormalities of the spine that are identified by requisite records prior to March 24, 2015.

Example: Veteran has been SC for degenerative disc disease (DDD) since 2012. Upon review of a claim for increase received on June 2, 2015, it is noted in VA medical records that the Veteran received treatment for bladder impairment secondary to DDD on July 7, 2014. Because the VA medical records constitute a claim for increase under rules in effect prior to March 24, 2015, it is permissible to apply previous rules from 38 CFR 3.157 (b) in adjudicating the bladder impairment issue.

References: For more information on

- assigning disability evaluations for
  - peripheral nerve disabilities to include radiculopathy, see M21-1, Part III, Subpart iv, 4.G.4, and
  - progressive spinal muscular atrophy, see M21-1, Part III, Subpart iv, G.4.1.c, and
- the historic application of 38 CFR 4.71a, DC 5285, for demonstrable deformity of a vertebral body, refer to VAOPGCPREC 03-2006.

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b. Definition: Incapacitating

By definition, an incapacitating episode of IVDS requires bedrest prescribed by a physician.

Episode of IVDS

In order to evaluate IVDS based on incapacitating episodes, there must be evidence the associated symptoms required bedrest as prescribed by a physician. The medical evidence of prescribed bedrest must be

- of record in the claims folder, ***or***
- reviewed and described by an examiner completing a Disability Benefits Questionnaire (DBQ).

Note: If the records do not adequately document prescribed bedrest, use the General Rating Formula to evaluate IVDS and advise the Veteran to submit medical evidence documenting the periods of incapacitating episodes requiring bedrest prescribed by a physician.

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c. Example of Evaluating IVDS

Situation: A Veteran's IVDS is being evaluated.

- LOM warrants a 20-percent evaluation based under the general rating formula
- mild radiculopathy of the left lower extremity warrants a 10-percent evaluation as a neurological complication, and
- medical evidence shows incapacitating episodes requiring bedrest prescribed by a physician of four weeks duration over the past 12 months which would result in a 40-percent evaluation based on the incapacitating episode formula.

Result: Assign a 40-percent evaluation based on incapacitating episodes.

Explanation:

- Evaluating IVDS using incapacitating episodes results in the highest evaluation.
- Since incapacitating episodes are used to evaluate IVDS, the associated LOM and neurological signs and symptoms will not be assigned a separate evaluation.

References: For additional information on

- evaluating spinal conditions, see M21-1, Part III, Subpart iv, 4.A.3.a, and
- determining whether evidence is sufficient to evaluate based on incapacitating episodes of IVDS, see M21-1, Part III, Subpart iv, 4.A.3.b.

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d. Evaluating Ankylosing Spondylitis

Ankylosing spondylitis may be evaluated as an active disease process or based upon LOM of the spine.

The table below describes appropriate action for evaluating ankylosing spondylitis.

If ankylosing spondylitis is ...	Then ...

an active process	evaluate under 38 CFR 4.71a, DC 5009 (using the criteria in 38 CFR 4.71a, DC 5002).
inactive	• evaluate under 38 CFR 4.71a, DC 5240 based on chronic residuals affecting the spine, and • separately evaluate other affected joints or body systems under the appropriate DC.

e. Evaluations for Knee Replacement

Total knee replacements are evaluated under 38 CFR 4.71a, DC 5055.

For guidance on rating action for claims involving partial knee replacement see the table below.

If a claim for evaluation of a partial knee replacement was ...	**Then ...**
filed and decided on or after July 16, 2015	do not assign an evaluation under 38 CFR 4.71a, DC 5055. ***Explanation***: Effective July 16, 2015, 38 CFR 4.71a was revised to clarify in a note that the provisions of 38 CFR 4.71a, DC 5055 apply only to total knee replacement.
• filed before July 16, 2015, and • pending (not finally adjudicated) on that date	the case must be evaluated under 38 CFR 4.71a, DC 5055 if this would be more favorable than another applicable DC. ***Explanation***: This result is required by • *Hudgens v. McDonald*, 823 F.3d 630 (Fed. Cir. 2016), and • M21-1, Part IV, Subpart ii, 2.K.6.
• filed before July 16, 2015, and • finally adjudicated before that date	do not revise the decision as clearly and unmistakably erroneous whether it • assigned an evaluation under 38 CFR 4.71a, DC 5055, or • found that an evaluation could not be assigned under 38 CFR 4.71a, DC 5055. ***Explanation***: The regulation action effective July 16, 2015, explained

	that VA's long standing policy was that partial knee replacements could not be evaluated under 38 CFR 4.71a, DC 5055. However, the Court in *Hudgens v. McDonald*, 823 F.3d 630 (Fed. Cir. 2016) found that prior to the revision the regulation was ambiguous as to whether it covered partial knee replacements and they noted conflicting decisions had been issued.

References: For more information on

- handling requests for separate knee evaluations in cases of total knee replacement, see M21-1, Part III, Subpart iv, 4.A1.g
- evaluations for partial knee replacements, see *Hudgens v. McDonald*, 823 F.3d 630 (Fed. Cir. 2016)
- changes of law, precedential court decisions and claim pendency, see M21-1, Part IV, Subpart ii, 2.K.6
- determining the effective date of a convalescence rating for a joint replacement, see M21-1, Part IV, Subpart ii, 2.J.4.e, and
- rating issues for DCs, such as 38 CFR 4.71a, DC 5055, that provide for definite periods of convalescence, see M21-1, Part IV, Subpart ii, 2.J.5.

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ef. Evaluating Noncompensable Knee Conditions

Evaluate a noncompensable knee condition by analogy to 38 CFR 4.71a, DC 5257 if

- there is no associated arthritis
- the schedular criteria for a noncompensable evaluation under 38 CFR 4.71a, DC 5260 or DC 5261 are not met, *and*
- the condition cannot be appropriately evaluated under 38 CFR 4.71a, DC 5258, 5259, 5262, or 5263.

References: For more information on

- using analogous DCs, see 38 CFR 4.20, and
- when to assign a zero-percent evaluation, see 38 CFR 4.31.

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fg. Definition: Lateral Instability of the Knee

Lateral instability, as referred to in 38 CFR 4.71a, DC 5257 includes evaluations based on posterior or anterior instability.

Note: ***Medial instability*** is a direction of lateral instability, and when present due to SC knee injury, should be evaluated under 38 CFR 4.71a, DC 5257.

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gh. Separate Evaluations for Knee Instability

A separate evaluation for knee instability may be assigned in addition to any evaluation(s) assigned based on limitation of knee motion. OGC has issued

and LOM

Precedent Opinions that an evaluation under 38 CFR 4.71a, DC 5257, does not pyramid with evaluations based on LOM.

Exception: Do not rate instability separately from a total knee replacement.

- The 30-percent and 100-percent evaluations under 38 CFR 4.71a, DC 5055, are minimum and maximum evaluations and, as such, encompass all identifiable residuals post knee replacement – including LOM, instability, and functional impairment.
- The 60-percent and intermediate evaluations by their plain text provide the exclusive methods by which residuals can be evaluated at 40 or 50 percent and contemplate instability.
- Post arthroplasty, there may be instability with weakness (giving way) and pain.
- Note that the only way to obtain an evaluation in excess of 30 percent under 38 CFR 4.71a, DC 5262 (one of the specified bases for an intermediate evaluation under 38 CFR 4.71a, DC 5055) is if there is nonunion with loose motion and need for a brace. This clearly suggests instability is incorporated in the intermediate criteria.

Important: The rating activity must pay close attention to the combined evaluation of the knee disability prior to replacement surgery and to follow all required due process and protected evaluation procedures.

References: For more information on

- pyramiding and separating individual decisions in a rating decision, see M21-1, Part III, Subpart iv, 6.C.5.d
- separate evaluation of knee instability, see
  - VAOPGCPREC 23-97, and
  - VAOPGCPREC 9-98, and
- due process issues pertinent to knee replacements including
  - change of DC for a protected disability evaluation, see
    - 38 CFR 3.951
    - M21-1, Part III, Subpart iv, 8.C.1.k, and
    - M21-1, Part IV, Subpart ii, 2.J.5, and
  - reduction procedures that would apply prior to assignment of a post-surgical minimum evaluation lower than the running award rate, see
    - 38 CFR 3.105(e)
    - M21-1, Part III, Subpart iv, 8.D.1
    - M21-1, Part IV, Subpart ii, 3.A.3, and
    - M21-1, Part IV, Subpart ii, 2.J.

~~h~~i. Separate Evaluations – LOM and Meniscus Disabilities

Do not assign separate evaluations for

- a meniscus disability
  - 38 CFR 4.71a, DC 5258 (dislocated semilunar cartilage), or
  - 38 CFR 4.71a, DC 5259 (symptomatic removal of semilunar cartilage), ***and***

- LOM of the same knee
  – 38 CFR 4.71a, DC 5260, (limitation of flexion) or
  – 38 CFR 4.71a, DC 5261, (limitation of extension).

Explanation: LOM of the knee is contemplated by the meniscus DCs.
- Although 38 CFR 4.71a, DC 5258, refers to "dislocated" cartilage and "locking" of the knee the rating criteria contemplate LOM of the knee through functional impairment with use (namely pain and effusion).
- 38 CFR 4.71a, DC 5259, provides for a compensable evaluation for a "symptomatic" knee post removal of the cartilage. VAOPGCPREC 9-98 states "DC 5259 requires consideration of 38 CFR 4.40 and 38 CFR 4.45 because removal of semilunar cartilage may result in complications producing loss of motion."

~~i~~j. Separate Evaluations, Knee Instability and Meniscus Disabilities

Do not assign separate evaluations for

- subluxation or lateral instability under 38 CFR 4.71a, DC 5257, and
- a meniscus disability
  – 38 CFR 4.71a, DC 5258, or
  – 38 CFR 4.71a, DC 5259

Explanation: The criteria for both of those codes contemplate instability.
- Dislocation and locking under 38 CFR 4.71a, DC 5258 is consistent with instability.
- The broad terminology of "symptomatic" under 38 CFR 4.71a, DC 5259 also contemplates instability.

~~j~~k. Separate Evaluations – Genu Recurvatum

When evaluating genu recurvatum, which involves hyperextension of the knee beyond 0 degrees of extension, under 38 CFR 4.71a, DC 5263

- do *not also* evaluate separately under 38 CFR 4.71a, DC 5261, but
- *do* evaluate separately under other evaluations *if* manifestations that are not overlapping, such as limitation of flexion under 38 CFR 4.71a, DC 5260, are attributed to genu recurvatum, and
- do *not* evaluate separately under 38 CFR 4.71a, DC 5257; however, if instability is manifested from genu recurvatum at the "moderate" or "severe" level, evaluate under 38 CFR 4.71a, DC 5263-5257.

~~k~~l. Evaluating Shin Splints

Evaluate shin splints analogously with 38 CFR 4.71a, DC 5262. The table below explains the process and necessary considerations for evaluating shin splints.

Step	Action
1	Is a chronic disability present?

	• If *yes*, go to Step 2. • If *no*, deny SC.
2	• Determine whether the shin splint disability affects the right, left, or bilateral extremity(ies). • Go to Step 3.
3	• Determine whether shin splints affect the knee or the ankle. • Go to Step 4.
4	Has SC been established for a knee or ankle joint condition affecting the same joint as the shin splints? • If *yes* – grant SC for the shin splints – assign a single evaluation for the symptoms of the shin splint condition with the symptoms caused by the other SC knee or ankle joint condition, and – evaluate the predominant symptoms under the most favorable DC(s) for that joint. ▪ If the shin splints are the predominant disability, go to Step 5. ▪ If the other SC disability of the knee or ankle joint is the predominant disability, evaluate under the criteria for the other SC disability and go to Step 6. • If *no* – award SC for the shin splints under 38 CFR 4.71a, DC 5299-5262, and – go to Step 5. ***Note***: For all awards of SC for shin splints, in the DIAGNOSIS field in the Veterans Benefits Management System-- Rating **(**VBMS-R) indicate • which side (right or left) is affected, and • whether there is knee or ankle involvement. ***Example***: *shin splints, right lower extremity, with ankle impairment*.
5	• Access the Musculoskeletal - Other calculator within VBMS-R • Choose SHIN SPLINTS from diagnosis drop down. • Go to Step 6.
6	• Utilize information from the DBQ and/or other medical evidence of record to determine whether the associated knee or ankle symptoms are mild, moderate, or severe, and • choose the corresponding level of symptoms.

m. Moderate and Marked LOM of the Ankle

Consider the following when evaluating LOM of the ankle under 38 CFR 4.71a, DC 5271:

- An example of moderate limitation of ankle motion is

– less than 15 degrees dorsiflexion, or
– less than 30 degrees plantar flexion.
- An example of marked LOM is
– less than five degrees dorsiflexion, or
– less than 10 degrees plantar flexion.

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mn. Considering Ankle Instability

Do not assign separate evaluations for LOM and instability of the ankle.

DCs for the ankle, including 38 CFR 4.71a, DC 5271 and 38 CFR 4.71a, DC 5262, include broad language that does not explicitly include consideration of any particular ankle symptomatology.

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no. Evaluating Plantar Fasciitis

Evaluate plantar fasciitis analogous to pes planus, 38 CFR 4.71a, DC 5276.

The most common symptom seen with plantar fasciitis is heel pain. The following considerations apply when evaluating the heel pain

- 38 CFR 4.59 is not applicable because the heel is not a joint.
- Heel pain is consistent with the criteria for a moderate disability under 38 CFR 4.71a, DC 5276 based on pain on manipulation and use of the feet.
- Moderate disability under 38 CFR 4.71a, DC 5276 warrants assignment of a 10-percent evaluation for heel pain without application of 38 CFR 4.59.

Note: When SC is established for pes planus and plantar fasciitis, evaluate the symptoms of both conditions together under 38 CFR 4.71a, DC 5276.

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op. Identifying the Digits of the Foot

Follow the guidelines listed below to accurately specify the injured digits of the foot.

- Refer to the digits of the foot as
– first or great toe
– second
– third
– fourth, or
– fifth.
- Each digit, except the great toe, includes three phalanges
– the proximal phalanx (closest to the ankle)
– the middle phalanx, and
– the distal phalanx (closest to the tip of the toe).
- The joint between the proximal and middle phalanges is called the ***proximal interphalangeal*** (PIP) joint.
- The joint between the middle and distal phalanges is called the ***distal interphalangeal*** (DIP) joint.
- The great toes each have only two phalanges, the proximal phalanx and the distal phalanx. Therefore, each great toe has only a single joint, called the

interphalangeal (IP) joint.
- The joints connecting the phalanges in the feet to the metatarsals are the ***metatarsophalangeal*** (MTP) joints.
- Designate either right or left for the digits of the foot.

Note: If the location of the injury is unclear, obtain x-rays to clarify the exact point of injury.

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pq. Definition of Metatarsalgia or Morton's Disease

Metatarsalgia means pain in the forefoot – under the metatarsal heads.

Morton's Disease or ***Morton's Neuroma*** refers to a painful lesion of a plantar interdigital nerve.

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qr. Evaluating Metatarsalgia or Morton's Disease

Anterior metatarsalgia of any type, to include cases due to Morton's Disease, will be evaluated under 38 CFR 4.71a, DC 5279.

The DC provides for an evaluation of 10 percent regardless of whether the condition is unilateral or bilateral.

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rs. Pyramiding of Metatarsalgia and Either Plantar Fasciitis or Pes Planus

Do not assign separate evaluations for metatarsalgia and plantar fasciitis or pes planus. The evaluation criteria are similar enough that providing separate evaluations will compensate the same facet of disability, violating the prohibition against pyramiding in 38 CFR 4.14.

A 10-percent evaluation under 38 CFR 4.71a, DC 5279 is assigned solely for having pain under the metatarsal heads which would necessarily mean pain with manipulation and use.

The criteria for pes planus or plantar fasciitis for a 10-percent evaluation in 38 CFR 4.71a, DC 5276 include "pain on manipulation and use of the feet, unilateral or bilateral." The criteria for higher evaluations including findings of findings such as accentuated pain on manipulation and use or extreme tenderness of the "plantar surfaces of the feet."

Combine the evaluations under 38 CFR 4.71a, DC 5276. Do not rate by analogy when there is an applicable DC. However if one or both conditions resulted from an injury to the foot, you may also assign an evaluation for the combined conditions under 38 CFR 4.71a, DC 5284.

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st. Evaluating Arthritis of the Minor Joints of the Toes

For guidance on evaluating arthritis of a group of minor joints of the toes refer to the table below.

If arthritis ...	Then ...

• affects a group of minor joints in one foot • is documented by x-ray evidence • results in LOM, ***and*** • is confirmed by satisfactory evidence of painful motion, pain on use or other findings such as swelling	assign a 10-percent evaluation under 38 CFR 4.71a, DC 5003.
• affects minor joint groups in *both* feet, ***and*** • is documented by x-ray evidence, ***but*** • does not result in LOM	assign a 10-percent evaluation under 38 CFR 4.71a, DC 5003. ***Exception***: Assign a 20-percent evaluation if there are occasional incapacitating exacerbations).

References: For more information on

- assigning evaluations under 38 CFR 4.71a, DC 5003 when a compensable rating cannot be assigned under a DC for LOM of a joint, see M21-1, Part III, Subpart iv, 4.A.7.b, and
- treating motion as limited where it becomes painful for the purpose of applying 38 CFR 4.71a, DC 5003, pursuant to the holding in *Mitchell v. Shinseki*, 25 Vet.App. 32 (2011), see M21-1, Part III, Subpart iv, 4.A.1.c.

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tu. Pain on Motion or Use of the Toes

In cases involving conditions other than arthritis ***do not*** automatically assign a 10-percent evaluation based on painful motion with joint or periarticular pathology under 38 CFR 4.59.

Explanation: The Court of Appeals for Veterans Claims held in *Sowers v. McDonald*, 27 Vet.App. 472 (2016) that *where a DC does not provide for a compensable evaluation for a joint*, 38 CFR 4.59 *does not require that a compensable evaluation be assigned*.

Important: This guidance does not mean that a compensable evaluation cannot be assigned based on toe pain where diagnostic criteria contemplate it – such as in cases of pain under the metatarsal heads from metatarsalgia.

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uv. Considering Toes Injuries Under 38 CFR 4.71a, DC 5284

In cases where either arthritis or another foot disability is involved

- consider functional impairment, and
- determine whether, depending on the nature of the disability and history of injury, it is more advantageous to evaluate the condition under 38 CFR 4.71a, DC 5284 (”Other Foot Injuries”).

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4. Congenital Musculoskeletal Conditions

Introduction

This topic contains information on congenital conditions, including

- recognizing variations in musculoskeletal development and appearance, and
- considering notable congenital or developmental defects.

Change Date

December 13, 2005

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a. Recognizing Variations in Musculoskeletal Development and Appearance

Individuals vary greatly in their musculoskeletal development and appearance. Functional variations are often seen and can be attributed to

- the type of individual, and
- his/her inherited or congenital variations from the normal.

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b. Considering Notable Congenital or Developmental Defects

Give careful attention to congenital or developmental defects such as

- absence of parts
- subluxation (partial dislocation of a joint)
- deformity or exostosis (bony overgrowth) of parts, and/or
- accessory or supernumerary (in excess of the normal number) parts.

Note congenital defects of the spine, especially

- spondylolysis
- spina bifida
- unstable or exaggerated lumbosacral joints or angle, or
- incomplete sacralization.

Notes:

- Do not automatically classify spondylolisthesis as a congenital condition, although it is commonly associated with a congenital defect.
- Do not overlook congenital diastasis of the rectus abdominus, hernia of the diaphragm, and the various myotonias.

Reference: For more information on congenital or developmental defects, see 38 CFR 4.9.

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5. RA

Introduction

This topic contains information about RA, including

- characteristics of RA
- periods of flares and remissions of RA
- clinical signs of RA
- radiologic changes found in RA
- disability factors associated with RA, and
- points to consider in rating decisions involving joints affected by RA.

Change Date

May 11, 2015

a. Characteristics of RA

The following are characteristics of rheumatoid arthritis (RA), also diagnosed as atrophic or infectious arthritis, or arthritis deformans:

- the onset
  - occurs before middle age, and
  - may be acute, with a febrile attack, and
- the symptoms include a usually laterally symmetrical limitation of movement
  - first affecting PIP and MCP joints
  - next causing atrophy of muscles, deformities, contractures, subluxations, and
  - finally causing fibrous or bony ankylosis (abnormal adhesion of the bones of the joint).

Important: Marie-Strumpell disease, also called rheumatoid spondylitis or ankylosing spondylitis, is *not* the same disease as RA. RA and Marie-Strumpell disease have separate and distinct clinical manifestations and progress differently.

Reference: For more information on evaluating ankylosing spondylitis, see M21-1, Part III, Subpart iv, 4.A.3.d.

b. Periods of Flares and Remissions of RA

The symptoms of RA come and go, depending on the degree of tissue inflammation. When body tissues are inflamed, the disease is active. When tissue inflammation subsides, the disease is inactive (in remission).

Remissions can occur spontaneously or with treatment, and can last weeks, months, or years. During remissions, symptoms of the disease disappear, and patients generally feel well. When the disease becomes active again (relapse), symptoms return.

Note: The return of disease activity and symptoms is called a flare. The course of RA varies from patient to patient, and periods of flares and remissions are typical.

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c. Clinical Signs of RA

The table below contains information about the clinical signs of RA.

Stage of Disease	Symptoms
Initial	• periarticular and articular swelling, often free fluid, with proliferation of the synovial membrane, and • atrophy of the muscles. ***Note***: Atrophy is increased to wasting if the disease is unchecked.
Late	• deformities and contractures • subluxations, or • fibrous or bony ankylosis.

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d. Radiologic Changes Found in RA

The table below contains information about the radiologic changes found in RA.

Stage of Disease	Radiologic Changes
Early	• slight diminished density of bone shadow, and • increased density of articular soft parts without bony or cartilaginous changes of articular ends. ***Note***: RA and some other types of infectious arthritis do not require x-ray evidence of bone changes to substantiate the diagnosis, since x-rays do not always show their existence.
Late	• diminished density of bone shadow • loss of bone substance or articular ends, and • subluxation or ankylosis.

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e. Disability Factors Associated With RA

Give special attention to the following disability factors associated with RA in addition to, or in advance of, demonstrable x-ray changes:

- muscle spasms
- periarticular and articular soft tissue changes, such as
  - – synovial hypertrophy
  - – flexion contracture deformities
  - – joint effusion, and
  - – destruction of articular cartilage, and

- constitutional changes such as
  - emaciation
  - dryness of the eyes and mouth (Sjogren's syndrome)
  - pulmonary complications, such as inflammation of the lining of the lungs or lung tissue
  - anemia
  - enlargement of the spleen
  - muscular and bone atrophy
  - skin complications, such as nodules around the elbows or fingers
  - gastrointestinal symptoms
  - circulatory changes
  - imbalance in water metabolism, or dehydration
  - vascular changes
  - cardiac involvement, including pericarditis
  - dry joints
  - low renal function
  - postural deformities, and
  - low-grade edema of the extremities.

Reference: For more information on the features of RA, see http://www.niams.nih.gov/Health_Info/Rheumatic_Disease/default.asp.

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f. Points to Consider in Rating Decisions Involving Joints Affected by RA

In the DIAGNOSIS field of the rating decision, state which joints are affected by RA as evidenced by any of the following findings:

- synovial hypertrophy or joint effusion
- severe postural changes; scoliosis; flexion contracture deformities
- ankylosis or LOM of joint due to bony changes, and/or
- destruction of articular cartilage.

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6. Degenerative Arthritis

Introduction

This topic contains information about degenerative arthritis, including

- characteristics of degenerative arthritis
- diagnostic symptoms of degenerative arthritis
- radiologic changes found in degenerative arthritis
- symptoms of degenerative arthritis of the spine and pelvic joints, and
- points to consider in the rating decision for degenerative and traumatic arthritis.

Change Date

January 11, 2016

a. Characteristics of Degenerative Arthritis

The following are characteristics of degenerative arthritis, also diagnosed as osteoarthritis or hypertrophic arthritis:

- The onset generally occurs after the age of 45.
- It has no relation to infection.
- It is asymmetrical (more pronounced on one side of the body than the other).
- There is limitation of movement in the late stages only.

b. Diagnostic Symptoms of Degenerative Arthritis

Diagnostic symptoms of degenerative arthritis include

- the presence of Heberden's nodes or calcific deposits in the terminal joints of the fingers with deformity
- ankylosis, in rare cases
- hyperostosis and irregular, notched articular surfaces of the joints
- destruction of cartilage
- bone eburnation, and
- the formation of osteophytes.

Note: The flexion contracture deformities and severe constitutional symptoms described under RA do not usually occur in degenerative arthritis.

c. Radiologic Changes Found in Degenerative Arthritis

The table below contains information about the radiologic changes found in degenerative arthritis.

Stage	Radiologic Changes
Early	delicate spicules of calcium at the articular margins without

	• diminished density of bone shadow, and • increased density of articular of parts.
Late	• ridging of articular margins • hyperostosis • irregular, notched articular surfaces, and • ankylosis only in the spine.

d. Symptoms of Degenerative Arthritis of the Spine and Pelvic Joints

Degenerative arthritis of the spine and pelvic joints is characterized clinically by the same general characteristics as arthritis of the major joints except that

- limitation of spine motion occurs early
- chest expansion and costovertebral articulations are not usually affected
- referred pain is commonly called "*intercostal neuralgia"* and "*sciatica*," and
- localized ankylosis may occur if spurs on bodies of vertebrae impinge.

e. Points to Consider in the Rating Decision for Degenerative and Traumatic Arthritis

Degenerative and traumatic arthritis require x-ray evidence of bone changes to substantiate the diagnosis.

Note: In evaluating arthritis of the spine, the principles for extending SC to joints affected by the subsequent development of degenerative arthritis (as contemplated under 38 CFR 4.71a, DC 5003), is not dependent on the choice of DC.

Example: Veteran is SC for degenerative arthritis of the spine under 38 CFR 4.71a, DC 5242 and subsequently develops degenerative arthritis in the right elbow, with no intercurrent cause noted. In this case, the principles of extending SC to joints, as contemplated in 38 CFR 4.71a, DC 5003, also apply even though the Veteran is rated under 38 CFR 4.71a, DC 5242. Thus, SC for arthritis of the right elbow may be established.

Reference: For more information on considering x-ray evidence when evaluating arthritis and non-specific joint pain, see

- 38 CFR 4.71a, DC 5003, and
- M21-1, Part III, Subpart iv, 3.D.4.g.

7. LOM in Arthritis Cases

Introduction

This topic contains information on LOM due to arthritis, including

- arthritis compensable under DCs based on ROM
- joint conditions not compensable under DCs not based on ROM
- reference for rating decisions involving LOM
- arthritis previously rated as a single disability
- using DCs 5013 through 5024 in rating decisions, and
- considering the effects of a change of diagnosis in arthritis cases.

Change Date

September 23, 2016

a. Arthritis Compensable Under DCs Based on ROM

For a joint or group of joints affected by degenerative arthritis (or a condition evaluated using the arthritis criteria such as traumatic arthritis), first attempt to assign an evaluation using the DC for ROM of the affected joint (38 CFR 4.71a, DC 5200-series).

When the requirements for compensable LOM of a joint are met under a DC other than 38 CFR 4.71a, DC 5003, hyphenate that DC in the conclusion with a preceding "5003-."

Example: Degenerative arthritis of the knee manifested by limitation of knee extension justifying a 10-percent evaluation under 38 CFR 4.71a, DC 5261 would use the hyphenated DC "5003-5261."

Exception: If other joints affected by arthritis are compensably evaluated in the same rating decision, use only the DC appropriate to these particular joints which supports the assigned evaluation and omit the modifying "5003."

b. Joint Conditions Not Compensable Under DCs Not Based on ROM

Whenever LOM due to arthritis is noncompensable under codes appropriate to a particular joint, assign 10 percent under 38 CFR 4.71a, DC 5003 for each major joint or group of minor joints affected by limited or painful motion as prescribed under 38 CFR 4.71a, DC 5003.

If there is no limited or painful motion, but there is x-ray evidence of degenerative arthritis, assign under 38 CFR 4.71a, DC 5003 either a 10-percent evaluation or a 20-percent evaluation for occasional incapacitating exacerbations, based on the involvement of two or more major joints or two or more groups of minor joints.

Important: Do *not* combine under 38 CFR 4.25 a 10- or 20-percent evaluation that is based solely on x-ray findings with evaluations that are based on limited or painful motion. See example in M21-1, Part III, Subpart

iv, 4.A.8.d.

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c. Reference: Rating Decisions Involving LOM

For more information on rating decisions involving LOM, see M21-1, Part III, Subpart iv, 4.A.7.

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d. Arthritis Previously Rated as a Single Disability

The rating activity may encounter cases for which arthritis of multiple joints is rated as a single disability.

Use the information in the table below to process cases for which arthritis was previously evaluated as a single disability but the criteria for assignment of separate evaluations for affected joints was met at the time of the prior decision.

If …	Then …
• the separate evaluation of the arthritic disability results in no change in the combined degree previously assigned, and • a rating decision is required	reevaluate using the current procedure with the same effective date as previously assigned.
reevaluating the arthritic joint separately results in an increased combined evaluation	apply 38 CFR 3.105(a) to retroactively increase the assigned evaluation.
reevaluating the arthritic joint separately results in a reduced combined evaluation	• request an examination, and • if still appropriate, propose reduction under 38 CFR 3.105(a) and 38 CFR 3.105(e). ***Exception***: Do not apply 38 CFR 3.105(a) if the assigned percentage is protected under 38 CFR 3.951. ***Reference***: For more information on protected rating decisions, see M21-1, Part III, Subpart iv, 8.C.

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e. Using DCs 5013 Through 5024 in Rating Decisions

Use the table below to evaluate cases that use 38 CFR 4.71a, DCs 5013 through 5024.

