

## VASRD OVERVIEW

Current as of 30 MAR 2010

### Step 4 of Adjudication: VASRD Diagnostic codes (DCs) and Rating

<http://www.warms.vba.va.gov/bookc.html>

This document is for general instructional purposes only. It is not intended to create new policy or rules. To the extent it includes errors, is inconsistent with policy, or appears to create new rules, it is to be disregarded. See companion document titled: "PDA Guidance and Policy Compilation."

This information addresses the following components of the 10 Point Standard:

1.	Correct VASRD DC and matching VASRD DC words.*
3.	Foundation for % rating using identified medical/surgical history; objective physical findings; clinical data; and/or subjective complaints.*
4.	When applicable, citation to special regulatory provisions (e.g., §4.26; §4.55a; §4.96a; etc.).*

\* Not required when VA provides PDES rating

See [21 Aug 09 Memo to PEB Presidents: Standard for Findings and Recommendations](#).

#### Outline:

- I. [Determining the Disability Ratings: VASRD PLUS!](#)
- II. [6 Steps in Determining VASRD DC and Rating](#)
- III. [Rating Schedule: General Structure](#)
- IV. [Memorandums to PEB Presidents](#)
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### I. Determining the Disability Ratings: VASRD PLUS! [Back to Outline](#)

14 OCT 2008 provides that rating are based on the VASRD PLUS

- VASRD interpretation by United States Court of Appeals for Veterans Claims. <http://www.uscourts.cavc.gov/> Example: [DeLuca v. Brown](#)  
<http://vets.yuku.com/reply/91807/t/Re-Deluca-question.html>

To the extent the rationale is sound, VA GC Precedent Opinions <http://www.va.gov/ogc/precedentopinions.asp> - *may be persuasive*. However, unlike USCAVC cases, VA GC Precedent Opinions are not “binding” on the PEB.

### II. 6 Steps in Determining VASRD DC and Rating: [Back to Outline](#)

- A. Review all applicable VASRD DCs.
- B. Consider special regulatory provision to include VASRD Subpart A and the DTM 14 Oct 2008 E7.4. Extra-Schedular Ratings.
- C. Review introductory language to section and notes within the selected VASRD DC.
- D. Consider whether rating is based on “ands” or “ors.”
- E. Review the higher rating to verify Soldier doesn’t also meet the requirements for the higher rating.
- F. Verify whether “on point” CAVC or VA GC Precedent Opinion impacts rating.

### III. Rating Schedule: General Structure [Back to Outline](#)

Subpart A - General Policy in Rating

Subpart B - Disability Ratings

- Rules at the beginning of each of 15 body systems
- 4-digit VASRD Diagnostic Code Number (usually a diagnosis)
- Many conditions are rated with reference to a “general rating formula” (Spine; Seizures) or under a “primary disability” (GU)
- Column of Disability % Ratings
- Descriptions of Requirements for rating
- Notes

A. Rating based on DC scheme PLUS  
Subpart A: General Policy in Rating - §§ 4.1 - 4.31.

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Example, § 4.14 Avoidance of Pyramiding.)

### B. Rules at the beginning of each of the 15 body systems

E.g., § 4.96 (a) Rating coexisting respiratory conditions

1. Ratings under DC 6600 through 6817 and 6822 through 6845 will not be combined with each other.
2. Where there is lung or pleural involvement, ratings under DC 6819 and 6820 will not be combined with each other or with DC 6600 through 6817 or 6822 through 6847.
3. A single rating will be assigned under the DC which reflects the predominant disability with elevation to the next higher evaluation where the severity of the overall disability warrants such elevation.

### C. Ors vs. Ands

**Ors:** The Soldier only needs one to meet the specified rating. This is why it is important for the examiner to indicate whether OR not the Soldier has any of the rating criteria. E.g., Spine

**Ands:** Soldier needs more than one to meet specified rating. E.g., General Rating Formula for Mental Disorders. *But see VASRD 4.7, Higher of Two Evaluations.*

### D. Check your rating

Once you begin to settle in on a rating, check the VASRD requirements for the next higher rating. This is because the Soldier may also meet the requirements for a higher rating. The Soldier may meet the requirements for a higher rating when the rating is for a muscle injury ratings or where the rating based on scheme that references a series of "ors." E.g., cardiac disabilities.

## IV. Memorandums to PEB Presidents

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Several Memorandums to PEB Presidents address particular VASRD codes and provisions. These memos are posted on the PDA website. <https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm>. The essential information within these memos is incorporated into this document. See companion document titled:

## V. VASRD: Subpart A

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### VASRD §§ 4.1 - 4.31

General Policy in Rating

#### A. § 4.1 Essentials of Evaluative Rating.

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“The percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations.”