If the DC of the case is …	Then …
gout under 38 CFR 4.71a, DC 5017	evaluate the case as RA, 38 CFR 4.71a, 5002.
• 38 CFR 4.71a, 5013	evaluate the case according to the criteria for

through 5016, and • 38 CFR 4.71a, DC 5018 through 5024	limited motion or painful motion under 38 CFR 4.71a, DC 5003, degenerative arthritis. ***Note***: The provisions under 38 CFR 4.71a, DC 5003, regarding a compensable minimum evaluation of 10 percent for limited or painful motion apply to these DCs and no others. ***Reference***: For more information on evaluations of 10 and 20 percent based on x-ray findings, see 38 CFR 4.71a, DC 5003, Note (2).

f. Considering the Effects of a Change in Diagnosis in Arthritis Cases

A change of diagnosis among the various types of arthritis, particularly if joint disease has been recognized as SC for several years, has no significant bearing on the question of SC.

Note: In older individuals, the effects of more than one type of joint disease may coexist.

Reference: For information on evaluating RA, see 38 CFR 4.71a, DC 5002.

8. Examples of Rating Decisions for LOM in Arthritis Cases

Introduction

This exhibit contains four examples of rating decisions for LOM in arthritis cases including

- example of degenerative arthritis with separately compensable joints affected
- example of degenerative arthritis evaluated based on x-ray evidence only
- example of noncompensable degenerative arthritis of a single joint, and
- example of degenerative arthritis evaluated based on x-ray evidence only and another compensable evaluation.

Change Date

January 11, 2016

a. Example of Degenerative Arthritis With Separately Compensable Joints Affected

Situation: The Veteran has residuals of degenerative arthritis with limitation of abduction of the right shoulder (major) to 90 degrees and limitation of flexion of the right knee to 45 degrees.

Coded Conclusion:

1. SC (VE INC)	
5003-5201 20% from 12-14-03	Degenerative arthritis, right shoulder (dominant)
5260 10% from 12-14-03	Degenerative arthritis, right knee
COMB	30% from 12-14-03

Rationale: The shoulder and knee separately meet compensable requirements under 38 CFR 4.71a, DCs 5201 and 38 CFR 4.71a, DC 5260, respectively.

b. Example of Degenerative Arthritis Evaluated Based on X-Ray Evidence Only

Situation: The Veteran has x-ray evidence of degenerative arthritis of both knees without

- limited or painful motion of any of the affected joints, or
- incapacitating episodes.

Coded Conclusion:

1. SC (PTE INC)	
5003	Degenerative arthritis of the knees, x-ray evidence

10% from 12-30-01

Rationale: There is no limited or painful motion in either joint, but there is x-ray evidence of arthritis in more than one joint to warrant a 10-percent evaluation under 38 CFR 4.71a, DC 5003.

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c. Example of Noncompensable Degenerative Arthritis of a Single Joint

Situation: The Veteran has x-ray evidence of degenerative arthritis of the right knee without limited or painful motion.

Coded Conclusion:
1. SC (PTE INC)

5003	Degenerative arthritis, right knee, x-ray evidence only
0% from 12-30-01	

Rationale: There is no limited or painful motion in the right knee or x-ray evidence of arthritis in more than one joint to warrant a compensable evaluation under 38 CFR 4.71a, DC 5003.

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d. Example of Degenerative Arthritis Evaluated Based on X-Ray Evidence Only and Another Compensable Evaluation

Situation: The Veteran has x-ray evidence of degenerative arthritis of both knees without limited or painful motion or incapacitating exacerbations. The Veteran also has residuals of degenerative arthritis with limitation of abduction of the right shoulder (major) to 90 degrees.

Coded Conclusion:
1. SC (VE INC)

5003-5201	Degenerative arthritis, right shoulder (dominant)
20% from 12-14-03	
5260	Degenerative arthritis, right knee
0% from 12-14-03	
5260	Degenerative arthritis, left knee
0% from 12-14-03	
COMB	20% from 12-14-03

Rationale: Since the shoulder condition meets compensable requirements under 38 CFR 4.71a, DCs 5201, each knee condition must be evaluated under separate DCs. Based on Note (1) under 38 CFR 4.71a, DC 5003, ratings of

arthritis based on x-ray findings only (without limited or painful motion or incapacitating exacerbations) ***cannot*** be combined with ratings of arthritis based on limitation of motion.

9. Osteomyelitis

Introduction

This topic contains information about osteomyelitis, including

- requiring constitutional symptoms for assignment of a 100-percent or 60-percent evaluation under DC 5000
- historical evaluations for osteomyelitis
- assigning historical evaluations for osteomyelitis
- the reasons to discontinue a historical evaluation for osteomyelitis
- assigning a 10-percent evaluation for active osteomyelitis, and
- application of the amputation rule to evaluations for osteomyelitis.

Change Date

May 11, 2015

a. Requiring Constitutional Symptoms for Assignment of a 100-Percent or 60-Percent Evaluation Under DC 5000

Constitutional symptoms are a prerequisite to the assignment of either the 100-percent or 60-percent evaluations under 38 CFR 4.71a, DC 5000.

Since both the 60- and 100-percent evaluations are based on constitutional symptoms, neither is subject to the amputation rule.

Reference: For more information on the amputation rule, see 38 CFR 4.68.

b. Historical Evaluations for Osteomyelitis

Both the 10-percent evaluation and that part of the 20-percent evaluation that is based on "other evidence of active infection within the last five years" are

- historical evaluations, and
- based on recurrent episodes of osteomyelitis.

Note: The 20-percent historical evaluation based on evidence of active infection within the past five years *must* be distinguished from the 20-percent evaluation authorized when there is a discharging sinus.

c. Assigning Historical Evaluations for Osteomyelitis

An initial episode of active osteomyelitis is *not* a basis for either of the historical evaluations.

Assign the historical evaluation as follows

- When the first *recurrent* episode of osteomyelitis is shown
  – assign a 20-percent historical evaluation, and
  – extend the evaluation for five years from the date of examination showing the osteomyelitis to be inactive.

- Assign a closed evaluation at the expiration of the five-year extension.
- Assign the 10-percent historical evaluation only if there have been two or more recurrences of active osteomyelitis following the initial infection.

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d. Reasons to Discontinue a Historical Evaluation for Osteomyelitis

Do *not* discontinue the historical evaluation, even if treatment includes saucerization, sequestrectomy, or guttering, because the osteomyelitis is not considered cured.

Exception: If there has been removal or radical resection of the affected bone
- consider osteomyelitis cured, and
- discontinue the historical evaluation.

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e. Assigning a 10-Percent Evaluation for Active Osteomyelitis

When the evaluation for amputation of an extremity or body part affected by osteomyelitis would be 0 percent, assign a 10-percent evaluation if there is active osteomyelitis.

References: For more information on
- applying the amputation rule to evaluations for active osteomyelitis, see M21-1, Part III, Subpart iv, 4.A.9.f, and
- evaluating osteomyelitis, see 38 CFR 4.71a, DC 5000.

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f. Application of the Amputation Rule to Evaluations for Osteomyelitis

Use the following table to determine how the amputation rule affects evaluations assigned for osteomyelitis.

If the osteomyelitis evaluation is ...	**Then the amputation rule ...**
10 percent based on active osteomyelitis of a body part where the amputation evaluation would normally be 0 percent	does not apply.
• 10 percent based on active osteomyelitis of a body part where the amputation evaluation would normally be 0 percent, or • 30 percent or less under 38 CFR 4.71a, DC 5000, *and* • the 10-percent evaluation is combined with evaluations for – ankylosis – limited motion – nonunion or malunion – shortening, or – other musculoskeletal impairment	applies to the combined evaluation.

60 percent based on constitutional symptoms of osteomyelitis, per 38 CFR 4.71a, DC 5000	does not apply since the 60-percent evaluation is based on constitutional symptoms.

Reference: For more information on the amputation rule, see
- 38 CFR 4.68, and
- M21-1, Part III, Subpart iv, 4.A.12.d.

10. Examples of the Proper Rating Procedure for Osteomyelitis

Introduction

This exhibit contains eight examples of the proper procedure for rating osteomyelitis, including

- example of evaluating osteomyelitis based on a history of a single active initial episode
- example of evaluating an active initial episode of osteomyelitis
- example of evaluating osteomyelitis following review exam for initial active episode
- example of evaluating osteomyelitis with current discharging sinus
- example of evaluating osteomyelitis with a historical evaluation following a single recurrence with scheduled reduction due to inactivity
- example of evaluating a recurrence of osteomyelitis
- example of evaluating osteomyelitis following second recurrence, and
- example of evaluating osteomyelitis following curative resection of affected bone.

Change Date

May 11, 2015

a. Example of Evaluating Osteomyelitis Based on a History of a Single Active Initial Episode

Situation: The Veteran was diagnosed with osteomyelitis in service with discharging sinus. At separation from service the osteomyelitis was inactive with no involucrum or sequestrum. There is no evidence of recurrence.

Result: As there has been no recurrence of active osteomyelitis following the initial episode in service, the historical evaluation of 20 percent is not for application. The requirements for a 20-percent evaluation based on activity are not met either.

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia
0% from 12-2-93

b. Example of Evaluating an Active Initial Episode of Osteomyelitis

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.a, but the Veteran had a discharging sinus at the time of separation from service.

Result: The Veteran meets the criteria for a 20-percent evaluation based on a discharging sinus. Schedule a future examination to ascertain the date of inactivity.

Coded Conclusion:

1. SC (PTE INC)
5000 Osteomyelitis, right tibia, active
20% from 12-2-93

---

c. Example of Evaluating Osteomyelitis Following Review Exam for Initial Active Episode

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.b. Subsequent review examination reveals the sinus tract was healed and there is no other evidence of active infection.

Result: Since the Veteran has not had a recurrent episode of osteomyelitis since service, a historical evaluation of 20 percent is not for application. Take rating action under 38 CFR 3.105(e).

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia, inactive
20% from 12-2-93
0% from 3-1-95

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d. Example of Evaluating Osteomyelitis With Current Discharging Sinus

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.b. The Veteran is hospitalized July 2l, 1996, with active osteomyelitis of the right tibia shown with discharging sinus. There is no involucrum, sequestrum, or constitutional symptom. Upon release from the hospital the discharging sinus is still present.

Result: Assign the 20-percent evaluation based on evidence showing draining sinus from the proper effective date. Schedule a future examination to ascertain date of inactivity.

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia, active
0% from 3-1-95
20% from 7-21-96

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e. Example of Evaluating Osteomyelitis With a Historical Evaluation Following a Single Recurrence With Scheduled Reduction Due to Inactivity

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.d. A routine future examination was conducted on July 8, 1997, showing the osteomyelitis to be inactive. There was no discharging sinus, no involucrum, sequestrum, or constitutional symptom. The most recent episode of active osteomyelitis (July 21, 1996) constitutes the first “recurrent” episode of active osteomyelitis.

Result: Continue the previously assigned 20-percent evaluation, which was awarded on the basis of discharging sinus as a historical evaluation for five years from the examination showing inactivity.

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia, inactive
20% from 7-21-96
0% from 7-8-02

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f. Example of Evaluating a Recurrence of Osteomyelitis

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.e. In October 1999, the Veteran was again found to have active osteomyelitis with a discharging sinus, without involucrum, sequestrum, or constitutional symptoms.

Result: Continue the 20-percent evaluation. Reevaluation is necessary to remove the future reduction to 0 percent, and to schedule a future examination to establish the date of inactivity.

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia, active
20% from 7-21-96

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g. Example of Evaluating Osteomyelitis Following Second Recurrence

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.f. A review examination was conducted on April 8, 2000. The examination showed the discharging sinus was inactive, and there was no other evidence of active osteomyelitis. The most recent episode of osteomyelitis (October 1999) constitutes the second "recurrent" episode of active osteomyelitis.

Result: The historical evaluations of 20 and 10 percent both apply.

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia, inactive
20% from 7-21-96
10% from 4-8-05

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h. Example of Evaluating Osteomyelitis Following Curative Resection of Affected Bone

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.g. The Veteran was hospitalized June 10, 2002, with a recurrent episode of active osteomyelitis. A radical resection of the right tibia was performed and at hospital discharge (June 21, 2002), the osteomyelitis was shown to be cured.

Result: Assign a temporary total evaluation of 100 percent under 38 CFR 4.30 with a 1-month period of convalescence. Following application of 38 CFR 3.105(e), reduce the evaluation for osteomyelitis to zero percent as an evaluation for osteomyelitis will not be applied following cure by removal or radical resection of the affected bone.

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia, P.O.
20% from 7-21-96
100% from 6-10-02 (Par. 30)
20% from 8-1-02
0% from 10-1-02

11. Muscle Injuries

Introduction

This topic contains information about rating muscle injuries, including

- types of muscle injuries
- standard muscle strength grading system for examinations
- identification of muscle groups (MGs) in examination reports
- general criteria for muscle evaluations
- fractures associated with gunshot wound (GSW) and shell fragment wounds (SFW)
- determining whether 38 CFR 4.55 applies to muscle injuries
- applying 38 CFR 4.55 to muscle injuries
- evaluating joint manifestations and muscle damage acting on the same joint
- evaluating damage to multiple muscles within the same MG
- considering peripheral nerve involvement in muscle injuries
- evaluating muscle injuries with peripheral nerve conditions of different etiology
- evaluating scars associated with muscle injuries, and
- applying the amputation rule to muscle injuries.

Change Date

May 11, 2015

a. Types of Muscle Injuries

A missile that penetrates the body results in two problems

- it destroys muscle tissue in its direct path by crushing it, then
- the temporary cavitation forces stretch the tissues adjacent to the missile track and result in additional injury or destruction.

Muscles are much more severely disrupted if multiple penetrating projectiles strike in close proximity to each other. Examples of this type of injury are

- explosive device injuries
- deforming or fragmenting rifle projectiles, or
- any rifle projectile that strikes bone.

For additional information regarding types of injuries, the effects of explosions and projectiles, and symptoms and complications, refer to the table below.

Type of Injury	Initial Effects	Signs, Symptoms, and Complications
gunshots	Entrance and exit wounds result. The amount of damage and relative size of entrance	• Exit wounds are generally larger than entrance wounds, and

	and exit wounds depends on many factors such as • caliber of bullet • distance from victim • organs, bone, blood vessels, and other structures hit.	• bullets are essentially sterile when they reach the body but carry particles into wound which could be sources of infection.
fragments from explosive devices	Most result in decreased tissue penetration compared to denser rifle bullets.	Multiple fragments in a localized area result in tissue disruption affecting a wide area.
tears and lacerations	Muscles that become isolated from nerve supply by lacerations will be non-functional.	• Torn muscle fibers heal with very dense scar tissue, but the nerve stimulation will not cross this barrier. • Parts of muscle isolated from the nerve will most likely remain non-contractile resulting in a strength deficit proportional to amount of muscle tissue disrupted. • Treatment for small tears is symptomatic. • Large tears/lacerations may require reconstruction.
through and through wound	Injuring instrument enters and exits the body.	Two wounds result • entrance wound, and • exit wound.

References: For more information on
- muscle groups (MGs) and corresponding DCs, see 38 CFR 4.73
- anatomical regions of the body, see 38 CFR 4.55(b), and
- gunshot wounds (GSWs) with pleural cavity involvement, see 38 CFR 4.97, DC 6840-6845, Note (3).

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b. Standard Muscle Strength Grading System for Examinations

Refer to the following table for information about how muscle strength is evaluated on an examination.

Numeric	Corresponding Strength	Indications on Exam

Grade	Assessment	
(0)	absent	no contraction felt
(1)	trace	muscle can be felt to tighten but no movement is produced
(2)	poor	muscle movement is produced against gravity but cannot overcome resistance
(3)	fair	muscle movement is produced against gravity but cannot overcome resistance
(4)	good	muscle movement is produced against resistance, however, less than normal resistance
(5)	normal	muscle movement can overcome a normal resistance

c. Identification of MG in Examination Reports

The examination report must include information to adequately identify the MG affected by either

- specifically noting which MG is affected, or
- noting which muscles are involved so that the name of the muscles may be used to identify the MG affected.

d. General Criteria for Muscle Evaluations

Evaluation of muscle disabilities is the result of a multi-factorial consideration. However, there are hallmark traits that are suggestive of certain corresponding evaluations. Refer to the following table for additional information regarding these hallmark traits and the suggested corresponding disability evaluation.

If the evidence shows a history of ...	Then consider evaluating the muscle injury as ...
open comminuted fracture *with* • muscle damage, or • tendon damage	severe. ***Note***: This level of impairment is specified by regulation at 38 CFR 4.56(a).
through and through or deep penetrating wound by small high velocity missile or large low velocity missile *with* • debridement • prolonged infection, or • sloughing of soft parts, and • intermuscular scarring	at least moderately severe.
through and through injury *with*	no less than moderate.

muscle damage	***Note***: This level of impairment is specified by regulation at 38 CFR 4.56(b).
retained fragments in muscle tissue	at least moderate.
deep penetrating wound *without* • explosive effect of high velocity missile, • residuals of debridement, or • prolonged infection	at least moderate.

Important: No single factor is controlling for the assignment of a disability evaluation for a muscle injury. The entire evidence picture must be taken into consideration.

Reference: For more information on assigning disability evaluations for muscle injuries, see

- *Troph v. Nicholson*, 20 Vet.App. 317 (2006)
- *Robertson v. Brown*, 5 Vet.App. 70 (1993)
- *Jones v. Principi*, 18 Vet.App. 248 (2004), and
- 38 CFR 4.55.

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e. Fractures Associated With GSW/SFW

All fractures associated with a GSW and/or shell fragment wound (SFW) will be considered open because all of them involve an opening to the outside. Most GSW/SFW fractures are also comminuted due to the shattering nature of the injury.

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f. Determining Whether 38 CFR 4.55 Applies to Muscle Injuries

38 CFR 4.55 applies to certain combinations of muscle injuries and joint conditions. Consider the provisions of 38 CFR 4.55 if

- there are multiple MGs involved
- the MG acts on a joint or joints, and/or
- there is peripheral nerve damage to the same body part affected by the muscle.

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g. Applying 38 CFR 4.55 to Muscle Injuries

If more than one MG is injured or affected or if the injured MG acts on a joint, conduct a preliminary review of the evidence to gather information needed to properly apply the provisions of 38 CFR 4.55. The information needed will include

- whether the affected MGs are in the same or different anatomic regions
- whether the MGs are acting on a single joint or multiple joints, and
- whether the joint or joints is/are ankylosed.

After the preliminary review is complete, use the evidence gathered and apply the following table to determine how 38 CFR 4.55 affects the evaluation of the muscle injury.

Step	Action
1	Does the MG(s) act on an ankylosed joint? • If *yes*, go to Step 2. • If *no*, go to Step 4
2	For MG(s) that act on an ankylosed joint, is the joint an ankylosed knee *and* is MG XIII disabled? • If *yes*, grant separate evaluations for the ankylosed knee and the MG XIII injury. For the MG XIII injury, assign the next lower level than that which would otherwise be assigned. Then go to Step 3. • If *no*, then is the ankylosed joint the shoulder *and* are MGs I and II *severely* disabled? – If *yes*, then assign a single evaluation for the muscle injury and the shoulder ankylosis under DC 5200. The evaluation will be at the level of unfavorable ankylosis. – If *no*, then no evaluation will be assigned for the muscle injury. The combined disability arising from the ankylosis and the muscle injury will be evaluated as ankylosis.
3	For the injury to MG XIII with an associated ankylosed knee, are there other MG injuries in the same anatomical region affecting the pelvic girdle and/or thigh? • If *no*, then no additional change to the evaluation for the muscle injury is warranted. • If *yes*, do the affected MG injuries act on the ankylosed knee? – If *yes*, then no separate evaluation for the muscle injury to a MG other than MG XIII can be assigned, as indicated in Step 2. – If *no*, then for the MG XIII injury that acts on the knee and the injury to another MG of the pelvic girdle and thigh acting on a different joint, is the different joint ankylosed? ▪ If *yes*, then no separate evaluation can be assigned for the other MG injury of the pelvic girdle and thigh, as indicated in Step 2. No further action is warranted. ▪ If *no*, then assign a single evaluation for the MG XIII injury and the injury to the other MG of the pelvic girdle and thigh anatomical region by determining the most severely injured MG and increasing by one level.
4	For muscle injury(ies) acting on unankylosed joint(s), is a single MG injury involved? • If *yes*, then grant a single evaluation for the muscle injury.

	• If *no*, then are the MG injuries in the same anatomical region? – If *yes*, go to Step 5. – If *no*, go to Step 6
5	Do the MGs in the same anatomical region act on a single joint? • If yes, are the MGs involved MG I and II acting on a shoulder joint? – If *yes*, then ▪ assign separate disability evaluations for the MGs, but ▪ the combined evaluation cannot exceed the evaluation for unfavorable ankylosis of the shoulder. – If *no*, then for the muscles in the same anatomical region acting on a single joint, ▪ assign separate disability evaluations for the MGs, but ▪ the combined evaluation must be less than the evaluation that would be normally assigned for unfavorable anklyosis of the joint involved. • If *no*, for the MGs in the same anatomical region acting on different joints, are the MG injuries compensable? – If *yes*, then assign a single disability evaluation for the affected MGs by ▪ determining the evaluation for the most severely injured MG, and ▪ increasing by one level and using as the combined evaluation. – If *no*, then assign a noncompensable evaluation for the combined MG injuries.
6	For MG injuries in different anatomical areas, is a single unankylosed joint affected? • If *yes*, are MG I and II affected and acting upon the shoulder? – If *yes*, then ▪ assign separate disability evaluations for the muscle injuries, but ▪ the combined evaluation cannot exceed the evaluation for unfavorable ankylosis of the shoulder. – If *no*, for the MG injuries in different anatomical areas affecting a single unankylosed joint (not including MG I and II acting on the shoulder) ▪ assign separate disability evaluations for the muscle injuries, but ▪ the combined evaluation must be lower than the evaluation that would be assigned for unfavorable ankylosis of the affected joint. • If *no*, then for MG injuries in different anatomical areas acting on different unankylosed joints, assign separate disability evaluations for each MG injury.

References: For additional information on

- evaluating joint manifestations and muscle damage acting on the same joint, see M21-1, Part III, Subpart iv, 4.A.11.h, and
- evaluating peripheral nerve involvement in muscle injuries, see M21-1 Part III, Subpart iv, 4.A.11.j.

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h. Evaluating Joint Manifestations and Muscle Damage Acting on the Same Joint

A separate evaluation for joint manifestations and muscle damage acting on the same joint are prohibited if both conditions result in the same symptoms.

Although LOM is not directly discussed in 38 CFR 4.56, the DC provisions within 38 CFR 4.73 describing the functions of various MGs are describing motion.

- The muscles move the joint.
- If the joint manifestation is LOM, that manifestation is already compensated through the evaluation assigned by a muscle rating decision.
- Evaluating the same symptoms under multiple DCs is prohibited by 38 CFR 4.14.

Note: Consider the degree of disability under the corresponding muscle DC and joint DC and assign the higher evaluation.

Exception: Per 38 CFR 4.55(c)(1), if MG XIII is disabled and acts on an ankylosed knee, separate disability evaluations can be assigned for the muscle injury and the knee ankylosis. However, the evaluation for the MG injury will be rated at the next lower level than that which would have otherwise been assigned.

Reference: For additional information concerning evaluating muscle injuries and joint conditions, see M21-1, Part III, Subpart iv, 4.A.11.f-g.

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i. Evaluating Damage to Multiple Muscles Within the Same MG

A separate evaluation cannot be assigned for each muscle within a single MG. Muscle damage to any of the muscles within the group must be included in a single evaluation assigned for the MG.

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j. Considering Peripheral Nerve Involvement in Muscle Injuries

When there is nerve damage associated with the muscle injury, use the following table to determine appropriate actions to take to evaluate the nerve damage and the muscle injury.

If ...	Then ...
• the nerve damage is in the same body part as the muscle injury, *and*	assign a single evaluation for the combined impairment by

• the muscle injury and the nerve damage affect the same functions of the affected body part	determining whether the nerve code or the muscle code will result in a higher evaluation. Assign the higher evaluation. ***Note***: If the muscle and nerve evaluations are equal, evaluate with the DC with the highest maximum evaluation available.
• the nerve damage is in the same body part as the muscle injury, *and* • the muscle injury and the nerve damage affect entirely different functions of the affected body part	assign separate evaluations for the nerve damage and the muscle injury.

k. Evaluating Muscle Injuries with Peripheral Nerve Conditions of Different Etiology

The provisions of 38 CFR 4.55 preclude the combining of a muscle injury evaluation with a peripheral nerve paralysis evaluation involving the same body part when the same functions are affected. A muscle injury and a peripheral nerve paralysis of the same body part, originating from separate etiologies, may not be rated separately.

- The exception to this rule is only when entirely different functions are affected.
- Etiology of the disability is irrelevant in rendering a determination regarding combining evaluations for muscle injuries and peripheral nerve paralysis.

Example: A Veteran is SC for GSW to the right leg MG XI at 10 percent. He develops SC diabetic peripheral neuropathy many years later. The peripheral neuropathy affects the external popliteal nerve. Since MG XI and the external popliteal nerve both control the same functions, dorsiflexion of the foot and extension of the toes, only a single disability evaluation can be assigned under either 38 CFR 4.73, DC 5311 or 38 CFR 4.73, DC 8521, whichever is more advantageous.

l. Evaluating Scars Associated With Muscle Injuries

Use the following table to determine appropriate action to take when evaluating scars associated with muscle injuries.

If ...	**Then ...**
there is scarring associated with the muscle injury	assign a separate evaluation for the scar, even if noncompensable.
there is painful or unstable scarring associated with the muscle injury	assign a separate compensable disability evaluation under 38 CFR 4.118, DC 7804.
there is scarring that results in	do not assign a separate evaluation if

functional loss under 38 CFR 4.118, DC 7805 that is compensable	the body part affected and the functional impairment resulting from the scar are the same as the part and function affected by the muscle injury.

Reference: For more information on assigning separate evaluations for the muscle injury and associated scarring, see

- *Esteban v. Brown*, 6 Vet.App. 259 (1994)
- *Jones v. Principi*, 18 Vet.App. 248 (2004), and
- 38 CFR 4.14.

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m. Applying the Amputation Rule to Muscle Injuries

The amputation rule applies to musculoskeletal conditions and any associated peripheral nerve injuries. Therefore, when assigning separate evaluations for the muscle injury, peripheral nerve injury directly related to that muscle injury must be considered in applying the amputation rule.

References: For more information on

- the amputation rule, see 38 CFR 4.68, and
- evaluating peripheral nerve disabilities associated with muscle injuries, see M21-1, Part III, Subpart iv, 4.A.11.j.

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12. Miscellaneous Musculoskeletal Considerations

Introduction

This topic contains general guidance on evaluating musculoskeletal conditions, including

- SC for fractures
- SC for osteopenia
- evaluating fibromyalgia
- applying the amputation rule, and
- considering conflicting decisions regarding loss of use (LOU) of an extremity.

Change Date

February 1, 2016

a. SC for Fractures

Decision makers must not automatically award SC for fracture or fracture residuals based on a mere service treatment record (STR) reference to a fracture.

- Where SC of a fracture or fracture residuals is *claimed*, SC will be established when sufficient evidence, such as x-rays, a surgical report, casting, or a physical evaluation board report, documents the fracture.
- If SC of a fracture has not been claimed and objective evidence such as x-ray report documents an in-service fracture, invite a claim for SC for the fracture.

The following considerations apply when granting SC for a fracture:

- SC will be established for a healed fracture even without current residual limited motion or functional impairment of a joint.
- Assign a DC consistent with the location of the fracture. The fracture will be rated as noncompensable in the absence of any disabling manifestations.

Reference: For more information about unclaimed chronic disabilities found in STRs, see M21-1, Part IV, Subpart ii, 2.A.

b. SC for Osteopenia

Osteopenia is clinically defined as mild bone density loss that is often associated with the normal aging process. Low bone density does not necessarily mean that an individual is losing bone, as this may be a normal variant.

Osteopenia is comparable to a laboratory finding which is not subject to SC compensation.

Use the following table to determine the appropriate action to take when SC for osteopenia has been granted.

If ...	Then ...
SC for osteopenia was granted by rating decision dated *prior to* December 19, 2013 (the date on which guidance was issued to clarify the proper procedures for considering SC for osteopenia)	• do not sever SC, as it was properly established based on guidance available at the time the decision was made, • do not reduce the previously assigned evaluation unless the condition has improved, and • consider claims for increased evaluation and schedule examination as warranted based on the facts of the case. ***Note***: Provisions of 38 CFR 3.951 and 38 CFR 3.957 regarding protection of SC remain applicable.
SC for osteopenia was granted by rating decision dated *on or after* December 19, 2013	propose to sever SC based on a finding of clear and unmistakable error (CUE).

Note: Osteoporosis, in contrast to osteopenia, is considered a disease entity characterized by severe bone loss that may interfere with mechanical support, structure, and function of the bone. SC for osteoporosis under 38 CFR 4.71a DC 5013 is warranted when the requirements are otherwise met.

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c. Evaluating Fibromyalgia

The criteria for evaluation of fibromyalgia under 38 CFR 4.71a, DC 5025 does not exclude assignment of separate evaluations when disabilities are diagnosed secondary to fibromyalgia. This includes, but is not limited to, disability diagnoses for which symptoms are included in the evaluation criteria under 38 CFR 4.71a, DC 5025, such as

- depression
- anxiety
- headache, and
- irritable bowel syndrome.

Notes:
- If signs and symptoms are not sufficient to warrant a diagnosis of a separate condition, then they are evaluated with the musculoskeletal pain and tender points under 38 CFR 4.71a, DC 5025.
- The same signs and symptoms cannot be used to assign separate evaluations under different DCs, per 38 CFR 4.14.

Reference: For more information on evaluating chronic pain syndrome

(somatic symptom disorder), see M21-1, Part III, Subpart iv, 4.H.1.j.

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d. Applying the Amputation Rule

The combined evaluation for disabilities of an extremity shall not exceed the evaluation for the amputation at the elective level, were amputation to be performed. The amputation rule is included in the musculoskeletal section of the rating schedule and, consequently, applies only to musculoskeletal disabilities and not to disabilities affecting other body systems.

Exceptions:

- Any peripheral nerve injury associated with the musculoskeletal injury will be considered when applying the amputation rule.
- Actual amputation with associated painful neuroma will be evaluated at the next-higher site of elective reamputation.

Note: The amputation rule does not apply to bilateral evaluations under DCs 5276 to 5279.

References: For more information on the

- amputation rule, see
  – 38 CFR 4.68, and
  – *Moyer v. Derwinski*, 2 Vet.App. 289 (1992)
- application of the amputation rule to rating decisions for osteomyelitis, see M21-1, Part III, Subpart iv, 4.A.9.f
- application of the amputation rule to rating decisions for muscle injuries, see M21-1, Part III, Subpart iv, 4.A.11.m, and
- VBMS-R amputation rule instructions, see the VBMS-R Job Aid.

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e. Considering Conflicting Decisions Regarding LOU of an Extremity

Forward the claims folder to the Director, Compensation Service (211B), for an advisory opinion under M21-1, Part III, Subpart vi, 1.A.2.a to resolve a conflict if

- the Insurance Center determines LOU of two extremities prior to rating consideration involving the same issue, and
- the determination conflicts with the proposed rating decision.

Note: This issue will generally be brought to the attention of the rating activity as a result of the type of personal injury, correspondence, or some indication in the claims folder that the insurance activity is involved.

EXHIBIT B

ADDRESSES. We seek any comments or information that may lead to the discovery of a significant environmental impact from this rule.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1231; 50 U.S.C. 191; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.T09–0595 to read as follows:

§ 165.T09–0595 Safety Zone; Town of Olcott Fireworks Display; Lake Ontario, Olcott, NY.

(a) *Location.* This zone will encompass all waters of Lake Ontario; Olcott, NY within a 1,050-foot radius of position 43°20′23.6″ N. and 078°43′09.5″ W. (NAD 83).

(b) *Enforcement period.* This regulation will be enforced on July 10, 2015; July 23, 2015; August 13, 2015; August 27, 2015; and September 6, 2015 from 9:30 p.m. until 11 p.m.

(c) *Regulations.* (1) In accordance with the general regulations in § 165.23, entry into, transiting, or anchoring within this safety zone is prohibited unless authorized by the Captain of the Port Buffalo or his designated on-scene representative.

(2) This safety zone is closed to all vessel traffic, except as may be permitted by the Captain of the Port Buffalo or his designated on-scene representative.

(3) The ''on-scene representative'' of the Captain of the Port Buffalo is any Coast Guard commissioned, warrant or petty officer who has been designated by the Captain of the Port Buffalo to act on his behalf.

(4) Vessel operators desiring to enter or operate within the safety zone must contact the Captain of the Port Buffalo or his on-scene representative to obtain permission to do so. The Captain of the Port Buffalo or his on-scene representative may be contacted via VHF Channel 16. Vessel operators given permission to enter or operate in the safety zone must comply with all directions given to them by the Captain of the Port Buffalo, or his on-scene representative.

Dated: June 25, 2015.

B.W. Roche,

Captain, U.S. Coast Guard, Captain of the Port Buffalo.

[FR Doc. 2015–17483 Filed 7–15–15; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AP38

Agency Interpretation of Prosthetic Replacement of a Joint

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs is publishing interpretive guidance for diagnostic codes (DC) 5051 through 5056, which establish rating criteria for prosthetic implant replacements of joints of the musculoskeletal system. The Schedule for Rating Disabilities under these DCs allows for a 1-year, 100-percent disability evaluation upon prosthetic replacement of a joint. This final rule clarifies that VA's longstanding interpretation of DCs 5051 through 5056 is that a 100-percent evaluation will be in place for a period of one year when the total joint, rather than the partial joint, has been replaced by a prosthetic implant.

DATES: *Effective Date:* This final rule is effective July 16, 2015.

FOR FURTHER INFORMATION CONTACT: Stephanie Li, Chief, Regulations Staff (211D), Compensation Service, Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, (202) 461–9700. (This is not a toll-free telephone number.)

SUPPLEMENTARY INFORMATION: Diagnostic codes (DCs) 5051 through 5056, under 38 CFR 4.71a, govern the Schedule for Rating Disabilities (Rating Schedule) for prosthetic replacement of joints under the musculoskeletal system. These DCs state that a 100-percent evaluation will be sustained for 1 year following the prosthetic replacement of the named joint. This period of total disability evaluation is designed to provide temporary convalescence for major surgery, such as total joint replacement. Following the convalescent period, a Department of Veterans Affairs (VA) or VA-approved examination is conducted to determine any residual disability, and a new rating evaluation is assigned based on such residuals.

The field of orthopedic medicine has progressed to such a degree that total prosthetic replacement of a joint is not always necessary. Surgical procedures, sometimes referred to generally as ''joint replacements,'' may only require partial replacement of the disabled joint.[1] Partial replacement has the benefit of not requiring the same length of time for convalescence.[2] The progression of this area of medical science has raised an issue as to whether a veteran who undergoes a partial replacement of a joint is entitled to the 100-percent rating evaluation during the convalescent period under DCs 5051 through 5056.

VA has long interpreted ''joint replacement,'' as used in § 4.71a, to mean total joint replacement. Recently, the United States Court of Appeals for Veterans Claims (Veterans Court) issued a precedential panel decision upholding VA's interpretation of § 4.71a. In *Hudgens* v. *Gibson,* 26 Vet. App. 558 (2014), the Veterans Court upheld the Board of Veterans' Appeals decision that DC 5055 applies only to total knee prosthetic replacements. The Veterans Court determined that the plain language of DC 5055 was unambiguous. *Id.* at 561. The Veterans Court found that the medical definition of ''knee joint'' encompassed three distinct compartments of the knee and that ''[n]othing in the plain language of the regulation indicates that it applies to replacements of less than a complete knee joint . . .''. *Id.* In addition, the Veterans Court cited DC 5054, for hip joint prosthesis, as an example of when VA intends to evaluate partial joint replacement. Diagnostic Code 5054, also under § 4.71a, provides evaluation criteria for ''[p]rosthetic replacement of the head of the femur *or* of the acetabulum'' (italics added), which together make up the hip joint. *Id.* The Veterans Court concluded that ''DC 5055 applies only to total knee replacements, as the Secretary has demonstrated in other parts of § 4.71(a) [sic] that he is aware of how to include partial joint replacements as part of disability rating criteria in other parts of § 4.71(a) [sic].'' *Id.* at 562.

In view of the above court decision, and VA's longstanding interpretation, VA is amending its regulations to clarify that the language of § 4.71a, Prosthetic Implants, which refers to replacement of

[1] ''Patients with osteoarthritis that is limited to just one part of the knee may be candidates for unicompartmental knee replacement (also called a 'partial' knee replacement).'' ''Unicompartmental Knee Replacement,'' American Academy of Orthopedic Surgeons, Ortho Info, 1 (June 2010), *http://orthoinfo.aaos.org/topic.cfm?topic=A00585* (last visited Mar. 19, 2014).

[2] *Id.*

the named joint, refers to replacement of the joint as a whole, except where it is otherwise stated under DC 5054. To avoid confusion in applying these DCs, VA is adding an explanatory note under 38 CFR 4.71a, directly above DCs 5051 through 5056, which notifies readers that ''prosthetic replacement'' means a total, not a partial, joint replacement, except as it is otherwise stated under DC 5054.

This final rule provides interpretive guidance on VA's meaning of ''prosthetic replacement'' as noted in the preceding discussion and consistent with the recent *Hudgens* v. *Gibson* decision. This guidance does not represent a new agency interpretation or a substantive change to the eligibility criteria for any VA benefit; rather, it provides notice regarding VA's longstanding interpretation of its regulation on prosthetic implants, which the Veterans Court recently upheld. As such, VA is publishing this final rule without opportunity for public comment.

Administrative Procedure Act

The Secretary of Veterans Affairs finds that this is an interpretive rule, which, under 5 U.S.C. 553(b)(A), VA may promulgate without prior opportunity for public comment. *See also Perez* v. *Mortgage Bankers Ass'n,* 135 S. Ct. 1199, 1206 (2015). This rule merely restates VA's longstanding interpretation of its regulation, which the Veterans Court upheld. Therefore, a prior opportunity for notice and comment is unnecessary. Additionally, based on the above cited justification, VA finds good cause to dispense with the delayed-effective-date requirement of 5 U.S.C. 553(d)(2).

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a ''significant regulatory action'' requiring review by the Office of Management and Budget (OMB), unless OMB waives such review, as ''any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order.''

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined, and it has been determined not to be a significant regulatory action under Executive Order 12866. VA's impact analysis can be found as a supporting document at *http://www.regulations.gov,* usually within 48 hours after the rulemaking document is published. Additionally, a copy of this rulemaking and its impact analysis are available on VA's Web site at *http://www.va.gov/orpm/,* by following the link for ''VA Regulations Published From FY 2004 Through Fiscal Year to Date.''

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601–612). This final rule will directly affect only individuals and will not directly affect small entities. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

This final rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.100, Automobiles and Adaptive Equipment for Certain Disabled Veterans and Members of the Armed Forces; 64.104, Pension for Non-Service-Connected Disability for Veterans; 64.106, Specially Adapted Housing for Disabled Veterans; 64.109, Veterans Compensation for Service-Connected Disability; 64.116, Vocational Rehabilitation for Disabled Veterans.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Robert L. Nabors II, Chief of Staff, Department of Veterans Affairs, approved this document on July 6, 2015, for publication.

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

Dated: July 13, 2015.

William F. Russo,

Acting Director, Office of Regulation Policy & Management, Office of the General Counsel, Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs amends 38 CFR part 4 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, unless otherwise noted.

Subpart B—Disability Ratings

■ 2. In § 4.71a, add a note preceding the footnote after the table ''Prosthetic Implants'' to read as follows:

§ 4.71a Schedule of ratings—musculoskeletal system.

* * * * *

PROSTHETIC IMPLANTS

* * * * *

Note: The term ''prosthetic replacement'' in diagnostic codes 5051 through 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.

* * * * *

■ 3. Amend appendix A to part 4 by revising the entries for diagnostic codes 5051 through 5056 to read as follows:

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

Sec.	Diagnostic Code No.	
*	*	*
	5051	Added September 22, 1978. Note July 16, 2015.
	5052	Added September 22, 1978. Note July 16, 2015.
	5053	Added September 22, 1978. Note July 16, 2015.
	5054	Added September 22, 1978. Note July 16, 2015.
	5055	Added September 22, 1978. Note July 16, 2015.
	5056	Added September 22, 1978. Note July 16, 2015.
*	*	*

[FR Doc. 2015–17417 Filed 7–15–15; 8:45 am]

BILLING CODE 8320–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R10–OAR–2015–0329; FRL–9930–69–Region 10]

Approval and Promulgation of Implementation Plans; Washington: Interstate Transport Requirements for the 2008 Lead and 2010 Nitrogen Dioxide National Ambient Air Quality Standards

AGENCY: Environmental Protection Agency.

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency (EPA) is approving a submittal by the Washington Department of Ecology (Ecology) demonstrating that the State Implementation Plan (SIP) meets certain interstate transport requirements of the Clean Air Act (CAA) for the National Ambient Air Quality Standards (NAAQS) promulgated for lead (Pb) on October 15, 2008 and nitrogen dioxide (NO_2) on January 22, 2010. Specifically, Ecology conducted an emissions inventory analysis and reviewed monitoring data to show that sources in Washington do not significantly contribute to nonattainment or interfere with maintenance of the 2008 Pb and 2010 NO_2 NAAQS in any other state.

DATES: This final rule is effective August 17, 2015.

ADDRESSES: The EPA has established a docket for this action under Docket ID No. EPA–R10–OAR–2015–0329. All documents in the docket are listed on the *www.regulations.gov* Web site. Although listed in the index, some information is not publicly available, *e.g.,* Confidential Business Information (CBI) or other information the disclosure of which is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through *www.regulations.gov* or in hard copy at the Air Programs Unit, Office of Air, Waste and Toxics, EPA Region 10, 1200 Sixth Avenue, Seattle, WA 98101. The EPA requests that if at all possible, you contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section to view the hard copy of the docket. You may view the hard copy of the docket Monday through Friday, 8:00 a.m. to 4:00 p.m., excluding Federal holidays.

FOR FURTHER INFORMATION CONTACT: For information please contact Jeff Hunt at (206) 553–0256, *hunt.jeff@epa.gov,* or by using the above EPA, Region 10 address.

SUPPLEMENTARY INFORMATION:

Table of Contents

I. Background Information
II. Final Action
III. Statutory and Executive Orders Review

I. Background Information

On October 15, 2008 (73 FR 66964) and January 22, 2010 (75 FR 6474), the EPA revised the Pb and NO_2 NAAQS, respectively. Within three years after promulgation of a new or revised standard, states must submit SIPs meeting the requirements of CAA sections 110(a)(1) and (2), often referred to as ''infrastructure'' requirements. On May 11, 2015, Ecology submitted a SIP revision to address the CAA section 110(a)(2)(D)(i)(I) requirements demonstrating that sources in Washington do not significantly contribute to nonattainment or interfere with maintenance of the 2008 Pb and 2010 NO_2 NAAQS in any other state. On May 27, 2015, the EPA proposed to find that the Washington SIP meets the CAA section 110(a)(2)(D)(i)(I) interstate transport requirements for the 2008 Pb and 2010 NO_2 NAAQS (80 FR 30200). An explanation of the CAA requirements, a detailed analysis of the submittal, and the EPA's reasons for approval were provided in the notice of proposed rulemaking, and will not be restated here. The public comment period for this proposed rule ended on June 26, 2015. The EPA received no comments on the proposal.

II. Final Action

The EPA reviewed the May 11, 2015 submittal from Ecology demonstrating that sources in Washington do not significantly contribute to nonattainment or interfere with maintenance of the 2008 Pb and 2010 NO_2 NAAQS in any other state. The EPA has determined that the Washington SIP meets the CAA section 110(a)(2)(D)(i)(I) interstate transport requirements for the 2008 Pb and 2010 NO_2 NAAQS. This action is being taken under section 110 of the CAA.

III. Statutory and Executive Orders Review

Under the CAA, the Administrator is required to approve a SIP submission that complies with the provisions of the CAA and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, the EPA's role is to approve state choices, provided that they meet the criteria of the CAA. Accordingly, this action merely approves State law as meeting Federal requirements and does not impose additional requirements beyond those imposed by State law. For that reason, this action:

EXHIBIT C

Key Changes

Changes Included in This Revision

The table below describes the changes included in this revision of Veterans Benefits Manual M21-1, Part III, "General Claims Process," Subpart iv, "General Rating Process."

Notes:

- M21-1, Part III, Subpart iv, Chapter 4, Section A (III.iv.4.A) previously contained guidance on evaluating pain, joint conditions, and functional loss, rating musculoskeletal disabilities of the spine and upper and lower extremities, congenital musculoskeletal conditions, arthritis, osteomyelitis, and muscle injuries.
  – Information on rating arthritis, osteomyelitis, and muscle injuries (old III.iv.4.A.6-12) is relocated to III.iv.4.B.
  – The remaining content (old III.iv.4.A.1-5 and 13) is being retained and reorganized as shown in the table below.
- Unless otherwise noted, the term "claims folder" refers to the official, numbered, Department of Veterans Affairs (VA) repository – whether paper or electronic – for all documentation relating to claims that a Veteran and/or his/her survivors file with VA.
- Minor editorial changes have also been made to
  – improve clarity and readability
  – add references
  – update incorrect or obsolete references
  – reassign alphabetical designations to individual blocks, where necessary, to account for new and/or deleted blocks within a topic
  – update the labels of individual blocks and the titles of topics to more accurately reflect their content, and
  – bring the document into conformance with M21-1 standards.

Reason(s) for Notable Change	Citation
• To relocate guidance on evaluating painful motion of minor joints and joint groups from old M21-1, Part III, Subpart iv, Chapter 4, Section A, Topic 1, Block j (III.iv.4.A.1.j) to a new Block p. • To clarify and reorganize guidance on proper evaluation of fingers and toes when painful motion is present. • To remove the examples for relocation to a new Block q.	III.iv.4.A.1.p
• To add a new Block q for relocation of examples of painful motion of minor joints, previously located in old III.iv.4.A.1.j. • To clarify proper procedures for use of diagnostic code (DC) 5280 when considering painful motion.	III.iv.4.A.1.q
To add a new Block r with guidance on application of painful motion to DC 5276.	III.iv.4.A.1.r

To add a new Block s with guidance on the Evaluation Builder workaround for painful motion of the fingers.	III.iv.4.A.1.s
To add a new Block t with guidance on the Evaluation Builder workaround for painful motion of the feet.	III.iv.4.A.1.t
To add a new Block n to incorporate the definition of ankyloses of the joints.	III.iv.4.A.2.n
To add a new Block d to incorporate guidance on handling joint stability findings.	III.iv.4.A.6.d
• To relocate old III.iv.4.A.4.i to a new Block f. • To completely revise the guidance on handling meniscal disabilities to reflect the policy change effected by *Lyles v. Shulkin*, 29 Vet.App. 107 (2017).	III.iv.4.A.6.f
• To relocated old III.iv.4.A.4.j to a new Block g. • To remove the guidance on the prohibition of separate evaluations for instability and meniscal disabilities as effective by the Lyles holding. • To add examples of proper evaluations of meniscal disabilities.	III.iv.4.A.6.g
To add a new Block h with guidance on the Evaluation Builder workaround for meniscal disabilities.	III.iv.4.A.6.h
To add a new Block c to clarify guidance on assigning separate evaluation for co-existing foot disabilities.	III.iv.4.A.7.c
• To add information from the August 2014 Compensation Bulletin Addendum and the November 2015 Quality Call concerning application of the amputation rule. • To change the order of old Blocks d and e.	III.iv.4.A.8.e

Reason(s) for Change	Citation
To add language within the notes section to clarify that objective evidence of painful motion is not required under 38 CFR 4.59.	III.iv.4.A.1.a
To clarify that the *DeLuca* holding is not limited in impact to painful motion.	III.iv.4.A.1.c
To clarify that the *Mitchell* holding is not limited in impact to painful motion.	III.iv.4.A.1.e
To add language to refer readers to correlated information concerns applicability of guidance to specific DCs.	III.iv.4.A.1.i
To reorder old III.iv.4.a.1.k to new Block j and old III.iv.4.a.1.l to new Block k based on the relocation of old III.iv.4.a.1.j elsewhere in the topic.	III.iv.4.A.1.j and k
To add a new Block l to outline the steps to take to apply 38 CFR 4.59.	III.iv.4.A.1.l
To add a new Topic 4 for relocation of information on disabilities of the hands, previously included at III.iv.4.A.3.	III.iv.4.A.4
To relocate old III.iv.4.A.3.f-i to new Blocks a-d.	III.iv.4.A.4.a-d
To relocate old III.iv.4.A.3.k-m to new Blocks e-g.	III.iv.4.A.4.e-g
• To relocate old III.iv.4.A.3.n to a new Block h. • To add painful motion as another method in which a finger disability can warrant a compensable evaluation. • To reword the guidance on the *Spicer* holding for the purpose of clarification only.	III.iv.4.A.4.h

To relocate old III.iv.4.A.3.j to a new Block i.	III.iv.4.A.4.i
To add a new Topic 6 for relocation of information on disabilities of the legs, previously included in old III.iv.4.A.4.	III.iv.4.A.6
To relocate old III.iv.4.A.4.e-g to new Blocks a-c.	III.iv.4.A.6.a-c
• To relocate old III.iv.4.A.4.h to a new Block e. • To reword the guidance on intermediate evaluations for knee replacements for the purpose of clarification only.	III.iv.4.A.6.e
To relocate old III.iv.4.A.4.k-p to new Blocks i-n.	III.iv.4.A.6.i-n
To add a new Topic 7 for relocation of information on disabilities of the feet, previously included in III.iv.4.A.4.	III.iv.4.A.7
To relocate old III.iv.4.A.4.w to a new Block a.	III.iv.4.A.7.a
To relocate old III.iv.4.A.4.r to a new Block b.	III.iv.4.A.7.b
To relocate old III.iv.4.A.4.v to a new Block d.	III.iv.4.A.7.d
To relocate old III.iv.4.A.4.q to a new Block e.	III.iv.4.A.7.e
To relocate old III.iv.4.A.4.s-u to new Blocks f-h.	III.iv.4.A.7.f-h
To remove old III.iv.4.A.5 on congenital musculoskeletal conditions as the information has been relocated to new III.iv.4.A.8.	--
To remove old Topics 6-12 for relocation to III.iv.4.B.	--
To reorder old III.iv.4.a.13.e to new Block d and old III.iv.4.a.13.d to new Block e.	III.iv.4.A.8.d and e
To relocate old III.iv.4.A.5.a to an new Block g.	III.iv.4.A.8.g
To relocate old III.iv.4.A.5.b to a new Block h.	III.iv.5.A.8.h

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Signature

Beth Murphy, Director
Compensation Service

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Section A. Musculoskeletal Conditions

Overview

In This Section This section contains the following topics:

Topic	Topic Name
1	Evaluating Painful Motion
2	Evaluating Joint Conditions and Functional Loss
3	Evaluating Musculoskeletal Disabilities of the ~~Upper Extremities~~Arms
4	Evaluating Musculoskeletal Disabilities of the Hands
5~~4~~	Evaluating Musculoskeletal Disabilities of Spine ~~and Lower Extremities~~
6	Evaluating Musculoskeletal Disabilities of the Legs
7	Evaluating Musculoskeletal Disabilities of the Feet
~~5~~	~~Congenital Musculoskeletal Conditions~~
~~6~~	~~Rheumatoid Arthritis (RA)~~
~~7~~	~~Degenerative Arthritis~~
~~8~~	~~Limitation of Motion (LOM) in Arthritis Cases~~
~~9~~	~~Examples of Rating Decisions for LOM in Arthritis Cases~~
~~10~~	~~Osteomyelitis~~
~~11~~	~~Examples of the Proper Rating Procedure for Osteomyelitis~~
~~12~~	~~Muscle Injuries~~
8~~13~~	Miscellaneous Musculoskeletal Considerations

1. Evaluating Painful Motion

Introduction

This topic contains information on evaluating painful motion, including

- establishing the minimum compensable evaluation under 38 CFR 4.59
- precedential court holdings impacting 38 CFR 4.59
- assessing functional loss due to pain per *DeLuca v. Brown*
- applicability of 38 CFR 4.59 beyond arthritis per *Burton v. Shinseki*
- assessing functional loss due to pain per *Mitchell v. Shinseki*
- satisfactory evidence of painful motion per *Petitti v. McDonald*
- selecting a diagnostic code (DC) and minimum compensable evaluation for 38 CFR 4.59 per *Sowers v. McDonald*
- assessing joint disabilities for pain per *Correia v. McDonald*
- ~~selecting a DC for application of 38 CFR 4.59 per *Southall-Norman v. McDonald*~~
-
- ~~evaluating painful motion of minor joints or joint groups under 38 CFR 4.59~~
- assessing medical evidence for functional loss due to pain
- entering *DeLuca* and *Mitchell* data in Evaluation Builder~~, and~~
- applying 38 CFR 4.59
- examples of considering
  – 38 CFR 4.59 for shoulder disabilities
  – non-objective pain under 38 CFR 4.59, and
  – pain with passive range of motion (ROM) under 38 CFR 4.59
- evaluating painful motion of minor joints or joint groups under 38 CFR 4.59
- examples of painful motion of minor joints
- example of painful motion and DC 5276, and
- evaluation builder workaround for painful motion of the
  – fingers, and
  – feet.

Change Date

~~October 24, 2017~~April 13, 2018

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a. Establishing the Minimum Compensable Evaluation Under 38 CFR 4.59

An actually painful joint can be a basis for assignment of a compensable evaluation even though the specific criteria for a compensable evaluation listed in a diagnostic code (DC) for the joint are not met.

The regulatory language at 38 CFR 4.59 provides that

- pain of a joint due to joint or periarticular (structures surrounding the joint) pathology is indicative of disability, and
- an actually painful joint justifies the assignment of the minimum compensable evaluation for the joint under the applicable ~~diagnostic code (~~DC~~).~~

Guidance for assessment of a disability to determine whether painful motion exists is also included in 38 CFR 4.59. Particularly, ~~38 CFR 4.59~~this regulation

- describes ways in which painful motion can be discerned, such as
  – facial expression
  – wincing, etc., on pressure of manipulation
  – muscle spasms, or
  – crepitation in tendons, ligaments, or joint structures
- requires that the findings be noted in the medical evidence to assist the rating authority in assigning a disability rating that adequately accounts for painful motion, and
- explains the kinds of test results that must be obtained to permit an adjudicator to assess the effect of painful motion, including range of motion (ROM) tests
  – for passive and active motion
  – in both weight-bearing and nonweight-bearing circumstances, and
  – for the opposite undamaged joint for comparison purposes, if possible.

Notes:

- 38 CFR 4.71a, DC 5002 and 5003 (and several other DCs that incorporate the criteria from those DCs by reference) provide that where limitation of motion (LOM) of joint(s) is noncompensable under DCs specific to the involved joint(s), a compensable evaluation can be assigned for the LOM if objectively confirmed by findings such as satisfactory evidence of painful motion. ~~However~~In contrast, 38 CFR 4.59 provides an alternate basis for assigning a compensable evaluation for disabilities rated under those DCs on the basis of credible lay evidence of painful motion. The minimum compensable evaluation may be assigned under 38 CFR 4.59 based on subjective painful motion, and does not require objective evidence of painful motion.
- Multiple precedential decisions of the Court of Appeals for Veterans Claims (CAVC) have impacted the application of 38 CFR 4.59, as discussed at M21-1, Part III, Subpart iv, 4.A.1.b-~~i~~t. These holdings must be applied in determining whether the minimum compensable evaluation for a disability based on painful motion is warranted under 38 CFR 4.59.

Reference: For more information on considering painful motion when assigning multiple LOM evaluations for a joint, see M21-1, Part III, Subpart iv, 4.A.2.c.

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b. Precedential Court Holdings Impacting 38 CFR 4.59

Multiple precedential decisions have impacted the application of 38 CFR 4.59. Refer to the table below for a listing of impactful precedential court holdings, a brief description of the impact, and the applicability date (date of decision) for each. More detailed explanations for each holding and its impact on the application of 38 CFR 4.59 in claims processing can be found

in M21-1, Part III, Subpart iv, 4.A.1.c-i.

Holding	Summary of Impact	Date of Decision
DeLuca v. Brown, 8 Vet.App. 202 (1995)	Clarified exam requirements to assess the impact of pain on functional impairment including additional loss of motion due to pain.	December 22, 1995
Burton v. Shinseki, 25 Vet.App. 1 (2011)	38 CFR 4.59 is not limited in applicability to arthritis claims.	August 4, 2011
Mitchell v. Shinseki, 25 Vet.App. 32 (2011)	Clarified • exam requirements for assessing impact of painful motion with use and during flare-ups, and • that when assigning a disability evaluation based on loss of ~~range of motion (~~ROM~~)~~, painful motion is not considered the same as limited motion unless the pain actually causes a loss of motion.	August 23, 2011
Petitti v. McDonald, 27 Vet.App. 415 (2015)	• 38 CFR 4.59 does not require objective evidence of painful motion for assignment of a minimal compensable evaluation for a joint. • 38 CFR 4.71a, DC 5002 does require objective evidence of painful motion.	October 28, 2015
Sowers v. McDonald, 27 Vet.App. 472 (2016)	38 CFR 4.59 is • limited by the DC applicable to the claimant's disability, and • inapplicable to a DC that does not provide a compensable evaluation. ***Note***: The *Sowers* holding influenced a subsequent policy decision to assign the minimum compensable evaluation under the corresponding DC for painful motion under 38 CFR 4.59.	February 12, 2016 ***Note***: The policy decision to assign the minimum compensable evaluation under the corresponding DC for painful motion under 38 CFR 4.59 is effective May 23, 2016.
Correia v. McDonald, 28	• Clarified exam requirements for ROM testing to evaluate	July 5, 2016

Vet.App. 158 (2016)	joint disabilities for painful motion in weight-bearing, nonweight-bearing, with active and passive motion, and in comparison to the opposite joint. • Directed that pain with passive motion (even in the absence of another indication of painful motion) is sufficient to satisfy the criteria for entitlement to the minimum compensable evaluation under 38 CFR 4.59.	
Southall-Norman v. McDonald, 28 Vet.App. 346 (2016)	38 CFR 4.59 is not limited to DCs involving limited ROM.	December 15, 2016

Reference: For more information on assignment of effective dates associated with precedential court decisions, see M21-1, Part III, Subpart iv, 5.C.7.l-q.

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c. Assessing Functional Loss Due to Pain Per Deluca v. Brown

In *DeLuca v. Brown*, 8 Vet.App. 202 (1995), the CAVC held that in examinations of musculoskeletal disabilities, the examiner must be asked to give an opinion on whether pain could significantly limit functional ability during flare-ups or with repeated use over a period of time.

This information must be portrayed in terms of the degree of additional ROM lost due to pain on use or during flare-ups.

Impact on application of 38 CFR 4.59:

- Examinations must address the *DeLuca* criteria.
- The *DeLuca* holding is not limited in impact to painful motion. The holding impacts consideration of functional impairment due to pain and other factors as discussed in 38 CFR 4.40, 38 CFR 4.45, and M21-1, Part III, Subpart iv, 4.A.2.
- Decision makers must properly assess the *DeLuca* findings in conjunction with 38 CFR 4.40, 38 CFR 4.45, and 38 CFR 4.59. The disability is evaluated based on most severe loss of motion due to pain or following repetitive motion testing.
- The *Deluca* decision was effective December 22, 1995.

Note: The *DeLuca* holding had limited impact on the application of 38 CFR 4.59 other than the fact that it may elicit evidence concerning the presence of pain. However, *DeLuca* does impact application of 38 CFR 4.40 and 38 CFR 4.45. In *DeLuca*, CAVC also clarified that the plain language of 38 CFR 4.45 does not limit the evaluation criteria contained therein to muscle injuries.

Reference: For more information on assessing examinations for adequacy in

conjunction with the *DeLuca* holding, see
- M21-1, Part III, Subpart iv, 4.A.1.j-k, and
- M21-1, Part III, Subpart iv, 3.D.4.g-h.