### **B. § 4.2 Interpretation of examination reports.**

*When the PEB does not have the information it needs to accurately adjudicate each of the Soldier's conditions, this provision underscores the importance of requesting additional information from the MEB. The PEB should not try to fill in gaps left by the MEB. See Memorandum to PEB Presidents, “PEB Proceedings Standard for Findings and Recommendations”.*

<https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm>

### **C. § 4.3 Resolution of reasonable doubt.**

1. “It is the defined and consistently applied policy of the Department of Veterans affairs to administer the law under a broad interpretation, consistent, however, with the facts shown in every case. When after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding the degree of disability such doubt will be resolved in favor or the claimant. See §3.102 of this chapter. Compare with Prime Directive posted on PDA website. “Make [regulations and policies] work to benefit our Soldiers.”

#### 2. 38 CFR § 3.102 Reasonable Doubt.

“... [Reasonable doubt exists when there is] an approximate balance of positive and negative evidence which does not satisfactorily prove or disprove the claim. It is a substantial doubt and one within the range of probability as distinguished from pure speculation or remote possibility. It is not a means of reconciling actual conflict or a contradiction in the evidence. Mere suspicion or doubt as to the truth of any statements submitted, as distinguished from impeachment or contradiction by evidence or known facts, is not justifiable basis for denying the application of the reasonable doubt doctrine if the entire, complete record otherwise warrants involving this doctrine. The reasonable doubt doctrine is also applicable even in the absence of official records, particularly if the basic incident allegedly arose under combat, or similarly strenuous conditions, and is consistent with the probably results of such known hardships.

3. *When attempting to determine which of several codes, or rating percentages within a code, are most appropriate for a particular case, and where the rating criteria is not clearly met by any of the proposed codes, the VASRD instructs the Soldier is to be rated at the higher percentage when the Soldier's disability more nearly approximates the criteria for that rating.*

### **D. § 4.6 Evaluation of evidence.**

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1. "... Every element in any way affecting the probative value to be assigned to the evidence in each individual claim must be thoroughly and conscientiously studied by *each member* of the rating board in the light of the established policies of the Department of Veterans Affairs to the end that decisions will be equitable and just as contemplated by the requirements of the law."

2. *This provision underscores the idea that each PEB is composed of three members. Each member must assure themselves the decision is equitable and just as contemplated by the requirements of the law. See AR 635-40, 4-19 m. Minority reports. If a voting member of the PEB disagrees with the findings and recommendation of the other members, that member may prepare a minority report explaining wherein and why he or she differs with the other members. The minority report will be included in the record of the proceedings and referenced in the remarks section of the DA Form 199. A copy will be provided to the Soldier and his or her counsel. AR 635-30, 4-22. A (4). Provides that the USAPDA will review cases in which a voting member of the PEB submits a minority report.*

### **E. § 4.7 Higher of two evaluations.**

1. "Where there is a question as to which of two evaluations shall be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating will be assigned."

2. *This provision is used when there is a gap in rating criteria at the different percent ratings. Newer rating schemes eliminate gaps. See General Rating Formula for Diseases and Injuries of the Spine, and its associated Note (4) providing that each range of motion is to be rounded to the nearest five degrees.*

### 3. Application of VASRD § 4.7:

- a. **VASRD DC 5252, Limitation of thigh flexion.** *This DC provides a 20% rating when thigh flexion is limited to 30 degrees. The 10% rating is met when flexion is limited to 45 degrees. The rating scheme does not specifically provide a rating when flexion is limited 31 to 44 degrees. The PEB may assign the 20% rating when the Soldier has thigh flexion limited to 35 degrees. (IAW DeLuca v. Brown, the PEB will also consider additional functional loss IAW VASRD §§ 4.10, 4.40, 4.45 and 4.59). See 5 MAY 2009 Memorandum to PEB Presidents, "Higher of Two Evaluations".*

<https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm>

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*b. VASRD DC 5201. The Soldier may be rated with reference to shoulder abduction or shoulder forward elevation (flexion) – whichever provides the higher rating. See Plate I. See 3 APR 2009 Memorandum to PEB Presidents, “Limitation of Motion (Arm) (DC 5201)”.*

<https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm>

*c. General rating formula for mental disorders. The Soldier may be rated at 30% when symptoms due to the mental disorder are severe enough to cause occupational and social impairment with occasional decrease in work efficiency or intermittent periods of inability to perform occupational tasks. See 3 FEB 2010 Memorandum to PEB Presidents, “General Rating Formula for Mental Disorders: Application of § 4.7, Higher of two evaluations”.*

<https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm>

### F. § 4.9 Congenital or developmental defects.

1. “... are not diseases or injuries in the meaning of applicable legislation for disability compensation purposes.”

2. *If a Soldier has a congenital condition that results in disability causing unfitness, the 8-year rule provides this condition is compensable.*

### G. § 4.10 Functional impairment.

1. “The basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment. Whether the upper or lower extremities, the back or abdominal wall, the eyes or ears, or the cardiovascular, digestive, or other system, or psyche are affected, evaluations are based upon lack of usefulness, of these parts or systems, especially in self-support. This imposes upon the medical examiner the responsibility of furnishing, in addition to the etiological, anatomical, pathological, laboratory and prognostic data required for ordinary medical classification, full description of the effects of disability upon the person’s ordinary activity. In this connection, it will be remembered that a person may be too disabled to engage in employment although he or she is up and about and fairly comfortable at home or upon limited activity.”