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d. Applicability of 38 CFR 4.59 Beyond Arthritis Per Burton v. Shinseki

Although the first sentence of 38 CFR 4.59 refers only to arthritis, the CAVC held in *Burton v. Shinseki*, 25 Vet.App. 1 (2011) that the regulation is, in fact, also applicable to joint conditions other than arthritis.

Impact on application of 38 CFR 4.59:
- Do not limit assignment of the minimum compensable evaluation under 38 CFR 4.59 to DCs involving arthritis.
- The *Burton* holding affirmed the Department of Veterans Affairs' (VA's) longstanding policy on the application of 38 CFR 4.59 to disabilities in addition to arthritis.
- The *Burton* holding is effective August 4, 2011.

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e. Assessing Functional Loss Due to Pain Per Mitchell v. Shinseki

In *Mitchell v. Shinseki*, 25 Vet.App. 32 (2011), the CAVC held that pain alone does not constitute a functional loss under VA regulations that evaluate disability based upon ROM loss. Thus, when assigning a disability evaluation based on loss of ROM, painful motion is not considered the same as limited motion unless the pain actually causes a loss of motion.

The CAVC also held that
- if pain is associated with movement, the examiner must give an opinion on whether pain could significantly limit functional ability during flare-ups or when the joint is used repeatedly over a period of time, and
- the opinion must, if feasible, be expressed in terms of the degree of additional ROM loss due to pain on use or during flare-ups.

Impact on application of 38 CFR 4.59:
- Examinations must address the *Mitchell* criteria.
- When painful motion on repeated use over time or during a flare-up results in additional loss of ROM, then the condition should be evaluated based on the additional loss of ROM.
- ROM must be actually limited. Do not assign an evaluation for loss of ROM based on the point at which pain accompanies motion unless the pain actually causes reduced ROM on objective assessment.
- The *Mitchell* holding is not limited in impact to painful motion. The holding impacts consideration of functional impairment due to pain and other factors as discussed in 38 CFR 4.40, 38 CFR 4.45, and M21-1, Part III, Subpart iv, 4.A.2.c.
- The *Mitchell* holding is effective August 23, 2011.

Reference: For more information on assessing examinations for adequacy in conjunction with the *Mitchell* holding, see
- M21-1, Part III, Subpart iv, 4.A.1.j-k, and

- M21-1, Part III, Subpart iv, 3.D.4.g-h.

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f. Satisfactory Evidence of Painful Motion Per Petitti v.McDonald

In *Petitti v. McDonald*, 27 Vet.App. 415 (2015), the CAVC held that 38 CFR 4.59 does not require *objective* evidence of painful motion for assignment of a minimal compensable evaluation of a joint. This guidance applies to all musculoskeletal disabilities irrespective of the DC that has already been assigned to the disability.

Note: Apply the historical criteria for acceptance of an informal claim under 38 CFR 3.157, as discussed in M21-1, Part III, Subpart iv, 5.C.9, when a report of examination or hospitalization at a VA or uniform services facility shows the presence of painful motion of a service-connected (SC) disability evaluated as noncompensable on before March 24, 2015.

Impact on application of 38 CFR 4.59:

- Under 38 CFR 4.59, objective evidence of painful motion is not required for assignment of the minimum compensable evaluation for the musculoskeletal disability. Lay evidence of painful motion is sufficient.
  – Lay testimony may consist of a Veteran's own statement to the extent that the statement describes symptoms capable of lay observation.
  – Lay testimony may consist of a description by another person detailing observations of a Veteran's difficulty walking, standing, sitting, or undertaking other activity.
- The following are examples (not an all-inclusive list) of symptoms sufficient to assign the minimum compensable evaluation for the joint under 38 CFR 4.59:
  – pain with weight-bearing or nonweight-bearing
  – pain with passive ROM
  – pain reported during repeated use, or
  – pain reported during flare-ups.
- The following are examples (not an all-inclusive list) of symptoms that can support a claimant's report of painful motion but are not sufficient evidence, by themselves, to support assignment of the minimum compensable evaluation under 38 CFR 4.59:
  – crepitus/joint crepitation (a clinical sign of a crackling or grating feeling or sound in a joint), and
  – pain on palpation.
- An examiner's opinion that painful motion would be present with repeated use over time or during flare-ups (as required in the *Mitchell* opinion) may be sufficient lay evidence to support a finding of painful motion, if found credible.
- A finding of painful motion under 38 CFR 4.59 based on lay or subjective reporting of pain is contingent on a credibility assessment as discussed at M21-1, Part III, Subpart iv, 5.A.2.b.
- Prior to the *Petitti* holding, longstanding VA policy was that objective evidence of painful motion was required to assign the minimum compensable evaluation under 38 CFR 4.59.

- The *Petitti* holding is effective October 28, 2015.

Reference: For more information on assignment of effective dates associated with

- informal claims accepted under 38 CFR 3.157, see M21-1, Part III, Subpart iv, 5.C.9, and
- precedential court decisions, see M21-1, Part III, Subpart iv, 5.C.7.l-p.

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g. Selecting a DC and Minimum Compensable Evaluation for 38 CFR 4.59 Per Sowers v. McDonald

In *Sowers v. McDonald*, 27 Vet.App. 472 (2016), the CAVC held that 38 CFR 4.59 is limited by the DC applicable to the claimant's disability, and where that DC does not provide a compensable rating, 38 CFR 4.59 does not apply.

Example: Painful motion of a right ring finger fracture that is rated under 38 CFR 4.71a, DC 5230 would not receive a compensable evaluation under 38 CFR 4.59 because this DC does not contain a compensable evaluation.

Important: In *Sowers*, the CAVC did not specifically hold that the minimum compensable evaluation must be assigned under the applicable DC for the disability involved. However, the holding did influence a subsequent policy determination that the minimum compensable evaluation under the DC must be assigned when painful motion is demonstrated under 38 CFR 4.59. This policy is effective May 23, 2016.

- This policy particularly affects painful motion of the shoulder evaluated under 38 CFR 4.71a, DC 5201. Under this DC, painful motion of the shoulder warrants assignment of a 20-percent evaluation.
- This decision represents a change in longstanding VA policy in which the minimum compensable evaluation was interpreted as a 10-percent evaluation irrespective of the DC involved.

Impact on application of 38 CFR 4.59:

- Effective February 12, 2016, the Sowers holding requires that 38 CFR 4.59 must be applied based on the DC applicable to the disability. In other words, the DC most appropriate to the disability being evaluated must be selected, and then 38 CFR 4.59 must be applied accordingly.
- Effective May 23, 2016, the minimum compensable evaluation refers to the lowest evaluation specified under the DC most applicable to the disability.

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h. Assessing Joint Disabilities for Pain Per Correia v. McDonald

In *Correia v. McDonald*, 28 Vet.App. 158 (2016), the CAVC held that the final sentence of 38 CFR 4.59 requires that certain ROM testing be conducted to assess for pain whenever possible in evaluating joint disabilities. Particularly,

- the joints involved must be tested for pain
  – on both active and passive motion, and
  – in weight-bearing and nonweight-bearing, and

- the ROM of the opposite, undamaged joint must be assessed for comparison, if possible.

CAVC also held that pain with passive motion, and not just active motion, warrants entitlement to the minimum compensable evaluation under 38 CFR 4.59.

Note: If the examiner cannot assess the motion of the opposite, undamaged joint, *and an opposite joint does exist*, the examiner should explain why the assessment is not possible. Examples of situations in which ROM of the opposite, undamaged joint cannot be assessed for comparison include (but are not limited to) the

- spinal disabilities, since there is no opposite joint
- disabilities wherein the opposite, undamaged joint has been amputated, or
- disabilities wherein the opposite joint is damaged or disabled and would not be an effective comparison to ascertain the degree of impairment of the SC joint.

Impact on application of 38 CFR 4.59:

- Examinations must address the *Correia* criteria.
- Assign the minimum compensable evaluation when there is evidence of painful motion with
  – active or passive motion, and/or
  – with weight-bearing or nonweight-bearing.
- Prior to the *Correia* holding, longstanding Veterans Benefits Administration policy was that only pain with active motion triggers application of 38 CFR 4.59.
- The *Correia* holding is effective July 5, 2016.

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i. Selecting a DC for Application of 38 CFR 4.59 Per Southall-Norman v. McDonald

In *Southall-Norman v. McDonald*, 28 Vet.App. 346 (2016), the CAVC held that 38 CFR 4.59 is

- not limited to the evaluation of musculoskeletal disabilities under DCs predicated upon ROM measurements, and
- applicable to the evaluation of musculoskeletal disabilities involving actually painful, unstable, or malaligned joints or periarticular regions, regardless of whether the DC under which the disability is evaluated is predicated upon ROM measurements.

Examples:

- 38 CFR 4.59 supports assignment of a 10-percent evaluation where great/first toe malalignment (hallux valgus) is actually painful, even though the regulatory criteria of 38 CFR 4.71a, DC 5280 do not mention ROM and the specified 10-percent criteria under that DC (operated with resection of the metatarsal head or severe, if equivalent to amputation of the great toe) are not met. Refer to M21-1, Part III, Subpart iv, 4.A.1.p-q for more information on the application of 38 CFR 4.59 to 38 CFR 4.71a, DC 5280.

- 38 CFR 4.59 supports assignment of a 10-percent evaluation where there is pain from a flat foot or feet (pes planus) even though the regulatory criteria of 38 CFR 4.71a, DC 5276 do not specifically mention ROM, the specified 10-percent criteria under that DC are not met, and the DC provides for a lower, zero percent, evaluation. Refer to M21-1, Part III, Subpart iv, 4.A.1.r for more information on the application of 38 CFR 4.59 to 38 CFR 4.71a, DC 5276.

Impact on application of 38 CFR 4.59:

- When musculoskeletal disability involves joint or periarticular pathology that is painful, 38 CFR 4.59 is applicable when painful motion is present without regard to whether the DC used for evaluation involves ROM.
- The *Southall-Norman* holding represents a change to longstanding VA policy which directed that 38 CFR 4.59 applies only to DCs involving ROM.
- The *Southall-Norman* holding is effective December 15, 2016.

~~k.~~j. Assessing Medical Evidence for Functional Loss Due to Pain

Medical evidence used to evaluate functional impairment due to pain must account for painful motion, pain on use, and pain during flare-ups or with repeated use over a period of time.

As a part of the assessment conducted in accordance with *DeLuca v. Brown*, 8 Vet.App. 202 (1995), the medical evidence must

- clearly indicate the exact degree of movement at which pain limits motion in the affected joint, and
- include the findings of at least three repetitions of ROM.

Per *Mitchell v. Shinseki*, 25 Vet.App. 32 (2011), when pain is associated with movement, an examiner must opine or the medical evidence must show whether pain could significantly limit functional ability

- during flare-ups, or
- when the joint is used repeatedly over a period of time, and
- if there is functional impairment found during flare-ups or with repeated use over a period of time, the examiner must provide, if feasible, the degree of additional LOM due to pain on use or during flare-ups.

Per *Correia v. McDonald*, 28 Vet.App. 158 (2016)

- the joints involved must be tested for pain
  – on both active and passive motion, and
  – in weight-bearing and nonweight-bearing, and
- if possible, the ROM of the opposite, undamaged joint must be assessed for comparison.

Important: If the examiner is unable to provide any of the above findings, he

or she must

- indicate that he/she cannot determine, without resort to mere speculation, whether any of these factors cause additional functional loss, and
- provide the rationale for this opinion.

Note: Per *Jones (M.) v. Shinseki*, 23 Vet.App. 382 (2010), the VA may only accept a medical examiner's conclusion that an opinion would be speculative if

- the examiner has explained the basis for such an opinion, identifying what facts cannot be determined, or
- the basis for the opinion is otherwise apparent in VA's review of the evidence.

Reference: For more information on reviewing musculoskeletal examination reports for sufficiency, see M21-1, Part III, Subpart iv, 3.D.4.g-h.

~~l.~~k. Entering DeLuca and Mitchell Data in the Evaluation Builder

The findings of De*Luca* repetitive ROM testing or the functional loss expressed in the *Mitchell* opinion will be used to evaluate the functional impairment of a joint due to pain.

- Only the most advantageous finding will be utilized to evaluate the joint condition.
- Do not "add" the LOM on *DeLuca* exam to the LOM expressed in a *Mitchell* opinion.

Note: For purposes of data entry in the Evaluation Builder ~~tool~~, if evaluating a joint where data fields are present for only initial ROM and for *DeLuca* (but not for *Mitchell*), enter either the *DeLuca* or the *Mitchell* data in the *DeLuca* field, whichever results in the higher disability evaluation.

References: For more information on the

- *Deluca* holding, see
  – M21-1, Part III, Subpart iv, 4.A.1.c, and
  – *DeLuca v. Brown*, 8 Vet.App. 202 (1995)~~, and~~
- *Mitchell* holding, see
  – M21-1, Part III, Subpart iv, 4.A.1.e, and
  – *Mitchell v. Shinseki*, 25 Vet.App. 32 (2011), and
- evaluating joint conditions and functional loss, see M21-1, Part III, Subpart iv, 4.A.2.

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l. Applying 38 CFR 4.59

Refer to the table below for procedures for assessing the applicability of and applying 38 CFR 4.59.

Step	Action
1	Determine the DC most applicable to the disability based on either

	• the disability and corresponding DC as specifically listed in the Rating Schedule, or • application of 38 CFR 4.20 for selection of the most appropriate analogous DC. Proceed to Step 2. ***Note***: Per *Sowers v. McDonald*, 27 Vet.App. 472 (2016), 38 CFR 4.59 is limited by the DC applicable to the claimant's disability.
2	Review findings on examination to determine whether painful motion is present. If painful motion is • present, proceed to Step 3, or • not present, do not apply 38 CFR 4.59. ***Note***: Per *Petitti v. McDonald*, 27 Vet.App. 415 (2015), 38 CFR 4.59 does not require objective evidence of painful motion for assignment of a minimal compensable evaluation for a joint.
3	If the DC • involves joint or periarticular pathology, go to Step 4, or • does not involve joint or periarticular pathology, then application of 38 CFR 4.59 is not warranted. ***Note***: Per *Southall-Norman v. McDonald*, 28 Vet.App. 346 (2016), 38 CFR 4.59 is not limited to DCs involving limited ROM.
4	Review the available evaluations under the selected DC. If the selected DC • allows for assignment of a compensable evaluation, then assign the minimum compensable evaluation for painful motion if other symptoms do not warrant a higher evaluation, or • does not allow for a compensable evaluation, then do not assign a compensable evaluation under 38 CFR 4.59. ***Note***: The holding in *Sowers v. McDonald*, 27 Vet.App. 472 (2016) influenced a subsequent policy decision to assign the minimum compensable evaluation under the corresponding DC for painful motion under 38 CFR 4.59.

m. Examples -- Considering 38 CFR 4.59 for Shoulder Disabilities

The following examples demonstrate the proper procedures for considering 38 CFR 4.59 when evaluating shoulder disabilities.

Example 1: Assume a shoulder strain with forward elevation and abduction limited to 145 degrees with credible evidence of pain while performing each

motion, starting at 140 degrees. Assign a 20-percent evaluation under 38 CFR 4.71a, DC 5201. Under 38 CFR 4.59 there is actually painful motion and joint or periarticular pathology (a strain). Therefore the intention of the rating schedule is that the decision maker will assign the minimum compensable evaluation provided under the DC appropriate to the disability at issue. The lowest specified compensable evaluation for shoulder motion under the DC is 20 percent.

Example 2: Assume the same facts as in Example 1, but the diagnosis is traumatic arthritis of the shoulder based on x-rays. Assign a 20-percent evaluation under 38 CFR 4.71a, DC 5010-5201 with application of 38 CFR 4.59. The ROM does not meet the criteria for a 20-percent evaluation under 38 CFR 4.71a, DC 5201 because arm motion is not limited at shoulder height. However, pursuant to 38 CFR 4.59 there is actually painful motion and joint or periarticular pathology (arthritis). Therefore, the intention of the rating schedule is that the decision maker will assign the minimum compensable evaluation provided under the DC appropriate to the disability at issue. The lowest specified compensable evaluation for shoulder motion under 38 CFR 4.71a, DC 5201 is 20 percent.

Although the diagnosis was traumatic arthritis, using 38 CFR 4.71a, DC 5010-5201 is more advantageous to the Veteran. However, in some cases, a 10-percent evaluation under the arthritis criteria may be appropriate. See Example 3.

Example 3: Assume the same facts as in Example 2 except that there was no pain on motion. There was a minor amount of swelling of the shoulder. Assign a 10-percent evaluation under 38 CFR 4.71a, DC 5010. There is x-ray evidence of traumatic arthritis and motion that is noncompensable under the applicable DC. There is no evidence of painful motion, so 38 CFR 4.59 is not applicable. Under 38 CFR 4.71a, DC 5010, traumatic arthritis is rated using the criteria of 38 CFR 4.71a, DC 5003, which requires that LOM be "objectively confirmed" by findings such as swelling, spasm, or satisfactory evidence of painful motion. In this case there was objective evidence supporting the LOM – namely the minor swelling of the shoulder.

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n. Examples—Considering Non-objective Pain Under 38 CFR 4.59

Example 1: On examination, a claimant reports current symptoms of regular pain of the right knee (particularly when fully straightening the knee) that is worsened with increased activity. The examiner finds normal ROM without pain on examination. Repetitive motion testing produces no evidence of pain or loss of motion. The assessment is right knee strain. Assign a 10-percent evaluation under 38 CFR 4.71a, DC 5261. The claimant's reports of joint pain are found to be credible. There is no basis to reject the complaints of pain as lacking in credibility. 38 CFR 4.59 does not require objective evidence of painful motion. The claimant's statement establishes that there is actually painful motion of the joint, even though it was not objectively verified on VA examination.

Example 2: On examination, a claimant reports constant pain of the left elbow (particularly when bending the arm). The examiner finds normal ROM without pain on examination. Repetitive motion testing produces no evidence of pain or loss of motion. There is no swelling or spasm. The assessment is degenerative arthritis of the left elbow corroborated by x-rays. Assign a 10-percent evaluation under 38 CFR 4.71a, DC 5003-5206. The claimant's reports of joint pain are found to be credible. There is no basis to reject the complaints of pain as lacking in credibility. Although 38 CFR 4.71a, DC 5003 requires noncompensable LOM and objective confirmation of LOM by spasm, swelling, or satisfactory evidence of painful motion, 38 CFR 4.59 provides an alternative basis for a compensable evaluation and does not require objective evidence of painful motion. The claimant's statement establishes that there is actually painful motion of the joint, even though pain was not objectively verified on VA examination.

Example 3: Start with the same facts as Example 2. However, in this example, claimant states on exam that he has had significant pain on elbow motion consistently for the last year and particularly in the last week. However, treatment records from the past year show normal, painless range of elbow motion and no history of pain at rest, or on motion. Notably, in a VA outpatient report from two days before the VA examination, the claimant told his treating doctor that his elbow was not painful and had not been painful at all in the last year. Continue the zero-percent evaluation. Although the Veteran reported elbow pain on examination, review of the evidence as a whole satisfactorily demonstrates that the Veteran's complaints of painful motion were not credible. Elbow motion is not found to be actually painful.

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o. Example—Considering Pain With Passive ROM Under 38 CFR 4.59

Service connection (SC) is established for left rotator cuff impingement. The Veteran reports shoulder pain when lifting the left arm – particularly with repetitive motion of the arm at or above shoulder height. The Veteran reported a feeling of weakness with repeated over the head motions like painting. On examination the Veteran had full active forward elevation, abduction and external and internal rotation of the shoulder including on repeated motion. There was no report of pain with active motion. Passive ROM testing for impingement including the Hawkin's Sign was positive and reproduced impingement with the guided movements at shoulder height. Assign a 20-percent evaluation under 38 CFR 4.71a, DC 5201. The Hawkin's Sign is a test for pain on passive ROM. Under 38 CFR 4.59 the shoulder is actually painful to passive ROM and there is joint or periarticular pathology (rotator cuff impingement). The intention of the rating schedule is that the decision maker will assign the minimum compensable evaluation provided under the DC appropriate to the disability at issue. The lowest specified compensable evaluation for limited ROM of the shoulder under the DC is 20 percent.

Note: Medical Electronic Performance Support System (EPSS) provides that a rotator cuff tear should be rated by analogy to 38 CFR 4.71a, DC 5203 (clavicle or scapula, impingement of) because the rotator cuff holds the

humeral head in the glenoid fossa of the scapula and consists of the muscles around the scapula. However 38 CFR 4.71a, DC 5203 in turn provides that rather than rating impairment of the scapula by dislocation, nonunion, or malunion it may also be rated "on impairment of function of the contiguous joint." Medical EPSS notes that rotator cuff impingement is characterized by pain and weakness with motions at or above shoulder height and advises that there may be ~~limitation of motion~~LOM of the arm for the purposes of 38 CFR 4.71a, DC 5201 in cases of rotator cuff disease.

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pj. Evaluating Painful Motion of Minor Joints or Joint Groups Under 38 CFR 4.59

The determining factor as to whether a minimum compensable evaluation may be assigned under 38 CFR 4.59 is whether the appropriate corresponding DC for the joint or periarticular region involved includes a compensable evaluation, as demonstrated in *Sowers v. McDonald*, 27 Vet.App. 472 (2016).

38 CFR 4.59 does not include a specific provision limiting application to major joints or provisions for how to consider groups of minor joints. Thus, major joint involvement or multiple minor joint involvement is not a factor in determining whether a minimum compensable evaluation may be assigned under 38 CFR 4.59.

The following principles apply when evaluating painful motion of the minor joints of the hands and feet:

- 38 CFR 4.71a, DC 5228 and 5229 allow for compensable evaluations for LOM of the thumb, index finger, and long finger. Consequently, compensable evaluations are warranted for painful motion of each of these fingers. Separate evaluations must be assigned for each SC digit evaluated under these DCs affected by painful motion.

~~***Examples:***~~

~~Hallux valgus with painful motion of the first toe is most appropriately evaluated under 38 CFR 4.71a, DC 5280. The minimum compensable evaluation for this DC is 10 percent. Therefore, a 10-percent evaluation is warranted for painful motion of the first toe.~~

~~Residuals of fracture of the little finger with painful motion is most appropriately evaluated under 38 CFR 4.71a, DC 5230. The only possible evaluation under this DC is a zero percent. Therefore, a compensable evaluation cannot be assigned for painful motion of the little finger.~~

- ~~Painful motion due to fracture of the index or long finger is most appropriately evaluated under 38 CFR 4.71a, DC 5229. The minimum compensable evaluation for this DC is 10 percent. Therefore, a 10-percent evaluation is available for painful motion of the index finger and an additional 10-percent evaluation is warranted for painful motion of the long finger, both under 38 CFR 4.71a, DC 5229~~Painful motion of multiple toes of one foot due to injuries is most appropriately evaluated under 38 CFR 4.71a, DC 5284 since there is no specific code for evaluation of injuries of single toes. A single evaluation is warranted for a single foot, whether it is affected by one or more painful toes or other painful joints of the foot. The minimum compensable evaluation for this DC is 10 percent. Therefore, a

single 10-percent evaluation is warranted for painful motion of one of more toes or other joints in a foot due to injury.

– Do not routinely utilize 38 CFR 4.71a, DC 5280 to evaluate painful motion of the first toe.

– Assignment of a 10-percent evaluation for painful motion of the first toe under 38 CFR 4.71a, DC 5280 is appropriate only when the disability being evaluated is hallux valgus or another disability that is most appropriately analogously evaluated as hallux valgus (as required in the *Sowers* holding).

Note: The definition of joint that is reliant on the distinction of major and minor joints at 38 CFR 4.45(f) is applicable for the purpose of rating arthritis but is ***not*** applicable to 38 CFR 4.59.

References: For more information on

- the application of 38 CFR 4.45(f) for major and minor joints, see *Spicer v. Shinseki*, 752 F.3d 1367 (2014)~~, and~~
- evaluating disabilities of the fingers, see M21-1, Part III, Subpart iv, 4.A.4.e-h~~3.n~~, and
- evaluating disabilities of the feet, see M21-1, Part III, Subpart iv, 4.A.7.

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q. Examples—Painful Motion of Minor Joints

Example 1: Hallux valgus with painful motion of the first toe is most appropriately evaluated under 38 CFR 4.71a, DC 5280. The minimum compensable evaluation for this DC is 10 percent. Therefore, a 10-percent evaluation is warranted for painful motion of the first toe. This is applicable only when the disability evaluated is hallux valgus or another disability warranting analogous evaluation under this DC.

Example 2: Residuals of fracture of the little finger with painful motion is most appropriately evaluated under 38 CFR 4.71a, DC 5230. The only possible evaluation under this DC is a zero percent. Therefore, a compensable evaluation cannot be assigned for painful motion of the little finger.

Example 3: Painful motion due to fracture of the index or long finger is most appropriately evaluated under 38 CFR 4.71a, DC 5229. The minimum compensable evaluation for this DC is 10 percent. Therefore, a 10-percent evaluation is available for painful motion of the index finger and an additional 10-percent evaluation is warranted for painful motion of the long finger, each under 38 CFR 4.71a, DC 5229.

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r. Example—Painful Motion and DC 5276

Situation: SC is warranted for flat feet under DC 5276. The clinical evidence shows complete relief of symptoms, including foot pain, with arch supports. However, the record also contains credible lay reports of pain.

Outcome: Although no more than a zero-percent evaluation is warranted under 38 CFR 4.71a, DC 5276 on the basis of complete symptom relief due to

an orthotic device, application of 38 CFR 4.59 warrants assignment of a 10-percent evaluation.

Rationale:

- Subjective, credible reports of painful motion trigger application of 38 CFR 4.59 pursuant to the *Petitti* holding.
- The criteria for assignment of the minimum compensable evaluation under 38 CFR 4.59 are entirely independent of the criteria for evaluation under the DC. Thus, the relief of symptoms of pain is immaterial to assignment of the minimum compensable evaluation for painful motion under 38 CFR 4.59 for pes planus or other analogously rated disabilities.
- Additionally, the *Southall-Norman* holding requires VA to apply 38 CFR 4.59 to all musculoskeletal codes involving joint or periarticular pathology to include even those, such as 38 CFR 4.71a, DC 5276, that do not specifically consider LOM.

Note: The minimum compensable evaluation under 38 CFR 4.71a, DC 5276 is a single 10 percent whether for unilateral or bilateral pes planus. Accordingly, assignment of a single 10-percent evaluation for painful motion due to pes planus is warranted per 38 CFR 4.59 regardless of whether the painful motion is unilateral or bilateral.

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s. Evaluation Builder Workaround for Painful Motion of the Fingers

Until the Evaluation Builder can be updated to reflect the policy and procedural changes affecting evaluation of painful motion of the fingers, decision makers are responsible for ensuring that proper disability evaluations are assigned for painful motion of the fingers.

The workaround provided below will assist decision makers in properly evaluating finger disabilities.

Step	Action
1	When a separate evaluation for painful motion of the thumb or fingers is warranted, as discussed at M21-1, Part III, Subpart iv, 4. A.1.p, do not utilize the Evaluation Builder to evaluate the fingers. Instead, utilize the *Disability Decision Information - manual entry* option in the Veterans Benefits Management System – Rating (VBMS-R). Enter the appropriate disability evaluation information for painful motion of the affected digit(s).
2	In the rating analysis, include the following language to explain the assignment of a 10-percent evaluation for painful motion of the thumb, index finger, or long finger: *We have assigned a 10 percent evaluation based on:* • *Painful motion of the [*input name of affected digit*]*. *38 CFR §4.59 allows consideration of functional loss due to painful motion to be rated to the minimum compensable rating for the affected disability. Since you demonstrate*

	painful motion, a minimum compensable evaluation of 10 percent is assigned.
3	Modify the text below to include only the criteria that is relevant to the fact pattern being addressed and incorporate into the rating narrative as the next higher evaluation criteria. *A higher evaluation of 20 percent is not warranted unless there is:* • *Limited motion of the thumb: with a gap of more than two inches (5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers; or,* • *Favorable ankylosis involving the index finger and any other finger; or,* • *Favorable ankylosis involving the long, ring and little fingers; or,* • *Unfavorable ankylosis involving the thumb; or,* • *Unfavorable ankylosis involving the long and ring fingers; or,* • *Unfavorable ankylosis involving the long and little fingers; or,* • *Unfavorable ankylosis involving the ring and little fingers; or,* • *Amputation of the thumb at distal joint or through distal phalanx; or,* • *Amputation of the index finger without metacarpal resection, at proximal interphalangeal joint or proximal thereto; or,* • *Amputation of the long, ring or middle finger with metacarpal resection (more than one-half the bone lost).* *In some situations, evaluation of disabilities of the hand requires multiple digits to be combined into a single diagnostic code. Therefore, some higher evaluation criteria listed above include all possible higher digit-combination criteria.*

t. Evaluation Builder Workaround for Painful Motion of the Feet

Until the Evaluation Builder can be updated to reflect the policy and procedural changes affecting evaluation of painful motion of the feet, decision makers are responsible for ensuring that proper disability evaluations are assigned for painful motion of the feet.

The workaround provided below will assist decision makers in properly evaluating foot disabilities.

Step	Action
1	When an evaluation for painful motion due to a foot disability evaluated under 38 CFR 4.71a, DC 5276-5284 is warranted, as

	discussed at M21-1, Part III, Subpart iv, 4. A.1.p, do not utilize the Evaluation Builder to evaluate the painful motion of the foot. Instead, utilize the *Disability Decision Information - manual entry* option in VBMS-R. Enter the appropriate disability decision information for the foot condition.
2	In the rating analysis, include the following language to explain the assignment of a 10-percent evaluation for painful motion due to the foot disability: *We have assigned a 10 percent evaluation based on:* • *Painful motion due to [*input name of disability*]*. *38 CFR §4.59 allows consideration of functional loss due to painful motion to be rated to the minimum compensable rating for the affected disability. Since you demonstrate painful motion, a minimum compensable evaluation of 10 percent is assigned.*
3	Utilize the Legacy Evaluation Builder to generate the appropriate next higher evaluation criteria for the selected DC.

2. Evaluating Joint Conditions and Functional Loss

Introduction

This topic contains information on evaluating joint conditions and functional loss, including

- assigning multiple LOM evaluations for a joint
- assigning a separate noncompensable evaluation when schedular zero-percent criteria are not specified
- considering pain when assigning multiple LOM evaluations for a joint
- example of compensable limitation of two joint motions
- example of compensable limitation of one motion with pain in another motion
- example of noncompensable limitation of two motions with pain
- example of evaluating a joint with full ROM and functional loss due to pain
- example of evaluating a joint with LOM and functional loss due to pain
- example of evaluating joints with arthritis by x-ray evidence only with other joint(s) affected by non-arthritic condition
- definition of
  – major joints
  – minor joints, and
  – minor joint groups~~, and~~
- importance of accurate measurements in joint cases, and
- ankylosis of the joints.

Change Date

~~October 24, 2017~~April 13, 2018

a. Assigning Multiple LOM Evaluations for a Joint

In VAOPGCPREC 9-2004, the Office of General Counsel (OGC) held that separate evaluations under 38 CFR 4.71a, DC 5260, (limitation of knee flexion) and 38 CFR 4.71a, DC 5261, (limitation of knee extension) can be assigned without pyramiding. Despite the fact that knee flexion and extension both occur in the same plane of motion, limitation of flexion (bending the knee) and limitation of extension (straightening the knee) represent distinct disabilities.

Important:

- The same principle and handling apply ***only*** to
  – qualifying elbow and forearm movement DCs, flexion (38 CFR 4.71a, DC 5206), extension (38 CFR 4.71a, DC 5207), and impairment of either supination or pronation (38 CFR 4.71a, DC 5213), and
  – qualifying hip movement DCs, extension (38 CFR 4.71a, DC 5251), flexion (38 CFR 4.71a, DC 5252), and abduction, adduction or rotation (38 CFR 4.71a, DC 5253).
- Always ensure that multiple evaluations do not violate the amputation rule in 38 CFR 4.68.

Note: The Federal Circuit has definitively ruled that multiple evaluations for the shoulder under 38 CFR 4.71a, DC 5201, are not permitted. In *Yonek v. Shinseki*, 722 F.3d 1355 (Fed. Cir. 2013) the court held that a Veteran is entitled to a single rating under 38 CFR 4.71a, DC 5201, even though a shoulder disability results in LOM in both flexion (raising the arm in front of the body) and abduction (raising the arm away from the side of the body).

References: For more information on

- pyramiding of evaluations, see
  – 38 CFR 4.14, and
  – *Esteban v. Brown*, 6 Vet.App. 259 (1994)
- painful motion in multiple evaluations for joint LOM, see M21-1, Part III, Subpart iv, 4.A.2.c
- assignment of separate evaluations for disabilities of the elbow, forearm, and wrist, see M21-1, Part III, Subpart iv, 4.A.3.c, and
- examples of actual LOM of two knee motions, see M21-1, Part III, Subpart iv, 4.A.2.d.

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b. Assigning a Separate Noncompensable Evaluation When Schedular Zero-Percent Criteria Are Not Specified

When considering a separate evaluation for a motion of a joint specified in M21-1, Part III, Subpart iv, 4.A.2.a, where zero-percent evaluation criteria are not provided by the DC, *any* LOM for that specific movement falling short of criteria for a compensable level of evaluation will be assigned a separate zero-percent evaluation.

38 CFR 4.31 provides that in every instance where the schedule does not provide a zero-percent evaluation for a DC, a zero-percent evaluation shall be assigned when the requirements for a compensable evaluation are not met.

The motions include

- 38 CFR 4.71a, DC 5207, limitation of extension of the elbow
- 38 CFR 4.71a, DC 5213, impairment of supination and pronation of the forearm
- 38 CFR 4.71a, DC 5251, limitation of extension of the hip
- 38 CFR 4.71a, DC 5252, limitation of flexion of the hip, and
- 38 CFR 4.71a, DC 5253, impairment of rotation, adduction, or abduction of the hip.

Example: Examination shows flexion of the hip limited to 60 degrees and extension limited to 5 degrees. Normal hip ROM is from zero degrees (fully extended) to 125 degrees (fully flexed). The limitation of extension to 5 degrees is rated 10 percent under 38 CFR 4.71a, DC 5251. 38 CFR 4.71a, DC 5252 (limitation of flexion) does not list criteria for a zero-percent evaluation but a 10-percent evaluation requires flexion limited to 45 degrees. Because there is limited flexion not meeting the 10-percent criteria and there is no defined schedular zero-percent evaluation criteria, a zero-percent evaluation is warranted for limited flexion of the hip under 38 CFR 4.71a, DC

5252.

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c. Considering Pain When Assigning Multiple LOM Evaluations for a Joint

When considering the role of pain in evaluations for multiple motions of a single joint, the following guidelines apply.

- When more than one qualifying joint motion is actually limited to a compensable degree and there is painful but otherwise noncompensable limitation of the complementary movement(s), ***only one compensable evaluation can be assigned***.
  – *Mitchell v. Shinseki*, 25 Vet.App. 32 (2011) reinforced that painful motion is the equivalent of limited motion only based on the specific language and structure of 38 CFR 4.71a, DC 5003, not for the purpose of 38 CFR 4.71a, DC 5260, and 38 CFR 4.71a, 5261. For arthritis, if one motion is actually compensable under its 52XX-series DC, then a 10-percent evaluation under 38 CFR 4.71a, DC 5003, is not available and the complementary motion cannot be treated as limited at the point where it is painful.
  – 38 CFR 4.59 does not permit separate compensable evaluations for *each* painful joint *motion*. It only provides that VA policy is to recognize actually painful motion as entitled to at least the minimum compensable evaluation for the *joint*.
- When each qualifying joint motion is painful but motion is not actually limited to a compensable degree under its applicable 52XX-series DC, ***only one compensable evaluation can be assigned***.
  – Assigning multiple compensable evaluations for pain is pyramiding.
  – A joint affected by arthritis established by x-ray may be evaluated as 10-percent disabling under 38 CFR 4.71a, DC 5003.
  – For common joint conditions that are not evaluated under the arthritis criteria such as a knee strain or chondromalacia patella, a 10-percent evaluation can be assigned for the joint based on pain on motion under 38 CFR 4.59. Do not apply instructions from Note (1) under 38 CFR 4.71a, DC 5003, for non-arthritic conditions, since the instructions are strictly limited to arthritic conditions. See example in M21-1, Part III, Subpart iv, 4.A.2.i.

References: For more information on

- pyramiding of evaluations, see
  – 38 CFR 4.14, and
  – *Esteban v. Brown*, 6 Vet.App. 259 (1994)
- assigning multiple evaluations for a single joint, see M21-1, Part III, Subpart iv, 4.A.2.a, and
- examples of evaluations for which one or both joint motions are not actually limited to a compensable degree but there is painful motion, see M21-1, Part III, Subpart iv, 4.A.2.e and f.

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d. Example 1:

Situation: Evaluation of chronic knee strain with the following examination

Compensable Limitation of Two Joint Motions

findings:

- Flexion is limited to 45 degrees.
- Extension is limited by 10 degrees.
- There is no painful motion.
- There is no additional limitation of flexion or extension on additional repetitions or during flare-ups.

Result: Assign a 10-percent evaluation under 38 CFR 4.71a, DC 5260, and a separate 10-percent evaluation under 38 CFR 4.71a, DC 5261.

Explanation: Each disability (limitation of flexion and limitation of extension) warrants a separate evaluation and the evaluations are for distinct disability.

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e. Example 2: Compensable Limitation of One Motion With Pain in Another Motion

Situation: Evaluation of knee tenosynovitis with the following examination findings:

- Flexion is limited to 45 degrees with pain at that point and no additional loss with repetitive motion.
- Extension is full to the 0-degree position, but active extension is limited by pain to 5 degrees.

Result: Assign a 10-percent evaluation under 38 CFR 4.71a, DC 5260 and a noncompensable evaluation under 38 CFR 4.71a, DC 5261.

Explanation:

- Flexion is compensable under 38 CFR 4.71a, DC 5260, but extension remains limited to a noncompensable degree under 38 CFR 4.71a, DC 5261.
- Under *Mitchell v. Shinseki*, 25 Vet.App. 32 (2011), the painful extension could only be considered limited for the purpose of whether a 10-percent evaluation can be assigned for the joint under 38 CFR 4.71a, DC 5003, which is not applicable in this example because a compensable evaluation was already assigned for flexion under 38 CFR 4.71a, DC 5260.
- 38 CFR 4.59 does not support a separate compensable evaluation for painful extension. The regulation states that the intention of the rating schedule is to recognize actually painful joints due to healed injury as entitled to at least the minimum compensable evaluation for the joint, not for each painful movement.
- If the fact pattern involved chondromalacia patella or a knee strain rather than tenosynovitis, the result would be the same.

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f. Example 3: Noncompensable Limitation of Two Motions With Pain

Situation: Evaluation of knee arthritis shown on x-ray with the following examination findings:

- Flexion is limited to 135 degrees with pain at that point.

- Extension is full to the 0-degree position with pain at that point.
- There is no additional loss of flexion or extension on repetitive motion.

Result: Assign one 10-percent evaluation for the knee under 38 CFR 4.71a, DC 5003.

Explanation:
- There is limitation of major joint motion to a noncompensable degree under 38 CFR 4.71a, DC 5260, and 38 CFR 4.71a, DC 5261, x-ray evidence of arthritis and satisfactory evidence of painful motion. Painful motion is limited motion for the purpose of applying 38 CFR 4.71a, DC 5003. Therefore, a 10-percent evaluation is warranted for the joint.
- Assigning two compensable evaluations, each for pain, would be pyramiding.
- Neither 38 CFR 4.71a, DC 5003, nor 38 CFR 4.59 permits separate 10-percent evaluations for painful flexion and extension; they provide for a 10-percent evaluation for a joint.
- If the fact pattern involved chondromalacia patella or a knee strain rather than arthritis, a 10-percent evaluation, not separate evaluations, would still be warranted. However, the authority would be 38 CFR 4.59 and 38 CFR 4.71a, DC 5260 would be used rather than 38 CFR 4.71a, DC 5003.

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g. Example of Evaluating a Joint with Full ROM and Functional Loss Due to Pain

Situation: Evaluation of a knee condition with normal initial ROM and additional functional loss indicated on *DeLuca* and *Mitchell* assessments.

- Examination reveals normal ROM for extension of the knee, but pain on motion is present.
- In applying the *DeLuca* repetitive use test, the examiner determines that after repetitive use extension of the knee is additionally limited, and the post-test ROM is to 10 degrees due to pain.
- The examiner provides a *Mitchell* assessment that during flare-ups the extension of the knee would be additionally limited to 15 degrees due to pain.

Result: Assign one 20-percent disability evaluation under 38 CFR 4.71a, DC 5261 for limited extension of the knee.

Explanation: 15-degree limitation of extension, expressed in the *Mitchell* opinion, is the most advantageous assessment of functional loss for extension of the knee in this scenario. Therefore, the knee will be evaluated based on extension limited to 15 degrees, resulting in a 20-percent evaluation under 38 CFR 4.71a, DC 5261.

References: For more information on
- the *Deluca* and *Mitchell* holdings, see M21-1, Part III, Subpart iv, 4.A.1.c and e
- assessing medical evidence in conjunction with the *DeLuca* and *Mitchell*

holdings, see M21-1, Part III, Subpart iv, 4.A.1.~~k~~j, and
- entering *DeLuca* and *Mitchell* findings in the Evaluation Builder, see M21-1, Part III, Subpart iv, 4.A.1.~~l~~k.

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h. Example of Evaluating a Joint With LOM and Functional Loss Due to Pain

Situation: Evaluation of a knee condition with limited initial ROM and additional functional loss indicated on *DeLuca* and *Mitchell* assessments.

- Flexion of the knee is limited to 70 degrees with pain on motion during initial examination.
- In applying the *DeLuca* repetitive use test, the examiner determines that after repetitive use flexion of the knee is additionally limited, and the post-test ROM is 50 degrees as a result of pain with repetitive use.
- The examiner provides a *Mitchell* assessment that during flare-ups the estimated ROM for flexion of the knee would be 30 degrees due to pain.

Result: Assign one 20-percent disability evaluation under 38 CFR 4.71a, DC 5260 for limited flexion of the knee.

Explanation: Flexion of the knee would be assessed at 30 degrees, as the ROM estimated in the *Mitchell* assessment is the most advantageous representation of the Veteran's limitation of flexion.

References: For more information on
- the *Deluca* and *Mitchell* holdings, see M21-1, Part III, Subpart iv, 4.A.1.c and e
- assessing medical evidence in conjunction with the *DeLuca* and *Mitchell* holdings, see M21-1, Part III, Subpart iv, 4.A.1.j~~k~~, and
- entering *DeLuca* and *Mitchell* findings in the Evaluation Builder, see M21-1, Part III, Subpart iv, 4.A.1.~~l~~k.

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i. Example of Evaluating Joints With Arthritis by X-Ray Evidence Only With Other Joint(s) Affected by Non-arthritic Condition

Example: A Veteran is rated 10 percent for bilateral arthritis of the elbows confirmed by x-ray evidence, without limited or painful motion or incapacitating exacerbations. Veteran subsequently files a claim for SC for chondromalacia of the right knee and is awarded a 20-percent evaluation based on VA examination, which revealed limitation of flexion of the right knee to 30 degrees.

Analysis: A 10-percent evaluation for bilateral arthritis of the elbows and a separate 20-percent evaluation for right knee chondromalacia is justified. In this case, the rating does not violate Note (1) under 38 CFR 4.71a, DC 5003, because the knee condition is not an arthritic condition.

Reference: For additional information on ratings not permissible under Note (1) under 38 CFR 4.71a, DC 5003, see M21-1, Part III, Subpart iv, 4.B~~A~~.4~~9~~.d.

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j. Definition: The term ***major joint*** means

Major Joints

- a shoulder
- an elbow
- a wrist
- a hip
- a knee, or
- an ankle.

Note: The use of the terms *major* and *minor* joint in 38 CFR 4.45(f) applies solely to the evaluation of joint conditions affected by arthritis as discussed in *Spicer v. Shinseki*, 752 F.3d 1367 (2014).

Reference: For more information on major joints, see 38 CFR 4.45(f).

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k. Definition: Minor Joints

The term ***minor joint*** means

- an interphalangeal joint (of the hand or foot)
- a metacarpal joint (hand)
- a metatarsal joint (foot)
- a carpal joint (hand)
- a tarsal joint (foot)
- cervical vertebrae
- dorsal vertebrae
- lumbar vertebrae
- the lumbosacral articulation, or
- a sacroiliac joint.

Note: The use of the terms *major* and *minor* joint in 38 CFR 4.45(f) applies solely to the evaluation of joint conditions affected by arthritis as discussed in *Spicer v. Shinseki*, 752 F.3d 1367 (2014).

References: For more information on

- the definition of a minor joint, see 38 CFR 4.45(f)
- the definition of minor joint groups, see M21-1, Part III, Subpart iv, 4.A.2.l
- considering minor joints under 38 CFR 4.59, see M21-1, Part III, Subpart iv, 4.A.1.p~~j~~
- the application of 38 CFR 4.45(f) for major and minor joints, see *Spicer v. Shinseki*, 752 F.3d 1367 (2014)
- the joints of the hand see M21-1, Part III, Subpart iv, 4.A.~~3.f and g~~4.a-b, and
- identifying the digits of the foot, see M21-1, Part III, Subpart iv, 4.A.7.b~~4.r~~.

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l. Definition: Minor Joint Groups

A ***minor joint group*** means

- multiple involvements of the interphalangeal, metacarpal and carpal joints of the same upper extremity, namely, combinations of
  – distal interphalangeal (DIP) joints

– proximal interphalangeal (PIP) joints
– metacarpophalangeal (MCP) joints, and/or
– carpometacarpal (CMC) joints

- multiple involvements of the interphalangeal, metatarsal and tarsal joints of the same lower extremity, namely, combinations of
  – interphalangeal (IP) joints
  – metatarsophalangeal (MTP) joints, and/or
  – transverse tarsal joints
- the cervical vertebrae
- the dorsal (thoracic) vertebrae
- the lumbar vertebrae or
- the lumbosacral articulation together with both sacroiliac joints.

Note: The use of the terms *major* and *minor* joint in 38 CFR 4.45(f) applies solely to the evaluation of joint conditions affected by arthritis as discussed in *Spicer v. Shinseki*, 752 F.3d 1367 (2014).

References: For more information on

- the definition of minor joint groups, see 38 CFR 4.45(f)
- considering minor joints under 38 CFR 4.59, see M21-1, Part III, Subpart iv, 4.A.1.p~~j~~
- the application of 38 CFR 4.45(f) for major and minor joints, see *Spicer v. Shinseki*, 752 F.3d 1367 (2014)
- evaluations for the fingers, see M21-1, Part III, Subpart iv, 4.A.~~3.n~~4.e-h
- evaluating arthritis of the minor joints of the toes, see M21-1, Part III, Subpart iv, 4.A.~~4~~7.d, and
- arthritis where a compensable evaluation cannot be assigned under another DC, see M21-1, Part III, Subpart iv, ~~5.A.7~~4.B.2.b.

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m. Importance of Accurate Measurements in Joint Cases

Accurate measurements are very important in joint cases. VA examinations must measure joint motion with a goniometer.

A number of d~~D~~isability b~~B~~enefits q~~Q~~uestionnaires (DBQs) relating to joints (*Hip and Thigh Conditions*, *Knee and Lower Leg Conditions*, *Ankle Conditions*, *Back (Thoracolumbar Spine) Conditions*, *Neck (Cervical Spine) Conditions*, *Shoulder and Arm Conditions*, *Elbow and Forearm Conditions*, *Wrist Conditions, and Hand and Finger Conditions*) require use of a goniometer.

Important: There is a presumption that examiners will conduct examinations in line with examination standards. Accordingly, treat examinations measurements on examinations that require a goniometer as having been taken using the device unless there is clear evidence that a goniometer was not used. Do not seek clarification of DBQs requiring goniometer use, or return the examination as insufficient, merely because the report does not explicitly refer to goniometer use.

References: For more information on

- the importance of accurate measurement of joints, see 38 CFR 4.46, and
- determining the sufficiency of examinations, see M21-1, Part III, Subpart iv, 3.D.3.

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n. Ankylosis of the Joints

Ankylosis is a condition of, or term used for the sign/symptom of, abnormal stiffness, immobility, or abnormal bending of a joint. It is a stiffness or immobility in a joint caused by bones fusing as a result of disease or injury or by intentional fusion through surgery.

Favorable ankyloses is fixation of a joint in a neutral position (at zero degrees).

Unfavorable ankyloses is fixation of a joint in flexion or extension that results in significant functional impairment.

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3. Evaluating Musculoskeletal Disabilities of the ~~Upper Extremities~~Arms

Introduction

This topic contains information on evaluating musculoskeletal disabilities of the ~~upper extremities~~arms, including

- considering separate evaluations for disabilities of the shoulder and arm
- example of separate evaluations for disabilities of the shoulder and arm
- assigning separate evaluations for disabilities of the elbow, forearm, and wrist
- example of separate evaluations for multiple disabilities of the elbow, forearm, and wrist, and
- considering impairment of supination and pronation of the forearm.
- ~~identifying digits of the hand~~
- ~~anatomy of the hand~~
- ~~anatomical position of the hand and fingers~~
- ~~ROM of the index, long, ring, and little fingers~~
- ~~rating Dupuytren's contracture of the hand~~
- ~~evaluating amputations of multiple fingers~~
- ~~evaluating amputations of single fingers~~
- ~~evaluating ankylosis of one or more fingers, and~~
- ~~compensable evaluations for the fingers.~~

Change Date

~~October 24, 2017~~April 13, 2018

a. Considering Separate Evaluations for Disabilities of the Shoulder and Arm

Separate evaluations may be given for disabilities of the shoulder and arm under 38 CFR 4.71a DCs 5201, 5202, or 5203 if the manifestations represent separate and distinct symptomatology that are neither duplicative nor overlapping.

Reference: For additional information concerning separate and distinct symptomatology, refer to

- 38 CFR 4.14, and
- *Esteban v. Brown*, 6 Vet.App. 259 (1994).

b. Example of Separate Evaluations for Disabilities of the Shoulder and Arm

Situation: A Veteran was involved in an automobile accident that resulted in multiple injuries to the upper extremities. The Veteran sustained the following injuries

- a humeral fracture resulting in restriction of arm motion at shoulder level, and
- a clavicular fracture resulting in malunion of the clavicle.

Result:
- assign a 20-percent evaluation for the impairment of the humerus under 38 CFR 4.71a, DC 5202-5201, and
- assign a separate 10-percent evaluation for malunion of the clavicle under 38 CFR 4.71a, DC 5203.

Notes:
- The hyphenated evaluation DC is assigned under 38 CFR 4.71a, DC 5202-5201 because the humerus impairment affects ROM.
- The separate evaluation for the clavicle disability is warranted because this disability does not affect ROM.

Exception: Multiple evaluations cannot be assigned under 38 CFR 4.71a, DC 5201 for limited flexion and abduction of the shoulder.

Reference: For additional information on evaluating shoulder conditions, see *Yonek v. Shinseki*, 722 F.3d 1355 (Fed. Cir. 2013).

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c. Assigning Separate Evaluations for Disabilities of the Elbow, Forearm, and Wrist

Impairments of the elbow, forearm, and wrist will be assigned separate disability evaluations. The motions of these joints are all viewed as clinically separate and distinct. Assign separate evaluations for impairment under the following DCs:

- elbow
  – flexion under 38 CFR 4.71a, DC 5206, or
  – extension under 38 CFR 4.71a, DC 5207
- forearm supination and pronation under 38 CFR 4.71a, DC 5213, and
- wrist flexion or ankylosis under 38 CFR 4.71a, DC 5214 or 38 CFR 4.71a, DC 5215.

Notes:
- 38 CFR 4.59 may be applied separately to the elbow, the forearm, and the wrist to result in potentially three separate evaluations for painful motion when the evidence otherwise supports such a finding. However, 38 CFR 4.59 may only be applied once to the elbow and may not be separately applied to both elbow flexion and elbow extension.
- When examination or other evidence denotes pain present in the joint or periarticular region but does not delineate the specific motions in which pain is present ***and*** there is a potential for a separate evaluation under 38 CFR 4.59 as discussed in M21-1, Part III, Subpart iv, 4.A.1, obtain a medical opinion to determine which motions are painful. When the examiner cannot delineate which motions are associated with pain, resolve doubt in favor of the Veteran and consider painful motion to be present in the separate plane such as to allow assignment of the separate minimum compensable evaluation under 38 CFR 4.59.

Reference: For additional information on assigning separate evaluations for

elbow motion, see M21-1, Part III, Subpart iv. 4.A.2.a.

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d. Example of Separate Evaluations for Disabilities of the Elbow, Forearm, and Wrist

Situation: A Veteran sustained multiple injuries to the right upper extremity in a vehicle rollover accident. The following impairments are due to the SC injuries:

- elbow flexion limited to 90 degrees
- elbow extension limited to 45 degrees
- full ROM on supination and pronation with painful supination, and
- full ROM of the wrist with pain on dorsiflexion.

Result: Assign the following disability evaluations

- 20 percent for limited elbow flexion under 38 CFR 4.71a, DC 5206
- 10 percent for limited elbow extension under 38 CFR 4.71a, DC 5207
- 10 percent for painful forearm supination under 38 CFR 4.71a, DC 5213, and
- 10 percent for painful wrist motion under 38 CFR 4.71a, DC 5215.

Explanation:

- Compensable LOM of elbow flexion and extension is present. Separate evaluations are warranted for elbow flexion and extension.
- Motion of the forearm is separate and distinct from elbow motion. Therefore, a separate evaluation is warranted for painful supination.
- Motion of the wrist is separate and distinct from forearm motion. Therefore, a separate evaluation is warranted for painful motion of the wrist.

Note: If elbow flexion is limited to 100 degrees and elbow extension is limited to 45 degrees, assign a single 20-percent disability evaluation under 38 CFR 4.71a, DC 5208.

References: For more information on

- separate evaluations for motion of a single joint, see
  – VAOPGCPREC 9-2004, and
  – M21-1, Part III, Subpart iv, 4.A.2.a
- separate evaluations for the elbow, forearm, and wrist, see M21-1, Part III, Subpart iv, 4.A.3.c
- evaluating painful motion of a joint, see
  – 38 CFR 4.59, and
  – M21-1, Part III, Subpart iv, 4.A.1
- considering painful motion when assigning multiple LOM evaluations for a joint, see M21-1, Part III, Subpart iv, 4.A.2.c, and
- considering impairment of supination and pronation of the forearm, see M21-1, Part III, Subpart iv, 4.A.3.e.

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e. Considering Impairment of

When preparing rating decisions involving impairment of supination and pronation of the forearm, consider the following facts:

Supination and Pronation of the Forearm

- Full pronation is the position of the hand flat on a table.
- Full supination is the position of the hand palm up.
- When examining limitation of pronation, the
  – arc is from full supination to full pronation, and
  – middle of the arc is the position of the hand, palm vertical to the table.

Assign the lowest, 20-percent evaluation when pronation cannot be accomplished through more than the first three-quarters of the arc from full supination.

Do *not* assign a compensable evaluation for both limitation of pronation and limitation of supination of the same extremity.

Reference: For more information on considering painful motion when assigning multiple LOM evaluations for a joint, see M21-1, Part III, Subpart iv, 4.A.2.c.

4. Evaluating Musculoskeletal Disabilities of the Hands

Introduction

This topic contains information on evaluating musculoskeletal disabilities of the hands, including

- identifying digits of the hand
- anatomy of the hand
- anatomical position of the hand and fingers
- ROM of the index, long, ring, and little fingers
- evaluating amputations of multiple fingers
- evaluating amputations of single fingers
- evaluating ankylosis of one or more fingers
- compensable evaluations for the fingers, and
- rating Dupuytren's contracture of the hand.

Change Date

April 13, 2018

af. Identifying Digits of the Hand

Follow the guidelines listed below to accurately specify the injured digits of the hand.

- The digits of the hand are identified as
  – thumb
  – index
  – long
  – ring, or
  – little.
- Do not use numerical designations for either the fingers or the joints of the fingers.
- Each digit, except the thumb, includes three phalanges
  – the proximal phalanx (closest to the wrist)
  – the middle phalanx, and
  – the distal phalanx (closest to the tip of the finger).
- The joint between the proximal and middle phalanges is called the ***proximal interphalangeal*** or ***PIP*** joint.
- The joint between the middle and distal phalanges is called the ***distal interphalangeal*** or ***DIP*** joint.
- The thumb has only two phalanges, the proximal phalanx and the distal phalanx. Therefore, each thumb has only a single joint, called the ***interphalangeal*** or ***IP*** joint.
- The joints connecting the phalanges in the hands to the metacarpals are the ***metacarpophalangeal*** or ***MCP*** joints.
- Designate either right or left for the digits of the hand.

Note: If the location of the injury is unclear, obtain x-rays to clarify the exact

point of injury.

References: For

- more information on determining dominant handedness, see 38 CFR 4.69, and
- an exhibit of the anatomy of the hand, see M21-1, Part III, Subpart iv, 4.A.4.b~~3.g~~.

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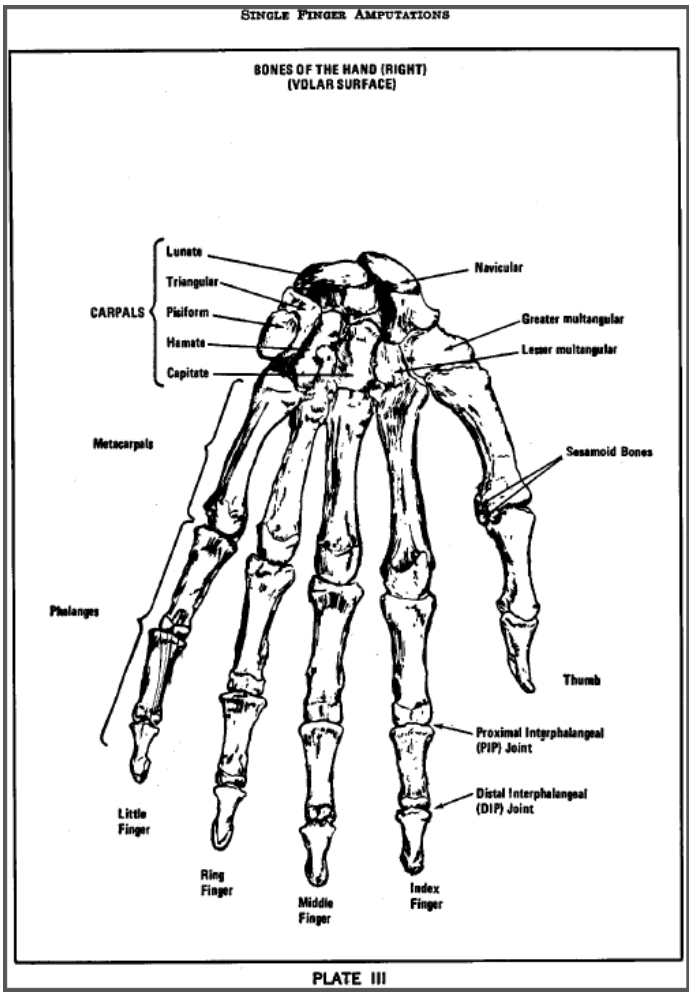
b~~g~~. Anatomy of the Hand

The following image is a reproduction of Plate III following 38 CFR 4.71a, DC 5156. It illustrates the bones of the hand, as well as the PIP and DIP joints.



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c~~h~~. Anatomical Position of the Hand and Fingers

The normal anatomical position of the hand (called the position of function of the hand in the rating schedule) and fingers is with the

- wrist dorsiflexed 20 to 30 degrees
- MCP and PIP joints flexed to 30 degrees, and
- thumb abducted and rotated so that the thumb pad faces the finger pads.

Reference: For more information on the normal anatomical position of the hand and fingers, see note (1) preceding 38 CFR 4.71a, DC 5216.

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id. ROM of the Index, Long, Ring, and Little Fingers

For the index, long, ring, and little fingers, zero degrees of flexion represents the fingers fully extended, making a straight line with the rest of the hand.

For these digits, the
- MCP joint has a range of zero to 90 degrees of flexion
- PIP joint has a range of zero to 100 degrees of flexion, and
- DIP joint has a range of zero to 70 or 80 degrees of flexion.

Reference: For more information on the ROM of the index, long, ring, and little fingers, see note (1) preceding 38 CFR 4.71a, DC 5216.

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ek. Evaluating Amputations of Multiple Fingers

The evaluation levels for amputations of multiple fingers are contained in 38 CFR 4.71a, DC 5126 to 5151.

Consider and apply the following principles as applicable when evaluating amputations of multiple fingers:

- Amputations other than at the PIP joints or through the proximal phalanges will be rated as ankylosis of the fingers.
  - Amputations at distal joints, or through distal phalanges (other than negligible losses) will be rated as favorable ankylosis of the fingers.
  - Amputation through middle phalanges will be rated as unfavorable ankylosis of the fingers.
- If there is amputation or resection of metacarpal bones (where more than one-half the bone is lost) in multiple fingers injuries add (not combine) 10 percent to the specified evaluation for the finger amputations subject to the amputation rule (at the forearm level).
- When an evaluation is assigned under 38 CFR 4.71a, DC 5126 to 5130 there will also be entitlement to special monthly compensation.
- Loss of use of the hand exists when no effective function remains other than that which would be equally well served by an amputation stump with a suitable prosthetic appliance.

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fl. Evaluating Amputations of Single Fingers

The rating schedule provisions for amputations of single fingers are at 38 CFR 4.71a, DC 5152 to 5156.

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gm. Evaluating Ankylosis of One or More Fingers

The rating schedule provisions for ankyloses of one or more fingers are at 38 CFR 4.71a, DC 5216 to 5227.

When considering an evaluation for ankylosis of the index, long, ring or little

finger, evaluate as:

- *favorable ankylosis* if ***either*** the MCP ***or*** PIP joint is ankylosed, ***and*** there is a gap of two inches (5.1 cm.) ***or less*** between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible
- *unfavorable ankylosis* if
  – ***either*** the MCP ***or*** PIP joint is ankylosed, ***and*** there is a gap of ***more than*** two inches (5.1 cm.) between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible, ***or***
  – ***both*** the MCP ***and*** PIP joints of a digit are ankylosed (even if each joint is individually fixed in a favorable position), ***or***
- *amputation without metacarpal resection at the PIP joint or proximal thereto* (38 CFR 4.71a, DC 5153 to 5156) if both the MCP and PIP joints of a digit are ankylosed, *and* either is in extension or full flexion, *or* there is rotation or angulation of a bone.

When considering an evaluation for ankylosis of the thumb, evaluate as:

- *favorable ankylosis* if ***either*** the carpometacarpal ***or*** IP joint is ankylosed, ***and*** there is a gap of two inches (5.1 cm.) ***or less*** between the thumb pad and fingers with the thumb attempting to oppose the fingers
- *unfavorable ankylosis* if
  – ***either*** the carpometacarpal ***or*** IP joint is ankylosed, ***and*** there is a gap of ***more than*** two inches (5.1 cm.) between the thumbpad and the fingers, with the thumb attempting to oppose the fingers, ***or***
  – ***both*** the capometacarpal ***and*** IP joints are ankylosed (even if each joint is individually fixed in a favorable position), ***or***
- *amputation at the carpometacarpal joint or joints or through proximal phalange* (38 CFR 4.71a, DC 5152) if both the carpometacarpal and IP joints are ankylosed, *and* either is in extension or full flexion, *or* there is rotation or angulation of a bone.

Note: Only joints in the position specified in M21-1, Part III, Subpart iv, 4.A.4.c-d~~3.h-i~~ are considered in a favorable position.

Reference: For more information on evaluation of ankylosis of the fingers, see the notes prior to 38 CFR 4.71a, DC 5216.

~~n~~h. Compensable Evaluations for the Fingers

When considering evaluations for the fingers based on LOM, a compensable evaluation can be assigned for any of the following:

- LOM of the thumb as specified in 38 CFR 4.71a, DC 5228.
- LOM of the index or long finger as specified in 38 CFR 4.71a, DC 5229.
- X-ray evidence of arthritis or other condition rated under the criteria of 38 CFR 4.71a, DC 5003, affecting a *group* of minor joints of the fingers of *one* hand. There must be

– noncompensable LOM in more than one of the joints comprising the group of affected minor joints, *and*
– findings such as swelling, muscle spasm or satisfactory evidence of painful motion in the affected minor joints of the joint group.

- X-ray-*only* evidence of arthritis (where there is no LOM) under the criteria of 38 CFR 4.71a, DC 5003, affecting *two or more groups* of minor joints – namely the fingers of *both* hands or a group of minor joints in one hand in combination with another group of minor joints.
- Painful motion of the thumb, index finger, or long finger as directed at M21-1, Part III, Subpart iv, 4.a.1.p.

Note: The Federal Circuit held in *Spicer v. Shinseki*, 752 F.3d 1367 (Fed. Cir. 2014) that when evaluating arthritis of the hand the minor joint *group* of IP joints of a hand is compensably disabled *only when two or more* joints in the group are affected by LOM. Refer to M21-1, Part III, Subpart iv, 4.A.2.j-k for more information on the applicability of the *Spicer* holding.

References: For more information on

- identifying the digits of the hand and the finger joints, see M21-1, Part III, Subpart iv, 4.A.~~3.f~~4.a
- anatomy of the hand, see M21-1, Part III, Subpart iv, 4.A.~~3.g~~4.b
- the definition of minor joint, see M21-1, Part III, Subpart iv, 4.A.2.k
- the definition of a group of minor joints, see M21-1, Part III, Subpart iv, 4.A.2.l
- ROM of the index, long, ring and little fingers, see M21-1, Part III, Subpart iv, 4.A.4.d~~3.i~~
- assigning evaluations under 38 CFR 4.71a, DC 5003 when a compensable rating based on LOM cannot be assigned under another DC, see M21-1, Part III, Subpart iv, 4.~~A.8~~B.3.b, and
- applying 38 CFR 4.59 to minor joints, see M21-1, Part III, Subpart iv, 4.A.1.p~~j~~.

~~j~~i. Rating Dupuytren's Contracture of the Hand

The rating schedule does not specifically list Dupuytren's contracture as a disease entity; therefore, assign an evaluation on the basis of limitation of finger movement.

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54. Evaluating Musculoskeletal Disabilities of the Spine ~~and Lower Extremities~~

Introduction

This topic contains information on evaluating musculoskeletal disabilities of the spine ~~and lower extremities~~, including

- evaluating manifestations of spine diseases and injuries
- definition of incapacitating episode of IVDS
- example of evaluating IVDS, and
- evaluating ankylosing spondylitis.
- ~~evaluations for knee replacement~~
- ~~evaluating noncompensable knee conditions~~
- ~~definition of lateral instability and subluxation of the knee~~
- ~~separate evaluations for knee instability and LOM~~
- ~~separate evaluations – LOM and meniscus disabilities~~
- ~~separate evaluations, knee instability and meniscus disabilities~~
- ~~separate evaluations – genu recurvatum~~
- ~~evaluating shin splints~~
- ~~example 1, evaluating shin splints~~
- ~~example 2, evaluating spin splints~~
- ~~moderate and marked LOM of the ankle~~
- ~~considering ankle instability~~
- ~~evaluating plantar fasciitis~~
- ~~identifying the digits of the foot~~
- ~~definition of metatarsalgia or Morton's disease~~
- ~~evaluating metatarsalgia or Morton's disease~~
- ~~pyramiding of metatarsalgia and either plantar fasciitis or pes planus~~
- ~~evaluating arthritis of the minor joints of the toes, and~~
- ~~selecting a DC for foot disabilities.~~

Change Date

~~October 24, 2017~~April 13, 2018

a. Evaluating Manifestations of Spine Diseases and Injuries

Evaluate diseases and injuries of the spine based on the criteria listed in the 38 CFR 4.71a, General Rating Formula for Diseases and Injuries of the Spine (General Rating Formula). Under this criteria, evaluate conditions based on chronic orthopedic manifestations (for example, painful muscle spasm or LOM) and any associated neurological manifestations (for example, footdrop, muscle atrophy, or sensory loss) by assigning separate evaluations for the orthopedic and neurological manifestations.

Evaluate intervertebral disc syndrome **(**IVDS) under 38 CFR 4.71a, DC 5243, either based on the General Rating Formula or the Formula for Rating IVDS Based on Incapacitating Episodes (Incapacitating Episode Formula), whichever formula results in the higher evaluation when all disabilities are

combined under 38 CFR 4.25.

Variations of diagnostic terminology exist for IVDS. When used in the clinical setting, the following terminology is consistent with the general designation of IVDS:

- slipped or herniated disc
- ruptured disc
- prolapsed disc
- bulging or protruded disc
- degenerative disc disease
- sciatica
- discogenic pain syndrome
- herniated nucleus pulposus, and
- pinched nerve.

Notes:

- When an SC thoracolumbar disability is present and objective neurological abnormalities or radiculopathy are diagnosed but the medical evidence does not identify a specific nerve root, rate the lower extremity radiculopathy under the sciatic nerve, 38 CFR 4.124a, DC 8520.
- If an evaluation is assigned based on incapacitating episodes, a separate evaluation may not be assigned for LOM, radiculopathy, or any other associated objective neurological abnormality as it would constitute pyramiding.
- Spinal fusion is a type of fixation of the spine. Evaluation based on ankylosis of the spine due to fusion is only warranted when the fixation affects the entire thoracolumbar or cervical spine segment. Fusion of only a portion of the cervical or thoracolumbar spine segment should be evaluated based on range or motion or IVDS as warranted by the evidence.

Important:

- Because spinal disease can cause objective neurological abnormalities, onset of a neurological complication represents medical progression or worsening of the spinal disease. For that reason and because neurological complications of spinal disease are contemplated in the evaluation criteria for spinal conditions under 38 CFR 4.71a, a claim asserting new complications of spinal disease is a claim for increase rather than a claim for secondary SC. Therefore when assigning effective dates for new neurological spinal complications, consider effective date provisions specifically for increases. The intention is to treat spinal complications cases in a way that is consistent with the handling of diabetes complications as set forth in M21-1, Part III, Subpart iv, 4.M~~F~~.1 and 2.
- Apply the previous provisions of 38 CFR 3.157 (b) (prior to March 24, 2015) when determining the effective date for neurological abnormalities of the spine that are identified by requisite records prior to March 24, 2015.

  Example: Veteran has been SC for degenerative disc disease (DDD) since 2012. Upon review of a claim for increase received on June 2,

2015, it is noted in VA medical records that the Veteran received treatment for bladder impairment secondary to DDD on July 7, 2014. Because the VA medical records constitute a claim for increase under rules in effect prior to March 24, 2015, it is permissible to apply previous rules from 38 CFR 3.157 (b) in adjudicating the bladder impairment issue.

References: For more information on

- assigning disability evaluations for
  - peripheral nerve disabilities to include radiculopathy, see M21-1, Part III, Subpart iv, 4.NG.4, and
  - progressive spinal muscular atrophy, see M21-1, Part III, Subpart iv, 4.NG.1.c, and
- historical application of
  - 38 CFR 4.40, and 38 CFR 4.45 to evaluations for IVDS, see VAOPGCPREC 36-1997, and
  - 38 CFR 4.71a, DC 5285, for demonstrable deformity of a vertebral body, refer to VAOPGCPREC 3-2006.

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b. Definition: Incapacitating Episode of IVDS

By definition, an incapacitating episode of IVDS requires bedrest prescribed by a physician.

In order to evaluate IVDS based on incapacitating episodes, there must be evidence the associated symptoms required bedrest as prescribed by a physician. The medical evidence of prescribed bedrest must be

- of record in the claims folder, ***or***
- reviewed and described by an examiner completing a DBQ.

Note: If the records do not adequately document prescribed bedrest, use the General Rating Formula to evaluate IVDS and advise the Veteran to submit medical evidence documenting the periods of incapacitating episodes requiring bedrest prescribed by a physician.

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c. Example of Evaluating IVDS

Situation: A Veteran's IVDS is being evaluated.

- LOM warrants a 20-percent evaluation based under the general rating formula
- mild radiculopathy of the left lower extremity warrants a 10-percent evaluation as a neurological complication, and
- medical evidence shows incapacitating episodes requiring bedrest prescribed by a physician of four weeks duration over the past 12 months which would result in a 40-percent evaluation based on the incapacitating episode formula.

Result: Assign a 40-percent evaluation based on incapacitating episodes.

Explanation:

- Evaluating IVDS using incapacitating episodes results in the highest evaluation.
- Since incapacitating episodes are used to evaluate IVDS, the associated LOM and neurological signs and symptoms will not be assigned a separate evaluation.

References: For additional information on

- evaluating spinal conditions, see M21-1, Part III, Subpart iv, 4.A.54.a, and
- determining whether evidence is sufficient to evaluate based on incapacitating episodes of IVDS, see M21-1, Part III, Subpart iv, 4.A.54.b.

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d. Evaluating Ankylosing Spondylitis

Ankylosing spondylitis may be evaluated as an active disease process or based upon LOM of the spine.

The table below describes appropriate action for evaluating ankylosing spondylitis.

If ankylosing spondylitis is ...	**Then ...**
an active process	evaluate under 38 CFR 4.71a, DC 5009 (using the criteria in 38 CFR 4.71a, DC 5002).
inactive	• evaluate under 38 CFR 4.71a, DC 5240 based on chronic residuals affecting the spine, and • separately evaluate other affected joints or body systems under the appropriate DC.

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6. Evaluating Musculoskeletal Disabilities of the Legs

Introduction

This topic contains information on evaluating musculoskeletal disabilities of the lower extremities (not including the feet), including

- evaluations for knee replacement
- evaluating noncompensable knee conditions
- definition of lateral instability and subluxation of the knee
- handling joint stability findings
- separate evaluations for knee instability and LOM
- separate evaluations of meniscal disabilities
- examples of evaluating meniscal disabilities
- evaluation builder workaround for meniscal disabilities
- separate evaluations – genu recurvatum
- evaluating shin splints
- example 1, evaluating shin splints
- example 2, evaluating shin splints
- moderate and marked LOM of the ankle, and
- considering ankle instability.

Change Date

April 13, 2018

ae. Evaluations for Knee Replacement

Total knee replacements are evaluated under 38 CFR 4.71a, DC 5055.

For guidance on rating action for claims involving partial knee replacement see the table below.

If a claim for evaluation of a partial knee replacement was ...	Then ...
filed and decided on or after July 16, 2015	do not assign an evaluation under 38 CFR 4.71a, DC 5055. ***Explanation**:* Effective July 16, 2015, 38 CFR 4.71a was revised to clarify in a note that the provisions of 38 CFR 4.71a, DC 5055 apply only to total knee replacement.
• filed before July 16, 2015, and • pending (not finally adjudicated) on that date	the case must be evaluated under 38 CFR 4.71a, DC 5055 if this would be more favorable than another applicable DC. ***Explanation***: This result is required by

	• *Hudgens v. McDonald*, 823 F.3d 630 (Fed. Cir. 2016), and • M21-1, Part III, Subpart iv, 5.C.7.l.
• filed before July 16, 2015, and • finally adjudicated before that date	do not revise the decision as clearly and unmistakably erroneous whether it • assigned an evaluation under 38 CFR 4.71a, DC 5055, or • found that an evaluation could not be assigned under 38 CFR 4.71a, DC 5055. ***Explanation***: The regulation action effective July 16, 2015, explained that VA's long standing policy was that partial knee replacements could not be evaluated under 38 CFR 4.71a, DC 5055. However, the Court in *Hudgens v. McDonald*, 823 F.3d 630 (Fed. Cir. 2016) found that prior to the revision the regulation was ambiguous as to whether it covered partial knee replacements and they noted conflicting decisions had been issued.

References: For more information on

- handling requests for separate ~~knee~~ evaluations ~~in cases~~ of instability following total knee replacement, see M21-1, Part III, Subpart iv, 4.A.6~~4~~.h
- evaluations for partial knee replacements, see *Hudgens v. McDonald*, 823 F.3d 630 (Fed. Cir. 2016)
- evaluating evidence and assigning effective dates associated with precedential court decisions, see M21-1, Part III, Subpart iv, 5.C.7.l
- determining the effective date of a convalescence rating for a joint replacement, see M21-1, Part IV, Subpart ii, 2.J.4.g~~e~~, and
- rating issues for DCs, such as 38 CFR 4.71a, DC 5055, that provide for definite periods of convalescence, see M21-1, Part IV, Subpart ii, 2.J.5.

~~f~~b. Evaluating Noncompensable Knee Conditions

Evaluate a noncompensable knee condition by analogy to 38 CFR 4.71a, DC 5257 if

- there is no associated arthritis
- the schedular criteria for a noncompensable evaluation under 38 CFR 4.71a, DC 5260 or DC 5261 are not met, *and*
- the condition cannot be appropriately evaluated under 38 CFR 4.71a, DC 5258, 5259, 5262, or 5263.

References: For more information on
- using analogous DCs, see 38 CFR 4.20, and
- when to assign a zero-percent evaluation, see 38 CFR 4.31.

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cg. Definitions: Lateral Instability and Subluxation of the Knee

Lateral instability, as referred to in 38 CFR 4.71a, DC 5257 includes evaluations based on posterior or anterior instability.

Note: ***Medial instability*** is a direction of lateral instability, and when present due to SC knee injury, should be evaluated under 38 CFR 4.71a, DC 5257.

Subluxation refers to partial or incomplete dislocation of the knee joint (*tibiofemoral* dislocation/subluxation) or tendency for the patella to dislocate from its track (*patellar* dislocation/subluxation).

Evaluate either condition using 38 CFR 4.71a, DC 5257. However, note the diagnostic criteria primarily contemplate patellar subluxation. True knee joint subluxation and patellar subluxation are much different conditions. Patellar subluxation is common and may be mild, moderate or severe. True chronic joint subluxation is very rare and, when present, can be expected to be severe or even tantamount to loss of use.

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d. Handling Joint Stability Findings

Apply the findings from joint stability testing reported by an examiner on the *Knee and Lower Leg Conditions Disability Benefits Questionnaire* as follows when evaluating recurrent subluxation or lateral instability under 38 CFR 4.71a, DC 5257.

DBQ Finding	Correlated Level of Impairment
1+ (0-5 millimeters)	slight
2+ (5-10 millimeters)	moderate
3+ (10-15 millimeters)	severe

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eh. Separate Evaluations for Knee Instability and LOM

A separate evaluation for knee instability may be assigned in addition to any evaluation(s) assigned based on limitation of knee motion. OGC has issued Precedent Opinions that an evaluation under 38 CFR 4.71a, DC 5257, does not pyramid with evaluations based on LOM.

Exception: Do not rate instability separately from a total knee replacement.
- The 30-percent and 100-percent evaluations under 38 CFR 4.71a, DC 5055, are minimum and maximum evaluations and, as such, encompass all identifiable residuals post knee replacement – including LOM, instability, and functional impairment.
- The ~~60-percent and~~ intermediate evaluations, including the 60-percent criteria under 38 CFR 4.71a, DC 5055 as well as the alternative evaluations available under the designated DCs at 38 CFR 4.71a, DC 5256, 5261, or 5262, also contemplate the residuals of post-knee replacement including but not limited to instability. ~~by their plain text provide the exclusive methods~~

~~by which residuals can be evaluated at 40 or 50 percent and contemplate instability.~~

- Post arthroplasty, there may be instability with weakness (giving way) and pain.
- Note that the only way to obtain an evaluation in excess of 30 percent under 38 CFR 4.71a, DC 5262 (one of the specified bases for an intermediate evaluation under 38 CFR 4.71a, DC 5055) is if there is nonunion with loose motion and need for a brace. This clearly suggests instability is incorporated in the intermediate criteria.

Important: The rating activity must pay close attention to the combined evaluation of the knee disability prior to replacement surgery and to follow all required due process and protected evaluation procedures.

References: For more information on

- pyramiding and separating individual ~~decisions~~ findings in a rating decision, see M21-1, Part III, Subpart iv, ~~6.C.5~~5.B.2.b~~.d~~
- separate evaluation of knee instability, see
  – VAOPGCPREC 23-1997, and
  – VAOPGCPREC 9-1998, and
- due process issues pertinent to knee replacements including
  – change of DC for a protected disability evaluation, see
    - 38 CFR 3.951
    - M21-1, Part III, Subpart iv, 8.C.1.k, and
    - M21-1, Part IV, Subpart ii, 2.J.5, and
  – reduction procedures that would apply prior to assignment of a post-surgical minimum evaluation lower than the running award rate, see
    - 38 CFR 3.105(e)
    - M21-1, Part III, Subpart iv, 8.D.1
    - M21-1, Part IV, Subpart ii, 3.A.3, and
    - M21-1, Part IV, Subpart ii, 2.J.

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f~~i~~. Separate Evaluation~~s – LOM and~~ of Menisca~~l~~us Disabilities

Evaluation of a knee disability under 38 CFR 4.71a, DC 5257, DC 5260, or 5261 does not, as a matter of law, preclude separate evaluation of a meniscal disability of the same knee under

~~Do not assign separate evaluations for~~

~~• a meniscus disability~~
– 38 CFR 4.71a, DC 5258 (dislocated semilunar cartilage), or
38 CFR 4.71a, DC 5259 (symptomatic removal of semilunar cartilage)~~. and~~
~~LOM of the same knee~~
~~38 CFR 4.71a, DC 5260, (limitation of flexion) or~~
~~38 CFR 4.71a, DC 5261, (limitation of extension).~~

~~Explanation: LOM of the knee is contemplated by the meniscus DCs. Although 38 CFR 4.71a, DC 5258, refers to "dislocated" cartilage and~~

~~"locking" of the knee the rating criteria contemplate LOM of the knee through functional impairment with use (namely pain and effusion).~~

– ~~38 CFR 4.71a, DC 5259, provides for a compensable evaluation for a "symptomatic" knee post removal of the cartilage. VAOPGCPREC 9-1998 states "DC 5259 requires consideration of 38 CFR 4.40 and 38 CFR 4.45 because removal of semilunar cartilage may result in complications producing loss of motion."~~

A meniscal disability may be rated separately under 38 CFR 4.71a, DC 5258/5259 apart from

- 38 CFR 4.71a, DC 5257 for manifestations of the knee disability other than recurrent subluxation and lateral instability, and/or
- 38 CFR 4.71a, DC 5260/5261 if a manifestation of the meniscal disability did not result in an elevation of the disability evaluation warranted under 38 CFR 4.71a, DC 5260/5261 via application of 38 CFR 4.40 and 38 CFR 4.45 pursuant to *DeLuca v. Brown*, 8 Vet.App. 202 (1995).

Important:

- Entitlement to a separate evaluation for the meniscal disability depends on whether the manifestations are utilized to assign an evaluation under a different DC. Evaluation of the same manifestation under multiple diagnoses is prohibited under 38 CFR 4.14. Thus, when all the symptoms of the meniscal disability are used to support elevation of an evaluation under 38 CFR 4.71a, DC 5260/5261 or assignment of an evaluation under 38 CFR 4.71a, DC 5257, a separate evaluation cannot be assigned under 38 CFR 4.71a, DC 5258/5259.
- The policy and procedures identified in this block reflect a change in policy resulting from the holding in *Lyles v. Shulkin*, 29 Vet.App. 107 (2017), effective November 29, 2017. Prior to the *Lyles* holding, separate evaluations for meniscal disabilities under 38 CFR 4.71a, DC 5258 or DC 5259 and other knee evaluations under 38 CFR 4.71a, DC 5257, 5260, or DC 5261 were prohibited. This is not considered a liberalizing change.

References: For more information on

- evaluation of meniscal disabilities, see *Lyles v. Shulkin*, 29 Vet.App. 107 (2017)
- examples of evaluation of meniscal disabilities, see M21-1, Part III, Subpart iv, 4.A.6.g, and
- the required Evaluation Builder workaround for proper evaluation of meniscal disabilities, see M21-1, Part III, Subpart iv, 4.A.6.h.

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g~~j~~. ~~Separate Evaluations, Knee Instability and Meniscus Disabilities~~Examples—

~~Do not assign separate evaluations for~~

~~• subluxation or lateral instability under 38 CFR 4.71a, DC 5257, and~~
~~• a meniscus disability~~
~~– 38 CFR 4.71a, DC 5258, or~~

Evaluating Meniscal Disabilities

~~38 CFR 4.71a, DC 5259~~

~~***Explanation***: The criteria for both of those codes contemplate instability.~~

- ~~Dislocation and locking under 38 CFR 4.71a, DC 5258 is consistent with instability.~~
- ~~The broad terminology of "symptomatic" under 38 CFR 4.71a, DC 5259 also contemplates instability.~~

Example 1: A Veteran's left knee disability, which includes a meniscal condition, is evaluated as 30-percent disabling on the basis of limitation of extension under 38 CFR 4.71a, DC 5261. The knee also manifests pain, swelling, popping, locking, and grinding due to the meniscus disability. These symptoms, which are consistent with the manifestations identified under 38 CFR 4.40 and 38 CFR 4.45, were considered and did not result in a higher evaluation under 38 CFR 4.71a, DC 5261. Therefore, they may be considered for assignment of a separate evaluation under 38 CFR 4.71a, DC 5258/5259.

Example 2: The evaluations and fact pattern for Example 1 are the same *except* that the VA examiner indicates that the pain, swelling, popping, locking, and grinding of the knee, which results from the meniscal disability, result in additional limitation of extension to 30 degrees during flare-ups or with repeated use over a period of time, which warrants an elevation of the rating to 40-percent under 38 CFR 4.71a, DC 5261. A separate evaluation under 38 CFR 4.71a, DC 5258/5259 is not warranted for the symptoms of pain, swelling, popping, locking, and grinding since these symptoms were considered under 38 CFR 4.40 and 38 CFR 4.45 in accordance with the *DeLuca* holding to elevate the evaluation to 40-percent under 38 CFR 4.71a, DC 5261. Assignment of a separate evaluation under 38 CFR 4.71a, DC 5258/5259 would constitute pyramiding.

Example 3: A Veteran's left knee disability, which includes the meniscus, is evaluated as 30-percent disabling on the basis of limitation of extension under 38 CFR 4.71a, DC 5261. Pain is present due to the meniscus disability. A VA examiner indicated that pain during repetitive motion testing as well as functional loss due to pain during flare-ups additionally limit extension to 30 degrees, which results in elevation of the 30-percent evaluation under 38 CFR 4.71a, DC 5261 to 40-percent. A separate evaluation under 38 CFR 4.71a, DC 5258/5259 is not warranted for the symptoms of pain since it was considered under 38 CFR 4.40 and 38 CFR 4.45 in accordance with the *DeLuca* holding to elevate the evaluation to 40-percent under 38 CFR 4.71a, DC 5261. Assignment of a separate evaluation under 38 CFR 4.71a, DC 5258/5259 would constitute pyramiding.

Example 4: A Veteran's right knee disability is evaluated as 20-percent disabling on the basis of limitation of extension. This disability includes arthritis of the joint and a post-operative meniscal condition. The knee also manifests pain, swelling, popping, locking, and grinding due to both arthritis and the meniscal condition. A VA examiner found that repetitive motion testing additionally limited extension by five degrees, from 15 to 20 degrees,

due to pain. The consideration of pain on motion, which is a manifestation identified under 38 CFR 4.40 and 38 CFR 4.45, results in elevation of the evaluation under 38 CFR 4.71a, DC 5261 to 30-percent. Since the swelling, popping, locking, and grinding, which were at least in part due to the meniscal condition, were not considered in awarding a higher evaluation under 38 CFR 4.71a, DC 5261 with application of 38 CFR 4.40 and 38 CFR 4.45, a separate evaluation may be awarded for the meniscus removal.

Example 5: Examination of the left knee disability reveals 2+ medial laxity and a history of meniscectomy with residual symptoms of stiffness, crepitus, and pain without effusion or locking. ROM is full with no additional functional impairment following repeated ROM testing. Since the stiffness, crepitus, and pain are separate symptoms and not used to support an evaluation under 38 CFR 4.71a, DC 5257/5260/5261 and the laxity is not used to support an evaluation for the meniscal symptoms, a 20-percent evaluation is warranted under 38 CFR 4.71a, DC 5257 with a separate 10-percent evaluation assigned under 38 CFR 4.71a, DC 5259.

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h. Evaluation Builder Workaround for Meniscal Disabilities

Until the Evaluation Builder can be updated to reflect the policy and procedural changes effected by the holding in *Lyles v. Shulkin*, 29 Vet.App. 107 (2017), decision makers are responsible for ensuring that proper disability evaluations are assigned for knee disabilities involving meniscal impairment.

The workaround provided below will assist decision makers in properly evaluating meniscal disabilities.

Step	Action
1	Analyze the medical evidence to determine whether symptoms of the meniscal disability exist and are not used to support an evaluation assigned under 38 CFR 4.71a, DC 5257/5260/5261. If symptoms of the meniscal disability exist and • are *not* used to support an evaluation under 38 CFR 4.71a, DC 5257/5260/5261, proceed to Step 2, or • are used to support an evaluation under 38 CFR 4.71a, DC 5257/5260/5261, enter all knee symptoms as a single decision point in the Evaluation Builder, as usual. No further special action is needed since a separate meniscal evaluation is not warranted.
2	The symptoms supporting the evaluation under 38 CFR 4.71a, DC 5258/5259 for the meniscal disability must be entered into the Evaluation Builder as a separate decision point from the remainder of the knee symptoms that are used to support the evaluation under 38 CFR 4.71a, DC 5257/5260/5261. ***Important***: Symptoms used to support an evaluation (including elevation of an evaluation under 38 CFR 4.40 and 38 CFR 4.45 in

	accordance with the *DeLuca* holding) under 38 CFR 4.71a, DC 5257/5260/5261 **cannot** be used to also support an evaluation under 38 CFR 4.71a, DC 5258/5259.
3	Override the pyramiding conflict that is generated due to the assignment of separate evaluations under 38 CFR 4.71a, DC 5260/5261 and 38 CFR 4.71a, DC 5258/5259. In the justification field for the override, annotate that separate evaluations are warranted per the *Lyles* decision.

ik. Separate Evaluations – Genu Recurvatum

When evaluating genu recurvatum, which involves hyperextension of the knee beyond zero degrees of extension, under 38 CFR 4.71a, DC 5263

- do *not also* evaluate separately under 38 CFR 4.71a, DC 5261, but
- *do* evaluate separately under other evaluations *if* manifestations that are not overlapping, such as limitation of flexion under 38 CFR 4.71a, DC 5260, are attributed to genu recurvatum, and
- do *not* evaluate separately under 38 CFR 4.71a, DC 5257; however, if instability is manifested from genu recurvatum at the "moderate" or "severe" level, evaluate under 38 CFR 4.71a, DC 5263-5257.

jl. Evaluating Shin Splints

Evaluate shin splints analogously with 38 CFR 4.71a, DC 5262. The table below explains the process and necessary considerations for evaluating shin splints.

Step	Action
1	Is a chronic disability present? • If *yes*, go to Step 2. • If *no*, deny SC.
2	• Determine whether the shin splint disability affects the right, left, or bilateral extremity(ies). • Go to Step 3.
3	• Determine whether shin splints affect the knee or the ankle. • Go to Step 4.
4	Has SC been established for a knee or ankle joint condition affecting the same joint as the shin splints? • If *yes*, – grant SC for the shin splints – assign a single evaluation for the symptoms of the shin splint condition with the symptoms caused by the other SC knee or ankle joint condition, and – evaluate the predominant symptoms under the most favorable DC(s) for that joint. ▪ If the shin splints are the predominant disability, go to Step 5.

	▪ If the other SC disability of the knee or ankle joint is the predominant disability, evaluate under the criteria for the other SC disability and go to Step 6. • If *no*, – award SC for the shin splints under 38 CFR 4.71a, DC 5299-5262, and – go to Step 5. ***Note***: For all awards of SC for shin splints, in the DIAGNOSIS field in ~~the Veterans Benefits Management System – Rating (~~VBMS-R~~)~~ indicate • which side (right or left) is affected, and • whether there is knee or ankle involvement. ***Example***: *shin splints, right lower extremity, with ankle impairment.*
5	• Access the Musculoskeletal - Other calculator within VBMS-R. • Choose SHIN SPLINTS from diagnosis drop down. • Go to Step 6.
6	• Utilize information from the DBQ and/or other medical evidence of record to determine whether the associated knee or ankle symptoms are mild, moderate, or severe, and • choose the corresponding level of symptoms.

Notes:
- The term "shin splints" is synonymous with the term "medial tibial stress syndrome." You may also see the related assessments "compartment syndrome" and/or "stress fractures" in treatment records. Rate any of those diagnoses using the guidance in this block.
- Both the *Knee and Lower Leg Conditions Disability Benefits Questionnaire* and the *Ankle Disability Benefits Questionnaire* elicit workup of shin splints and stress fractures. Each asks whether the knee or ankle is predominantly affected and asks the examiner to use the alternate DBQ as appropriate.

References: For more information on
- shin splints, stress fractures, and compartment syndrome, see the Medical EPSS, and
- determining the sufficiency of examinations, see M21-1, Part III, Subpart iv, 3.D.3.

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k~~m~~. Example 1 – Evaluating Shin Splints

Situation: The original claim is for SC for left leg shin splints. Records show complaints of shin pain in both legs starting during the period of active duty but on discharge only left tibia pain was reported. A bone scan from close to discharge was negative. X-rays were negative. The diagnosis was recurrent mild left leg shin splints.

VA examination using the *Knee and Lower Leg Conditions Disability*

Benefits Questionnaire showed that the Veteran reported a history of left mid tibia pain. She reported that in connection with the shin pain she had developed some left knee pain on use – usually with protracted walking on hard surfaces wearing boots. X-rays of the shin and knee were normal. The left tibia was slightly tender to palpation. There was slightly painful left knee flexion at the end point. The assessment was left leg shin splints. The examiner characterized the condition as mild.

Result: Referring to the table in M21-1, Part III, Subpart iv, 4.A.6.j~~4.l~~, grant SC. Use 38 CFR 4.71a, DC 5299-5262. The description should be "shin splints, left lower extremity, with knee impairment." Assign a 10-percent evaluation for a mild condition.

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l~~n~~. Example 2 – Evaluating Shin Splints

Situation: SC has been previously established for left ankle arthritis. A 10-percent evaluation was assigned for x-ray evidence of arthritis of the joint with painful motion. The current claim is for "ankle/left shin splints."

With regard to the tibia, records show complaints of left tibia pain with running during service. A bone scan in service treatment records showed minor stress fractures of the tibia. Initial assessments in service records were shin splints and left tibia stress fracture. Follow-up imaging showed that the stress fractures were healed. The discharge exam noted a history of left tibia stress fracture. The Veteran reported continued minor shin pain. The assessment was shin splints.

VA examination using the *Knee and Lower Leg Conditions Disability Benefits Questionnaire* showed that the Veteran reported a history of continued but worsened left middle to lower tibia pain since service. She said she continued to have left ankle pain on use as well as periodic twinges of pain in the left knee. X-rays of the tibia and knee were normal. X-rays of the ankle showed the SC left ankle arthritis. The tibia was moderately to significantly tender to palpation. There was pain with slight LOM of the left ankle. There was no LOM of the left knee or painful motion. The assessment was left leg shin splints with ankle and occasional knee pain, as well as left ankle arthritis. The examination found that the left ankle was more disabled than the knee. The shin splints were characterized as moderate.

Result: Referring to the table in M21-1, Part III, Subpart iv, 4.A.~~3.l~~6.j, grant SC for shin splints. Assign a single evaluation for the symptoms of the shin splints with the symptoms caused by the SC ankle arthritis and evaluate the predominant symptoms at 20 percent using 38 CFR 4.71a, DC 5299-5262. This would be the most favorable rating. Arthritis of the ankle joint with painful motion of the ankle would be rated only at 10 percent but shin splints with moderate ankle disability can be rated at 20 percent using the 38 CFR 4.71a, DC 5262 criteria. Change the description to "shin splints, left lower extremity, with ankle arthritis."

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mo. Moderate and Marked LOM of the Ankle

Consider the following when evaluating LOM of the ankle under 38 CFR 4.71a, DC 5271:

- An example of moderate limitation of ankle motion is
  – less than 15 degrees dorsiflexion, or
  – less than 30 degrees plantar flexion.
- An example of marked LOM is
  – less than five degrees dorsiflexion, or
  – less than 10 degrees plantar flexion.

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np. Considering Ankle Instability

Do not assign separate evaluations for LOM and instability of the ankle.

DCs for the ankle, including 38 CFR 4.71a, DC 5271 and 38 CFR 4.71a, DC 5262, include broad language that does not explicitly include consideration of any particular ankle symptomatology.

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7. Evaluating Musculoskeletal Disabilities of the Feet

Introduction

This topic contains information on evaluating musculoskeletal disabilities of the feet, including

- selecting a DC for foot disabilities
- identifying the digits of the foot
- assigning separate evaluations for multiple foot disabilities
- evaluating arthritis of the minor joints of the toes
- evaluating plantar fasciitis
- definition of metatarsalgia or Morton's disease
- evaluating metatarsalgia or Morton's disease, and
- pyramiding of metatarsalgia and either plantar fasciitis or pes planus.

Change Date

April 13, 2018

~~w~~a. Selecting a DC for Foot Disabilities

Foot injuries are rated under 38 CFR 4.71a, DC 5284. The application of this DC is limited to disabilities resulting from actual injuries to the foot, as opposed to disabilities caused by, for example, degenerative conditions. However, conditions that are not specifically listed under 38 CFR 4.71a may be rated by analogy under 38 CFR 4.71a, DC 5284~~DC 5284~~.

38 CFR 4.71a, DC 5284~~DC 5284~~ does not apply to the other eight conditions of the foot specifically listed under 38 CFR 4.71a, DCs 5276 through 5283. The listed conditions must be rated under the specified DCs and cannot be rated by analogy under 38 CFR 4.71a, DC 5284~~DC 5284~~.

In cases where a foot injury *and* either arthritis or another foot disability is involved

- consider functional impairment, and
- determine whether, depending on the nature of the disability and history of injury, it is more advantageous to evaluate the condition under 38 CFR 4.71a, DC 5284 or another DC.

References: For more information on

- limited applicability of 38 CFR 4.71a, DC 5284 to foot injuries, see *Yancy v. McDonald*, 27 Vet.App. 484 (2016)
- prohibition of evaluating specific foot disabilities otherwise listed in 38 CFR 4.71a analogously under 38 CFR 4.71a, DC 5284, see *Copeland v. McDonald*, 27 Vet.App. 333 (2015), and
- applying 38 CFR 4.59 to disabilities of minor joints, see M21-1, Part III, Subpart iv, 4.A.1.p~~j~~.

b. Identifying the Digits of the Foot

Follow the guidelines listed below to accurately specify the injured digits of the foot.

- Refer to the digits of the foot as
  – first or great toe
  – second
  – third
  – fourth, or
  – fifth.
- Each digit, except the great toe, includes three phalanges
  – the proximal phalanx (closest to the ankle)
  – the middle phalanx, and
  – the distal phalanx (closest to the tip of the toe).
- The joint between the proximal and middle phalanges is called the ***proximal interphalangeal*** (PIP) joint.
- The joint between the middle and distal phalanges is called the ***distal interphalangeal*** (DIP) joint.
- The great toes each have only two phalanges, the proximal phalanx and the distal phalanx. Therefore, each great toe has only a single joint, called the ***interphalangeal*** (IP) joint.
- The joints connecting the phalanges in the feet to the metatarsals are the ***metatarsophalangeal*** (MTP) joints.
- Designate either right or left for the digits of the foot.

Note: If the location of the injury is unclear, obtain x-rays to clarify the exact point of injury.

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c. Assigning Separate Evaluations for Multiple Foot Disabilities

38 CFR 4.14 requires that the evaluation of the same disability and/or the same manifestation under various diagnoses is to be avoided.

The compact anatomical structure of the foot as well as the inter-related physiological functioning may make it difficult to differentiate the etiology of certain disability symptoms. When multiple SC foot disabilities are present but the etiology of the symptoms cannot be separated, assign a single disability evaluation for the predominant symptoms.

If, however, the etiology of the symptoms can be delineated, separate disability evaluations may be assigned under multiple DCs for foot disabilities provided that the principles of 38 CFR 4.14 have not been violated.

Reference: For more information on evaluating SC and non-service-connected (NSC) symptoms that cannot be separated, see M21-1, Part III, Subpart iv, 5.B.2.c.

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vd. Evaluating Arthritis of the Minor Joints of the Toes

For guidance on evaluating arthritis of a group of minor joints of the toes refer to the table below.

If arthritis ...	Then ...
• affects a group of minor joints in one foot • is documented by x-ray evidence • results in LOM, ***and*** • is confirmed by satisfactory evidence of painful motion, pain on use or other findings such as swelling	assign a 10-percent evaluation under 38 CFR 4.71a, DC 5003.
• affects minor joint groups in *both* feet, ***and*** • is documented by x-ray evidence, ***but*** • does not result in LOM	assign a 10-percent evaluation under 38 CFR 4.71a, DC 5003. ***Exception***: Assign a 20-percent evaluation if there are occasional incapacitating exacerbations).

References: For more information on

- assigning evaluations under 38 CFR 4.71a, DC 5003 when a compensable rating cannot be assigned under a DC for LOM of a joint, see M21-1, Part III, Subpart iv, 4.A.8B.3.b, and
- treating motion as limited where it becomes painful for the purpose of applying 38 CFR 4.71a, DC 5003, pursuant to the holding in *Mitchell v. Shinseki*, 25 Vet.App. 32 (2011), see M21-1, Part III, Subpart iv, 4.A.1.e3.c.

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qe. Evaluating Plantar Fasciitis

Evaluate plantar fasciitis analogous to pes planus, 38 CFR 4.71a, DC 5276.

The most common symptom seen with plantar fasciitis is heel pain. The following considerations apply when evaluating the heel pain.

- Heel pain is consistent with the criteria for a moderate disability under 38 CFR 4.71a, DC 5276 based on pain on manipulation and use of the feet.
- Moderate disability under 38 CFR 4.71a, DC 5276 warrants assignment of a 10-percent evaluation for heel pain without application of 38 CFR 4.59.
- When painful motion with joint or periarticular pathology is present and is a symptom of the plantar fasciitis, 38 CFR 4.59 is applicable. However, as previously noted, a 10-percent evaluation would most often be warranted under 38 CFR 4.71a, DC 5276 without consideration of 38 CFR 4.59.

Note: When SC is established for pes planus and plantar fasciitis, evaluate the symptoms of both conditions together under 38 CFR 4.71a, DC 5276.

Reference: For more information on rating by analogy, see

- M21-1, Part III, Subpart iv, 6.E.2, and
- M21-1, Part III, Subpart iv, 5.B.1.c.

~~s~~f. Definition of Metatarsalgia or Morton's Disease

Metatarsalgia means pain in the forefoot – under the metatarsal heads.

Morton's Disease or ***Morton's Neuroma*** refers to a painful lesion of a plantar interdigital nerve.

~~t~~g. Evaluating Metatarsalgia or Morton's Disease

Anterior metatarsalgia of any type, to include cases due to Morton's Disease, will be evaluated under 38 CFR 4.71a, DC 5279.

The DC provides for an evaluation of 10 percent regardless of whether the condition is unilateral or bilateral.

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h~~u~~. Pyramiding of Metatarsalgia and Either Plantar Fasciitis or Pes Planus

Do not assign separate evaluations for metatarsalgia and plantar fasciitis or pes planus. The evaluation criteria are similar enough that providing separate evaluations will compensate the same facet of disability, violating the prohibition against pyramiding in 38 CFR 4.14.

A 10-percent evaluation under 38 CFR 4.71a, DC 5279 is assigned solely for having pain under the metatarsal heads which would necessarily mean pain with manipulation and use.

The criteria for pes planus or plantar fasciitis for a 10-percent evaluation in 38 CFR 4.71a, DC 5276 include "pain on manipulation and use of the feet, unilateral or bilateral." The criteria for higher evaluations including findings ~~of findings~~ such as accentuated pain on manipulation and use or extreme tenderness of the "plantar surfaces of the feet."

Combine the evaluations under 38 CFR 4.71a, DC 5276. Do not rate by analogy when there is an applicable DC. However if one or both conditions resulted from an injury to the foot, you may also assign an evaluation for the combined conditions under 38 CFR 4.71a, DC 5284.

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5. Congenital Musculoskeletal Conditions

Introduction This topic contains information on congenital conditions, including

- recognizing variations in musculoskeletal development and appearance, and
- considering notable congenital or developmental defects.

Change Date February 9, 2017

6. RA

Introduction

This topic contains information about RA, including

- characteristics of RA
- periods of flares and remissions of RA
- clinical signs of RA
- radiologic changes found in RA
- disability factors associated with RA, and
- points to consider in rating decisions involving joints affected by RA.

Change Date

May 11, 2015

a. Characteristics of RA

The following are characteristics of rheumatoid arthritis (RA), also diagnosed as atrophic or infectious arthritis, or arthritis deformans:

- the onset
  - occurs before middle age, and
  - may be acute, with a febrile attack, and
- the symptoms include a usually laterally symmetrical limitation of movement
  - first affecting PIP and MCP joints
  - next causing atrophy of muscles, deformities, contractures, subluxations, and
  - finally causing fibrous or bony ankylosis (abnormal adhesion of the bones of the joint).

Important: Marie-Strumpell disease, also called rheumatoid spondylitis or ankylosing spondylitis, is *not* the same disease as RA. RA and Marie-Strumpell disease have separate and distinct clinical manifestations and progress differently.

Reference: For more information on evaluating ankylosing spondylitis, see M21-1, Part III, Subpart iv, 4.A.4.d.

b. Periods of Flares and Remissions of RA

The symptoms of RA come and go, depending on the degree of tissue inflammation. When body tissues are inflamed, the disease is active. When tissue inflammation subsides, the disease is inactive (in remission).

Remissions can occur spontaneously or with treatment, and can last weeks, months, or years. During remissions, symptoms of the disease disappear, and patients generally feel well. When the disease becomes active again (relapse), symptoms return.

Note: The return of disease activity and symptoms is called a flare. The course of RA varies from patient to patient, and periods of flares and remissions are typical.

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c. Clinical Signs of RA

The table below contains information about the clinical signs of RA.

Stage of Disease	Symptoms
Initial	• periarticular and articular swelling, often free fluid, with proliferation of the synovial membrane, and • atrophy of the muscles. ***Note***: Atrophy is increased to wasting if the disease is unchecked.
Late	• deformities and contractures • subluxations, or • fibrous or bony ankylosis.

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d. Radiologic Changes Found in RA

The table below contains information about the radiologic changes found in RA.

Stage of Disease	Radiologic Changes
Early	• slight diminished density of bone shadow, and • increased density of articular soft parts without bony or cartilaginous changes of articular ends. ***Note***: RA and some other types of infectious arthritis do not require x-ray evidence of bone changes to substantiate the diagnosis, since x-rays do not always show their existence.
Late	• diminished density of bone shadow • loss of bone substance or articular ends, and • subluxation or ankylosis.

---

e. Disability Factors Associated With RA

Give special attention to the following disability factors associated with RA in addition to, or in advance of, demonstrable x-ray changes:

- muscle spasms
- periarticular and articular soft tissue changes, such as
  - synovial hypertrophy
  - flexion contracture deformities
  - joint effusion, and
  - destruction of articular cartilage, and

- constitutional changes such as
  - emaciation
  - dryness of the eyes and mouth (Sjogren's syndrome)
  - pulmonary complications, such as inflammation of the lining of the lungs or lung tissue
  - anemia
  - enlargement of the spleen
  - muscular and bone atrophy
  - skin complications, such as nodules around the elbows or fingers
  - gastrointestinal symptoms
  - circulatory changes
  - imbalance in water metabolism, or dehydration
  - vascular changes
  - cardiac involvement, including pericarditis
  - dry joints
  - low renal function
  - postural deformities, and
  - low-grade edema of the extremities.

Reference: For more information on the features of RA, see http://www.niams.nih.gov/Health_Info/Rheumatic_Disease/default.asp.

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f. Points to Consider in Rating Decisions Involving Joints Affected by RA

In the DIAGNOSIS field of the rating decision, state which joints are affected by RA as evidenced by any of the following findings:

- synovial hypertrophy or joint effusion
- severe postural changes; scoliosis; flexion contracture deformities
- ankylosis or LOM of joint due to bony changes, and/or
- destruction of articular cartilage.

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7. Degenerative Arthritis

Introduction

This topic contains information about degenerative arthritis, including

- characteristics of degenerative arthritis
- diagnostic symptoms of degenerative arthritis
- radiologic changes found in degenerative arthritis
- symptoms of degenerative arthritis of the spine and pelvic joints, and
- points to consider in the rating decision for degenerative and traumatic arthritis.

Change Date

January 11, 2016

a. Characteristics of Degenerative Arthritis

The following are characteristics of degenerative arthritis, also diagnosed as osteoarthritis or hypertrophic arthritis:

- The onset generally occurs after the age of 45.
- It has no relation to infection.
- It is asymmetrical (more pronounced on one side of the body than the other).
- There is limitation of movement in the late stages only.

b. Diagnostic Symptoms of Degenerative Arthritis

Diagnostic symptoms of degenerative arthritis include

- the presence of Heberden's nodes or calcific deposits in the terminal joints of the fingers with deformity
- ankylosis, in rare cases
- hyperostosis and irregular, notched articular surfaces of the joints
- destruction of cartilage
- bone eburnation, and
- the formation of osteophytes.

Note: The flexion contracture deformities and severe constitutional symptoms described under RA do not usually occur in degenerative arthritis.

c. Radiologic Changes Found in Degenerative Arthritis

The table below contains information about the radiologic changes found in degenerative arthritis.

Stage	Radiologic Changes
Early	delicate spicules of calcium at the articular margins without

	• diminished density of bone shadow, and • increased density of articular of parts.
Late	• ridging of articular margins • hyperostosis • irregular, notched articular surfaces, and • ankylosis only in the spine.

d. Symptoms of Degenerative Arthritis of the Spine and Pelvic Joints

Degenerative arthritis of the spine and pelvic joints is characterized clinically by the same general characteristics as arthritis of the major joints except that

- limitation of spine motion occurs early
- chest expansion and costovertebral articulations are not usually affected
- referred pain is commonly called "*intercostal neuralgia"* and "*sciatica*," and
- localized ankylosis may occur if spurs on bodies of vertebrae impinge.

e. Points to Consider in the Rating Decision for Degenerative and Traumatic Arthritis

Degenerative and traumatic arthritis require x-ray evidence of bone changes to substantiate the diagnosis.

Note: In evaluating arthritis of the spine, the principles for extending SC to joints affected by the subsequent development of degenerative arthritis (as contemplated under 38 CFR 4.71a, DC 5003), is not dependent on the choice of DC.

Example: Veteran is SC for degenerative arthritis of the spine under 38 CFR 4.71a, DC 5242 and subsequently develops degenerative arthritis in the right elbow, with no intercurrent cause noted. In this case, the principles of extending SC to joints, as contemplated in 38 CFR 4.71a, DC 5003, also apply even though the Veteran is rated under 38 CFR 4.71a, DC 5242. Thus, SC for arthritis of the right elbow may be established.

Reference: For more information on considering x-ray evidence when evaluating arthritis and non-specific joint pain, see

- 38 CFR 4.71a, DC 5003, and
- M21-1, Part III, Subpart iv, 3.D.4.i.

8. LOM in Arthritis Cases

Introduction

This topic contains information on LOM due to arthritis, including

- arthritis compensable under DCs based on ROM
- joint conditions not compensable under DCs not based on ROM
- reference for rating decisions involving LOM
- arthritis previously rated as a single disability
- using DCs 5013 through 5024 in rating decisions, and
- considering the effects of a change of diagnosis in arthritis cases.

Change Date

September 23, 2016

a. Arthritis Compensable Under DCs Based on ROM

For a joint or group of joints affected by degenerative arthritis (or a condition evaluated using the arthritis criteria such as traumatic arthritis), first attempt to assign an evaluation using the DC for ROM of the affected joint (38 CFR 4.71a, DC 5200 series).

When the requirements for compensable LOM of a joint are met under a DC other than 38 CFR 4.71a, DC 5003, hyphenate that DC in the conclusion with a preceding "5003-."

Example: Degenerative arthritis of the knee manifested by limitation of knee extension justifying a 10-percent evaluation under 38 CFR 4.71a, DC 5261 would use the hyphenated DC "5003-5261."

Exception: If other joints affected by arthritis are compensably evaluated in the same rating decision, use only the DC appropriate to these particular joints which supports the assigned evaluation and omit the modifying "5003."

b. Joint Conditions Not Compensable Under DCs Not Based on ROM

Whenever LOM due to arthritis is noncompensable under codes appropriate to a particular joint, assign 10 percent under 38 CFR 4.71a, DC 5003 for each major joint or group of minor joints affected by limited or painful motion as prescribed under 38 CFR 4.71a, DC 5003.

If there is no limited or painful motion, but there is x-ray evidence of degenerative arthritis, assign under 38 CFR 4.71a, DC 5003 either a 10-percent evaluation or a 20-percent evaluation for occasional incapacitating exacerbations, based on the involvement of two or more major joints or two or more groups of minor joints.

Important: Do *not* combine under 38 CFR 4.25 a 10- or 20-percent evaluation that is based solely on x-ray findings with evaluations that are based on limited or painful motion. See example in M21-1, Part III, Subpart

iv, 4.A.9.d.

Reference: For more information on assigning a minimum evaluation based on painful motion as provided in 38 CFR 4.59 in cases rated under 38 CFR 4.71a, DC 5003, see M21-1, Part III, Subpart iv, 4.A.1.g.

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c. Reference: Rating Decisions Involving LOM

For more information on rating decisions involving LOM, see

- M21-1, Part III, Subpart iv, 4.A.8.e, and
- M21-1, Part III, Subpart iv, 4.A.9.

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d. Arthritis Previously Rated as a Single Disability

The rating activity may encounter cases for which arthritis of multiple joints is rated as a single disability.

Use the information in the table below to process cases for which arthritis was previously evaluated as a single disability but the criteria for assignment of separate evaluations for affected joints was met at the time of the prior decision.

If …	**Then …**
• the separate evaluation of the arthritic disability results in no change in the combined degree previously assigned, and • a rating decision is required	reevaluate using the current procedure with the same effective date as previously assigned.
reevaluating the arthritic joint separately results in an increased combined evaluation	apply 38 CFR 3.105(a) to retroactively increase the assigned evaluation.
reevaluating the arthritic joint separately results in a reduced combined evaluation	• request an examination, and • if still appropriate, propose reduction under 38 CFR 3.105(a) and 38 CFR 3.105(e). ***Exception***: Do not apply 38 CFR 3.105(a) if the assigned percentage is protected under 38 CFR 3.951. ***Reference***: For more information on protected rating decisions, see M21-1, Part III, Subpart iv, 8.C.

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e. Using DCs 5013 Through 5024 in Rating Decisions

Use the table below to evaluate cases that use 38 CFR 4.71a, DCs 5013 through 5024.

If the DC of the case is …	Then …
gout under 38 CFR 4.71a, DC 5017	evaluate the case as RA, 38 CFR 4.71a, 5002.
• 38 CFR 4.71a, 5013 through 5016, and • 38 CFR 4.71a, DC 5018 through 5024	evaluate the case according to the criteria for limited motion or painful motion under 38 CFR 4.71a, DC 5003, degenerative arthritis. ***Note***: The provisions under 38 CFR 4.71a, DC 5003, regarding a compensable minimum evaluation of 10 percent for limited or painful motion apply to these DCs and no others. ***Reference***: For more information on evaluations of 10 and 20 percent based on x-ray findings, see 38 CFR 4.71a, DC 5003, Note (2).

f. Considering the Effects of a Change in Diagnosis in Arthritis Cases

A change of diagnosis among the various types of arthritis, particularly if joint disease has been recognized as SC for several years, has no significant bearing on the question of SC.

Note: In older individuals, the effects of more than one type of joint disease may coexist.

Reference: For information on evaluating RA, see 38 CFR 4.71a, DC 5002.

9. Examples of Rating Decisions for LOM in Arthritis Cases

Introduction

This exhibit contains four examples of rating decisions for LOM in arthritis cases including

- example of degenerative arthritis with separately compensable joints affected
- example of degenerative arthritis evaluated based on x-ray evidence only
- example of noncompensable degenerative arthritis of a single joint, and
- example of degenerative arthritis evaluated based on x-ray evidence only and another compensable evaluation.

Change Date

January 11, 2016

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a. Example of Degenerative Arthritis With Separately Compensable Joints Affected

Situation: The Veteran has residuals of degenerative arthritis with limitation of abduction of the right shoulder (major) to 90 degrees and limitation of flexion of the right knee to 45 degrees.

Coded Conclusion:
1. SC (VE INC)

5003-5201 20% from 12-14-03	Degenerative arthritis, right shoulder (dominant)
5260 10% from 12-14-03	Degenerative arthritis, right knee
COMB	30% from 12-14-03

Rationale: The shoulder and knee separately meet compensable requirements under 38 CFR 4.71a, DCs 5201 and 38 CFR 4.71a, DC 5260, respectively.

---

b. Example of Degenerative Arthritis Evaluated Based on X-Ray Evidence Only

Situation: The Veteran has x-ray evidence of degenerative arthritis of both knees without

- limited or painful motion of any of the affected joints, or
- incapacitating episodes.

Coded Conclusion:
1. SC (PTE INC)

5003	Degenerative arthritis of the knees, x-ray evidence

10% from 12-30-01

Rationale: There is no limited or painful motion in either joint, but there is x-ray evidence of arthritis in more than one joint to warrant a 10-percent evaluation under 38 CFR 4.71a, DC 5003.

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c. Example of Noncompensable Degenerative Arthritis of a Single Joint

Situation: The Veteran has x-ray evidence of degenerative arthritis of the right knee without limited or painful motion.

Coded Conclusion:
1. SC (PTE INC)
5003 Degenerative arthritis, right knee, x-ray evidence only
0% from 12-30-01

Rationale: There is no limited or painful motion in the right knee or x-ray evidence of arthritis in more than one joint to warrant a compensable evaluation under 38 CFR 4.71a, DC 5003.

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d. Example of Degenerative Arthritis Evaluated Based on X-Ray Evidence Only and Another Compensable Evaluation

Situation: The Veteran has x-ray evidence of degenerative arthritis of both knees without limited or painful motion or incapacitating exacerbations. The Veteran also has residuals of degenerative arthritis with limitation of abduction of the right shoulder (major) to 90 degrees.

Coded Conclusion:
1. SC (VE INC)
5003-5201 Degenerative arthritis, right shoulder (dominant)
20% from 12-14-03

5260 Degenerative arthritis, right knee
0% from 12-14-03

5260 Degenerative arthritis, left knee
0% from 12-14-03

COMB 20% from 12-14-03

Rationale: Since the shoulder condition meets compensable requirements under 38 CFR 4.71a, DCs 5201, each knee condition must be evaluated under separate DCs. Based on Note (1) under 38 CFR 4.71a, DC 5003, ratings of

~~arthritis based on x-ray findings only (without limited or painful motion or incapacitating exacerbations) ***cannot*** be combined with ratings of arthritis based on LOM.~~

10. Osteomyelitis

Introduction

This topic contains information about osteomyelitis, including

- requiring constitutional symptoms for assignment of a 100-percent or 60-percent evaluation under DC 5000
- historical evaluations for osteomyelitis
- assigning historical evaluations for osteomyelitis
- the reasons to discontinue a historical evaluation for osteomyelitis
- assigning a 10-percent evaluation for active osteomyelitis, and
- application of the amputation rule to evaluations for osteomyelitis.

Change Date

May 11, 2015

a. Requiring Constitutional Symptoms for Assignment of a 100-Percent or 60-Percent Evaluation Under DC 5000

Constitutional symptoms are a prerequisite to the assignment of either the 100-percent or 60-percent evaluations under 38 CFR 4.71a, DC 5000.

Since both the 60- and 100-percent evaluations are based on constitutional symptoms, neither is subject to the amputation rule.

Reference: For more information on the amputation rule, see 38 CFR 4.68.

b. Historical Evaluations for Osteomyelitis

Both the 10-percent evaluation and that part of the 20-percent evaluation that is based on "other evidence of active infection within the last five years" are

- historical evaluations, and
- based on recurrent episodes of osteomyelitis.

Note: The 20-percent historical evaluation based on evidence of active infection within the past five years *must* be distinguished from the 20-percent evaluation authorized when there is a discharging sinus.

c. Assigning Historical Evaluations for Osteomyelitis

An initial episode of active osteomyelitis is *not* a basis for either of the historical evaluations.

Assign the historical evaluation as follows

- When the first *recurrent* episode of osteomyelitis is shown
  - assign a 20-percent historical evaluation, and
  - extend the evaluation for five years from the date of examination showing the osteomyelitis to be inactive.
- Assign a closed evaluation at the expiration of the five-year extension.
- Assign the 10-percent historical evaluation only if there have been two or

more recurrences of active osteomyelitis following the initial infection.

---

d. Reasons to Discontinue a Historical Evaluation for Osteomyelitis

Do *not* discontinue the historical evaluation, even if treatment includes saucerization, sequestrectomy, or guttering, because the osteomyelitis is not considered cured.

Exception: If there has been removal or radical resection of the affected bone

- consider osteomyelitis cured, and
- discontinue the historical evaluation.

---

e. Assigning a 10-Percent Evaluation for Active Osteomyelitis

When the evaluation for amputation of an extremity or body part affected by osteomyelitis would be zero percent, assign a 10-percent evaluation if there is active osteomyelitis.

References: For more information on

- applying the amputation rule to evaluations for active osteomyelitis, see M21-1, Part III, Subpart iv, 4.A.10.f, and
- evaluating osteomyelitis, see 38 CFR 4.71a, DC 5000.

---

f. Application of the Amputation Rule to Evaluations for Osteomyelitis

Use the following table to determine how the amputation rule affects evaluations assigned for osteomyelitis.

If the osteomyelitis evaluation is ...	**Then the amputation rule ...**
10 percent based on active osteomyelitis of a body part where the amputation evaluation would normally be zero percent	does not apply.
• 10 percent based on active osteomyelitis of a body part where the amputation evaluation would normally be zero percent, or • 30 percent or less under 38 CFR 4.71a, DC 5000, *and* • the 10-percent evaluation is combined with evaluations for – ankylosis – limited motion – nonunion or malunion – shortening, or – other musculoskeletal impairment	applies to the combined evaluation.
60 percent based on constitutional symptoms of osteomyelitis, per 38	does not apply since the 60-percent evaluation is based on constitutional

CFR 4.71a, DC 5000 symptoms.

Reference: For more information on the amputation rule, see
- 38 CFR 4.68, and
- M21-1, Part III, Subpart iv, 4.A.13.d.

11. Examples of the Proper Rating Procedure for Osteomyelitis

Introduction

This exhibit contains eight examples of the proper procedure for rating osteomyelitis, including

- example of evaluating osteomyelitis based on a history of a single active initial episode
- example of evaluating an active initial episode of osteomyelitis
- example of evaluating osteomyelitis following review exam for initial active episode
- example of evaluating osteomyelitis with current discharging sinus
- example of evaluating osteomyelitis with a historical evaluation following a single recurrence with scheduled reduction due to inactivity
- example of evaluating a recurrence of osteomyelitis
- example of evaluating osteomyelitis following second recurrence, and
- example of evaluating osteomyelitis following curative resection of affected bone.

Change Date

May 11, 2015

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a. Example of Evaluating Osteomyelitis Based on a History of a Single Active Initial Episode

Situation: The Veteran was diagnosed with osteomyelitis in service with discharging sinus. At separation from service the osteomyelitis was inactive with no involucrum or sequestrum. There is no evidence of recurrence.

Result: As there has been no recurrence of active osteomyelitis following the initial episode in service, the historical evaluation of 20 percent is not for application. The requirements for a 20-percent evaluation based on activity are not met either.

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia
0% from 12-2-93

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b. Example of Evaluating an Active Initial Episode of Osteomyelitis

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.11.a, but the Veteran had a discharging sinus at the time of separation from service.

Result: The Veteran meets the criteria for a 20-percent evaluation based on a discharging sinus. Schedule a future examination to ascertain the date of inactivity.

Coded Conclusion:

1. SC (PTE INC)
5000 Osteomyelitis, right tibia, active
20% from 12-2-93

---

c. Example of Evaluating Osteomyelitis Following Review Exam for Initial Active Episode

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.11.b. Subsequent review examination reveals the sinus tract was healed and there is no other evidence of active infection.

Result: Since the Veteran has not had a recurrent episode of osteomyelitis since service, a historical evaluation of 20 percent is not for application. Take rating action under 38 CFR 3.105(e).

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia, inactive
20% from 12-2-93
0% from 3-1-95

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d. Example of Evaluating Osteomyelitis With Current Discharging Sinus

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.11.b. The Veteran is hospitalized July 2l, 1996, with active osteomyelitis of the right tibia shown with discharging sinus. There is no involucrum, sequestrum, or constitutional symptom. Upon release from the hospital the discharging sinus is still present.

Result: Assign the 20-percent evaluation based on evidence showing draining sinus from the proper effective date. Schedule a future examination to ascertain date of inactivity.

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia, active
0% from 3-1-95
20% from 7-21-96

---

e. Example of Evaluating Osteomyelitis With a Historical Evaluation Following a Single Recurrence With Scheduled Reduction Due to Inactivity

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.11.d. A routine future examination was conducted on July 8, 1997, showing the osteomyelitis to be inactive. There was no discharging sinus, no involucrum, sequestrum, or constitutional symptom. The most recent episode of active osteomyelitis (July 21, 1996) constitutes the first "recurrent" episode of active osteomyelitis.

Result: Continue the previously assigned 20-percent evaluation, which was awarded on the basis of discharging sinus as a historical evaluation for five years from the examination showing inactivity.

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia, inactive
20% from 7-21-96
0% from 7-8-02

---

f. Example of Evaluating a Recurrence of Osteomyelitis

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.11.e. In October 1999, the Veteran was again found to have active osteomyelitis with a discharging sinus, without involucrum, sequestrum, or constitutional symptoms.

Result: Continue the 20 percent evaluation. Reevaluation is necessary to remove the future reduction to zero percent, and to schedule a future examination to establish the date of inactivity.

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia, active
20% from 7-21-96

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g. Example of Evaluating Osteomyelitis Following Second Recurrence

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.11.f. A review examination was conducted on April 8, 2000. The examination showed the discharging sinus was inactive, and there was no other evidence of active osteomyelitis. The most recent episode of osteomyelitis (October 1999) constitutes the second "recurrent" episode of active osteomyelitis.

Result: The historical evaluations of 20 and 10 percent both apply.

Coded Conclusion:
1. SC (PTE INC)
5000 Osteomyelitis, right tibia, inactive
20% from 7-21-96
10% from 4-8-05

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h. Example of Evaluating Osteomyelitis Following Curative Resection of Affected Bone

Situation: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.11.g. The Veteran was hospitalized June 10, 2002, with a recurrent episode of active osteomyelitis. A radical resection of the right tibia was performed and at hospital discharge (June 21, 2002), the osteomyelitis was shown to be cured.

Result: Assign a temporary total evaluation of 100 percent under 38 CFR 4.30 with a 1-month period of convalescence. Following application of 38 CFR 3.105(e), reduce the evaluation for osteomyelitis to zero percent as an evaluation for osteomyelitis will not be applied following cure by removal or radical resection of the affected bone.

~~***Coded Conclusion:***~~
~~1. SC (PTE INC)~~
~~5000~~ ~~Osteomyelitis, right tibia, P.O.~~
~~20% from 7-21-96~~
~~100% from 6-10-02 (Par. 30)~~
~~20% from 8-1-02~~
~~0% from 10-1-02~~

12. Muscle Injuries

Introduction

This topic contains information about rating muscle injuries, including

- types of muscle injuries
- standard muscle strength grading system for examinations
- identification of muscle groups (MGs) in examination reports
- general criteria for muscle evaluations
- fractures associated with gunshot wound (GSW) and shell fragment wounds (SFW)
- determining whether 38 CFR 4.55 applies to muscle injuries
- applying 38 CFR 4.55 to muscle injuries
- evaluating joint manifestations and muscle damage acting on the same joint
- evaluating damage to multiple muscles within the same MG
- considering peripheral nerve involvement in muscle injuries
- evaluating muscle injuries with peripheral nerve conditions of different etiology
- evaluating scars associated with muscle injuries
- applying the amputation rule to muscle injuries, and
- evaluating muscle disabilities not involving shrapnel, GSWs, or other projectile-type injury.

Change Date

October 24, 2017

a. Types of Muscle Injuries

A missile that penetrates the body results in two problems

- it destroys muscle tissue in its direct path by crushing it, then
- the temporary cavitation forces stretch the tissues adjacent to the missile track and result in additional injury or destruction.

Muscles are much more severely disrupted if multiple penetrating projectiles strike in close proximity to each other. Examples of this type of injury are

- explosive device injuries
- deforming or fragmenting rifle projectiles, or
- any rifle projectile that strikes bone.

For additional information regarding types of injuries, the effects of explosions and projectiles, and symptoms and complications, refer to the table below.

Type of Injury	Initial Effects	Signs, Symptoms, and Complications
gunshots	Entrance and exit wounds result. The	• Exit wounds are

	amount of damage and relative size of entrance and exit wounds depends on many factors such as • caliber of bullet • distance from victim • organs, bone, blood vessels, and other structures hit.	generally larger than entrance wounds, and • bullets are essentially sterile when they reach the body but carry particles into wound which could be sources of infection.
fragments from explosive devices	Most result in decreased tissue penetration compared to denser rifle bullets.	Multiple fragments in a localized area result in tissue disruption affecting a wide area.
tears and lacerations	Muscles that become isolated from nerve supply by lacerations will be non-functional.	• Torn muscle fibers heal with very dense scar tissue, but the nerve stimulation will not cross this barrier. • Parts of muscle isolated from the nerve will most likely remain non-contractile resulting in a strength deficit proportional to amount of muscle tissue disrupted. • Treatment for small tears is symptomatic. • Large tears/lacerations may require reconstruction.
through and through wound	Injuring instrument enters and exits the body.	Two wounds result • entrance wound, and • exit wound.

References: For more information on

- muscle groups (MGs) and corresponding DCs, see 38 CFR 4.73
- anatomical regions of the body, see 38 CFR 4.55(b), and
- gunshot wounds (GSWs) with pleural cavity involvement, see 38 CFR 4.97, DC 6840-6845, Note (3).

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b. Standard Muscle Strength Grading System for Examinations

Refer to the following table for information about how muscle strength is evaluated on an examination.

Numeric Grade	Corresponding Strength Assessment	Indications on Exam
(0)	absent	no contraction felt
(1)	trace	muscle can be felt to tighten but no movement is produced
(2)	poor	muscle movement is produced against gravity but cannot overcome resistance
(3)	fair	muscle movement is produced against gravity but cannot overcome resistance
(4)	good	muscle movement is produced against resistance, however, less than normal resistance
(5)	normal	muscle movement can overcome a normal resistance

c. Identification of MG in Examination Reports

The examination report must include information to adequately identify the MG affected by either

- specifically noting which MG is affected, or
- noting which muscles are involved so that the name of the muscles may be used to identify the MG affected.

d. General Criteria for Muscle Evaluations

Evaluation of muscle disabilities is the result of a multi-factorial consideration. However, there are hallmark traits that are suggestive of certain corresponding evaluations. Refer to the following table for additional information regarding these hallmark traits and the suggested corresponding disability evaluation.

If the evidence shows a history of ...	Then consider evaluating the muscle injury as ...
open comminuted fracture *with* • muscle damage, or • tendon damage	severe. ***Note***: This level of impairment is specified by regulation at 38 CFR 4.56(a).
through and through or deep penetrating wound by small high velocity missile or large low velocity missile *with* • debridement • prolonged infection, or • sloughing of soft parts, and • intermuscular scarring	at least moderately severe.

through and through injury *with muscle damage*	no less than moderate. ***Note***: This level of impairment is specified by regulation at 38 CFR 4.56(b).
retained fragments in muscle tissue	at least moderate.
deep penetrating wound *without* • explosive effect of high velocity missile, • residuals of debridement, or • prolonged infection	at least moderate.

Important: No single factor is controlling for the assignment of a disability evaluation for a muscle injury. The entire evidence picture must be taken into consideration.

Reference: For more information on assigning disability evaluations for muscle injuries, see

- *Tropf v. Nicholson*, 20 Vet.App. 317 (2006)
- *Robertson v. Brown*, 5 Vet.App. 70 (1993)
- *Jones v. Principi*, 18 Vet.App. 248 (2004), and
- 38 CFR 4.55.

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e. Fractures Associated With GSW/SFW

All fractures associated with a GSW and/or shell fragment wound (SFW) will be considered open because all of them involve an opening to the outside. Most GSW/SFW fractures are also comminuted due to the shattering nature of the injury.

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f. Determining Whether 38 CFR 4.55 Applies to Muscle Injuries

38 CFR 4.55 applies to certain combinations of muscle injuries and joint conditions. Consider the provisions of 38 CFR 4.55 if

- there are multiple MGs involved
- the MG acts on a joint or joints, and/or
- there is peripheral nerve damage to the same body part affected by the muscle.

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g. Applying 38 CFR 4.55 to Muscle Injuries

If more than one MG is injured or affected or if the injured MG acts on a joint, conduct a preliminary review of the evidence to gather information needed to properly apply the provisions of 38 CFR 4.55. The information needed will include

- whether the affected MGs are in the same or different anatomic regions
- whether the MGs are acting on a single joint or multiple joints, and
- whether the joint or joints is/are ankylosed.

After the preliminary review is complete, use the evidence gathered and apply the following table to determine how 38 CFR 4.55 affects the evaluation of the muscle injury.

Step	Action
1	Does the MG(s) act on an ankylosed joint? • If *yes*, go to Step 2. • If *no*, go to Step 4
2	For MG(s) that act on an ankylosed joint, is the joint an ankylosed knee *and* is MG XIII disabled? • If *yes*, grant separate evaluations for the ankylosed knee and the MG XIII injury. For the MG XIII injury, assign the next lower level than that which would otherwise be assigned. Then go to Step 3. • If *no*, then is the ankylosed joint the shoulder *and* are MGs I and II *severely* disabled? – If *yes*, then assign a single evaluation for the muscle injury and the shoulder ankylosis under DC 5200. The evaluation will be at the level of unfavorable ankylosis. – If *no*, then no evaluation will be assigned for the muscle injury. The combined disability arising from the ankylosis and the muscle injury will be evaluated as ankylosis.
3	For the injury to MG XIII with an associated ankylosed knee, are there other MG injuries in the same anatomical region affecting the pelvic girdle and/or thigh? • If *no*, then no additional change to the evaluation for the muscle injury is warranted. • If *yes*, do the affected MG injuries act on the ankylosed knee? – If *yes*, then no separate evaluation for the muscle injury to a MG other than MG XIII can be assigned, as indicated in Step 2. – If *no*, then for the MG XIII injury that acts on the knee and the injury to another MG of the pelvic girdle and thigh acting on a different joint, is the different joint ankylosed? ▪ If *yes*, then no separate evaluation can be assigned for the other MG injury of the pelvic girdle and thigh, as indicated in Step 2. No further action is warranted. ▪ If *no*, then assign a single evaluation for the MG XIII injury and the injury to the other MG of the pelvic girdle and thigh anatomical region by determining the most severely injured MG and increasing by one level.
4	For muscle injury(ies) acting on unankylosed joint(s), is a single MG injury involved?

- If *yes*, then grant a single evaluation for the muscle injury.
- If *no*, then are the MG injuries in the same anatomical region?
  - If *yes*, go to Step 5.
  - If *no*, go to Step 6

5 Do the MGs in the same anatomical region act on a single joint?

- If yes, are the MGs involved MG I and II acting on a shoulder joint?
  - If *yes*, then
    - assign separate disability evaluations for the MGs, but
    - the combined evaluation cannot exceed the evaluation for unfavorable ankylosis of the shoulder.
  - If *no*, then for the muscles in the same anatomical region acting on a single joint,
    - assign separate disability evaluations for the MGs, but
    - the combined evaluation must be less than the evaluation that would be normally assigned for unfavorable anklyosis of the joint involved.
- If *no*, for the MGs in the same anatomical region acting on different joints, are the MG injuries compensable?
  - If *yes*, then assign a single disability evaluation for the affected MGs by
    - determining the evaluation for the most severely injured MG, and
    - increasing by one level and using as the combined evaluation.
  - If *no*, then assign a noncompensable evaluation for the combined MG injuries.

6 For MG injuries in different anatomical areas, is a single unankylosed joint affected?

- If *yes*, are MG I and II affected and acting upon the shoulder?
  - If *yes*, then
    - assign separate disability evaluations for the muscle injuries, but
    - the combined evaluation cannot exceed the evaluation for unfavorable ankylosis of the shoulder.
  - If *no*, for the MG injuries in different anatomical areas affecting a single unankylosed joint (not including MG I and II acting on the shoulder)
    - assign separate disability evaluations for the muscle injuries, but
    - the combined evaluation must be lower than the evaluation that would be assigned for unfavorable ankylosis of the affected joint.
- If *no*, then for MG injuries in different anatomical areas acting on different unankylosed joints, assign separate disability evaluations for each MG injury.

References: For additional information on

- evaluating joint manifestations and muscle damage acting on the same joint, see M21-1, Part III, Subpart iv, 4.A.12.h, and
- evaluating peripheral nerve involvement in muscle injuries, see M21-1 Part III, Subpart iv, 4.A.12.j.

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h. Evaluating Joint Manifestations and Muscle Damage Acting on the Same Joint

A separate evaluation for joint manifestations and muscle damage acting on the same joint are prohibited if both conditions result in the same symptoms.

Although LOM is not directly discussed in 38 CFR 4.56, the DC provisions within 38 CFR 4.73 describing the functions of various MGs are describing motion.

- The muscles move the joint.
- If the joint manifestation is LOM, that manifestation is already compensated through the evaluation assigned by a muscle rating decision.
- Evaluating the same symptoms under multiple DCs is prohibited by 38 CFR 4.14.

Note: Consider the degree of disability under the corresponding muscle DC and joint DC and assign the higher evaluation.

Exception: Per 38 CFR 4.55(e)(1), if MG XIII is disabled and acts on an ankylosed knee, separate disability evaluations can be assigned for the muscle injury and the knee ankylosis. However, the evaluation for the MG injury will be rated at the next lower level than that which would have otherwise been assigned.

Reference: For additional information on applying 38 CFR 4.55 when evaluating muscle injuries and joint conditions, see M21-1, Part III, Subpart iv, 4.A.12.f-g.

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i. Evaluating Damage to Multiple Muscles Within the Same MG

A separate evaluation cannot be assigned for each muscle within a single MG. Muscle damage to any of the muscles within the group must be included in a single evaluation assigned for the MG.

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j. Considering Peripheral Nerve Involvement in Muscle Injuries

When there is nerve damage associated with the muscle injury, use the following table to determine appropriate actions to take to evaluate the nerve damage and the muscle injury.

If ...	**Then ...**
• the nerve damage is in the same	assign a single evaluation for the

body part as the muscle injury, *and* • the muscle injury and the nerve damage affect the same functions of the affected body part	combined impairment by determining whether the nerve code or the muscle code will result in a higher evaluation. Assign the higher evaluation. ***Note***: If the muscle and nerve evaluations are equal, evaluate with the DC with the highest maximum evaluation available.
• the nerve damage is in the same body part as the muscle injury, *and* • the muscle injury and the nerve damage affect entirely different functions of the affected body part	assign separate evaluations for the nerve damage and the muscle injury.

k. Evaluating Muscle Injuries with Peripheral Nerve Conditions of Different Etiology

The provisions of 38 CFR 4.55 preclude the combining of a muscle injury evaluation with a peripheral nerve paralysis evaluation involving the same body part when the same functions are affected. A muscle injury and a peripheral nerve paralysis of the same body part, originating from separate etiologies, may not be rated separately.

- The exception to this rule is only when entirely different functions are affected.
- Etiology of the disability is irrelevant in rendering a determination regarding combining evaluations for muscle injuries and peripheral nerve paralysis.

Example: A Veteran is SC for GSW to the right leg MG XI at 10 percent. He develops SC diabetic peripheral neuropathy many years later. The peripheral neuropathy affects the external popliteal nerve. Since MG XI and the external popliteal nerve both control the same functions, dorsiflexion of the foot and extension of the toes, only a single disability evaluation can be assigned under either 38 CFR 4.73, DC 5311 or 38 CFR 4.73, DC 8521, whichever is more advantageous.

l. Evaluating Scars Associated With Muscle Injuries

Use the following table to determine appropriate action to take when evaluating scars associated with muscle injuries.

If ...	**Then ...**
there is scarring associated with the muscle injury	assign a separate evaluation for the scar, even if noncompensable.
there is painful or unstable scarring associated with the muscle injury	assign a separate compensable disability evaluation under 38 CFR 4.118, DC 7804.

there is scarring that results in functional loss under 38 CFR 4.118, DC 7805 that is compensable

do not assign a separate evaluation if the body part affected and the functional impairment resulting from the scar are the same as the part and function affected by the muscle injury.

Reference: For more information on assigning separate evaluations for the muscle injury and associated scarring, see

- *Esteban v. Brown*, 6 Vet.App. 259 (1994)
- *Jones v. Principi*, 18 Vet.App. 248 (2004), and
- 38 CFR 4.14.

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m. Applying the Amputation Rule to Muscle Injuries

The amputation rule applies to musculoskeletal conditions and any associated peripheral nerve injuries. Therefore, when assigning separate evaluations for the muscle injury, peripheral nerve injury directly related to that muscle injury must be considered in applying the amputation rule.

References: For more information on

- the amputation rule, see 38 CFR 4.68, and
- evaluating peripheral nerve disabilities associated with muscle injuries, see M21-1, Part III, Subpart iv, 4.A.12.j.

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n. Evaluating Muscle Disabilities Not Involving Shrapnel, GWSs, or Other Projectile Type Injury

Generally, apply 38 CFR 4.73 to muscle injuries such as those arising from shrapnel, GSWs, or other projectiles or similar foreign objects entering the muscle from outside the body since the criteria for the evaluation weigh heavily on the type of wound, treatment, and current manifestations of the wound.

Generally, a disability such as that arising from injuries such as muscle strains, tears not resulting from injury by a foreign object entering the muscle, or muscle atrophy due to a SC joint or nerve injury should be evaluated under an appropriate DC based on associated functional impairment.

8~~13~~. Miscellaneous Musculoskeletal Considerations

Introduction

This topic contains general guidance on evaluating musculoskeletal conditions, including

- SC for fractures
- SC for osteopenia
- evaluating fibromyalgia
- ~~applying the amputation rule~~
- considering conflicting decisions regarding loss of use (LOU) of an extremity~~, and~~
- applying the amputation rule
- ~~non-service-connected (~~NSC~~)~~ amputation eliminating a distal SC disability
- recognizing variations in musculoskeletal development and appearance, and
- considering notable congenital or developmental defects.

Change Date

~~May 25, 2017~~April 13, 2018

a. SC for Fractures

Decision makers must not automatically award SC for fracture or fracture residuals based on a mere service treatment record (STR) reference to a fracture.

- Where SC of a fracture or fracture residuals is *claimed*, SC will be established when sufficient evidence, such as x-rays, a surgical report, casting, or a physical evaluation board report, documents the fracture.
- If SC of a fracture has not been claimed and objective evidence such as x-ray report documents an in-service fracture, invite a claim for SC for the fracture.

The following considerations apply when granting SC for a fracture:

- SC will be established for a healed fracture even without current residual limited motion or functional impairment of a joint.
- Assign a DC consistent with the location of the fracture. The fracture will be rated as noncompensable in the absence of any disabling manifestations.

Reference: For more information about unclaimed chronic disabilities found in STRs, see M21-1, Part IV, Subpart ii, 2.A.1.

b. SC for Osteopenia

Osteopenia is clinically defined as mild bone density loss that is often associated with the normal aging process. Low bone density does- not necessarily mean that an individual is losing bone, as this may be a normal variant.

Osteopenia is comparable to a laboratory finding which is not subject to SC compensation.

Use the ~~following~~ table below to determine the appropriate action to take when SC for osteopenia has been granted.

If ...	Then ...
SC for osteopenia was granted by rating decision dated *prior to* December 19, 2013 (the date on which guidance was issued to clarify the proper procedures for considering SC for osteopenia)	• do not sever SC, as it was properly established based on guidance available at the time the decision was made, • do not reduce the previously assigned evaluation unless the condition has improved, and • consider claims for increased evaluation and schedule examination as warranted based on the facts of the case. ***Note***: Provisions of 38 CFR 3.951 and 38 CFR 3.957 regarding protection of SC remain applicable.
SC for osteopenia was granted by rating decision dated *on or after* December 19, 2013	propose to sever SC based on a finding of clear and unmistakable error.

Note: Osteoporosis, in contrast to osteopenia, is considered a disease entity characterized by severe bone loss that may interfere with mechanical support, structure, and function of the bone. SC for osteoporosis under 38 CFR 4.71a, DC 5013 is warranted when the requirements are otherwise met.

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c. Evaluating Fibromyalgia

The criteria for evaluation of fibromyalgia under 38 CFR 4.71a, DC 5025 does not exclude assignment of separate evaluations when disabilities are diagnosed secondary to fibromyalgia. This includes, but is not limited to, disability diagnoses for which symptoms are included in the evaluation criteria under 38 CFR 4.71a, DC 5025, such as

- depression
- anxiety
- headache, and
- irritable bowel syndrome.

Notes:

- If signs and symptoms are not sufficient to warrant a diagnosis of a separate condition, then they are evaluated with the musculoskeletal pain and tender points under 38 CFR 4.71a, DC 5025.
- The same signs and symptoms cannot be used to assign separate evaluations

under different DCs, per 38 CFR 4.14.

Reference: For more information on evaluating chronic pain syndrome (somatic symptom disorder), see M21-1, Part III, Subpart iv, 4.O~~H~~.1.j.

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d~~e~~. Considering Conflicting Decisions Regarding LOU of an Extremity

Forward the claims folder to the Director, Compensation Service (211B), for an advisory opinion under M21-1, Part III, Subpart vi, 1.A.2.a to resolve a conflict if

- the Insurance Center determines LOU of two extremities prior to rating consideration involving the same issue, and
- the determination conflicts with the proposed rating decision.

Note: This issue will generally be brought to the attention of the rating activity as a result of the type of personal injury, correspondence, or some indication in the claims folder that the insurance activity is involved.

~~d~~e. Applying the Amputation Rule

The combined evaluation for disabilities of an extremity shall not exceed the evaluation for the amputation at the elective level, were amputation to be performed. The amputation rule is included in the musculoskeletal section of the rating schedule and, consequently, applies only to musculoskeletal disabilities and not to disabilities affecting other body systems.

~~Exceptions~~Notes:

- Any peripheral nerve injury associated with the musculoskeletal injury will be considered when applying the amputation rule.
- Actual amputation with associated painful neuroma will be evaluated at the next-higher site of elective reamputation.
- The amputation rule does not apply to evaluations of peripheral nerve disabilities of the extremities including, but not limited to, diabetic neuropathy, radiculopathy/sciatica due to a spinal disorder, or peripheral nerve injuries of non-musculoskeletal etiology.
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- ***~~Note:~~*** The amputation rule does not apply to bilateral evaluations under 38 CFR 4.71a, DCs 5276 to 5279 ***except*** when being compared to a bilateral lower extremity amputation.

References: For more information on the

- amputation rule, see
  – 38 CFR 4.68, and
  – *Moyer v. Derwinski*, 2 Vet.App. 289 (1992)
- application of the amputation rule to rating decisions for osteomyelitis, see M21-1, Part III, Subpart iv, 4.~~A.10~~B.5.f
- application of the amputation rule to rating decisions for muscle injuries, see M21-1, Part III, ~~-~~Subpart iv, 4.~~A.12~~B.7.m, and

- VBMS-R amputation rule instructions, see the *VBMS-R Job Aid*.

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f. NSC Amputation Eliminating a Distal SC Disability

For guidance on disability evaluation considerations when an ~~non-service-connected~~NSC disability results in amputation that eliminates a distal SC disability, see M21-1, Part III, Subpart iv, 5.B.3.e~~e~~.

g~~a~~. Recognizing Variations in Musculoskeletal Development and Appearance

Individuals vary greatly in their musculoskeletal development and appearance. Functional variations are often seen and can be attributed to

- the type of individual, and
- his/her inherited or congenital variations from the normal.

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h~~b~~. Considering Notable Congenital or Developmental Defects

Give careful attention to congenital or developmental defects such as

- absence of parts
- subluxation (partial dislocation of a joint)
- deformity or exostosis (bony overgrowth) of parts, and/or
- accessory or supernumerary (in excess of the normal number) parts.

Note congenital defects of the spine, especially

- spondylolysis
- spina bifida
- unstable or exaggerated lumbosacral joints or angle, or
- incomplete sacralization.

Notes:
- Do not automatically classify spondylolisthesis as a congenital condition, although it is commonly associated with a congenital defect.
- Do not automatically classify joint subluxation as a developmental or congenital condition.
- Do not overlook congenital diastasis of the rectus abdominus, hernia of the diaphragm, and the various myotonias.

References: For more information on
- congenital or developmental defects, see
  – 38 CFR 4.9, and
  – M21-1, Part IV, Subpart ii, 2.B.6, and
- knee joint and patellar subluxation, see M21-1, Part III, Subpart iv, 4.A.~~4.g~~6.c-d.