2. *If the examiner follows the [VA worksheet](#) for each of the Soldier’s conditions, the PEB should have the information it needs to make this assessment. Information of this nature is particularly important if the PEB is considering whether the Soldier’s condition(s)*

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render the Soldier "unemployable." See VASRD § 4.16, below. This information is also useful when considering whether the Soldier's condition warrants consideration for an "extra-schedular" rating. See DTM 14 MAR 2008, E7.4, and 38 CFR § 3.321(b).

### H. § 4.13 Effect of change of diagnosis.

When any change in evaluation is to be made, the rating agency should assure itself [of] an actual change in the conditions, for better or worse, and not merely a difference in thoroughness of the examination or in use of descriptive terms. ... [When a change is made] this will not preclude the correction of erroneous rating, nor will it preclude assignment of a rating in conformity with Section 4.7.

### I. § 4.14 Avoidance of pyramiding.

A. The evaluation of the same disability under various diagnoses is to be avoided. Disability from injuries to the muscles, nerves, and joints of an extremity may overlap to a great extent, so that special rules are included in the appropriate bodily system for their evaluation.

#### B. Some VASRD "Anti-pyramiding" Provisions:

##### § 4.55 Muscle injury provisions:

4.55a (prohibits use with nerve injury unless the injuries affect entirely different functions);

4.55 c (generally prohibits rating both a muscle and an ankylosed joint.)

§ 4.71. General rating formula for diseases and injuries of the spine.

§ 4.96 (a) Rating coexisting respiratory conditions.

§ 4.113 Coexisting abdominal conditions. See also VASRD § 4.114 Schedule of ratings—digestive system.

§ 4.115a Ratings of the genitourinary system – dysfunctions.

§ 4.130 Schedule of ratings—mental disorders. General rating formula for mental disorders.

C. For purposes of the PEB Proceedings standard, if PEB applies any of the above provisions to the Soldiers rating, it should reference the provision(s). (Item 4)

#### D. Pyramiding vs. Separate (Ratable) Disabilities:

- i. *Esteban v. Brown*, 6 Vet. App. 259 (1994). This case was decided by the Court of Veterans Appeals (COVA), now called the United States Court of Appeals for Veterans Claims (CAVC). NDAA 2008 requires we follow the legal interpretation of the VASRD as interpreted by CAVC. See 13 MAR 2008 DTM. Therefore, the NDAA 2008 requires we follow the holding of *Esteban v. Brown*.

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ii. *Residuals of injury to the face are rated separately as: DC 7800 (disfigurement), DC 7804 (painful scars), and DC 5325 (facial muscle damage) because “none of the symptomatology for any one of these three conditions is duplicative of or overlapping with the symptomatology of the other two conditions.”*

iii. *For purposes of symptomatology, it is useful to think in terms of evaluation criteria.*

iv. *Pyramiding and Knee ratings: Multiple Knee Ratings*  
*It is permissible to rate both VASRD 5003, and 5257, other impairment of (recurrent subluxation or lateral instability) when the evidence supports the Soldier has these two (unfitting) conditions.*

v. Both osteoarthritis and ligamentous injuries may be associated with pain and may cause similar profile restrictions and functional impairment, e.g., difficulty running and walking. If one considers only that both condition cause “pain” it may seem as though rating both conditions is pyramiding. However, when one considers specific VASRD rating criteria for the different conditions, i.e., limitation of motion and instability, it becomes clear that rating both conditions does not constitute pyramiding. Provided both conditions are unfitting, assign separate ratings for both conditions. Consider “combined effect.”

vi. See 30 SEP 09 Memorandum to PEB Presidents, “Assigning Multiple Limitation of Motion Codes”.

<https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm>

vii. *Example: VASRD DC 5025: Fibromyalgia*

Note: widespread pain means pain in both the left and right sides of the body that is both above and below the waist, and that affects both the axial skeleton (i.e., cervical spine, anterior chest, thoracic spine, or low back) and the extremities.

*The NARSUM includes evidence supporting the Soldier has both (symptomatic) cervical disc disease (diagnosed by MRI) and fibromyalgia. The physical profile includes both conditions and both conditions are listed as failing retention standards. Is it pyramiding to rate both conditions?*

*ANSWER: Assuming the PEB has determined the Soldier is unfit for neck issues and more generalized symptomatology, and where, as here, the evidence supports two separate (unfitting) conditions, it is not pyramiding to rate both separate conditions. The PEB should rate both conditions.*

**J. 38 CFR § 3.321 General rating considerations (b) Exceptional cases-(1) Compensation.**



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1. "...To accord justice ... to the exceptional case where the schedular evaluations are found to be inadequate, the Under Secretary for Benefits or the Director, Compensation and Pension service, upon field station submission, is authorized to approve on the basis of the criteria set forth in this paragraph an extra-schedular evaluation commensurate with the average earning capacity impairment due exclusively to the service-connected disability or disabilities. The governing norm in these exceptional cases is: A finding that the case presents such an exceptional or unusual disability picture with such related factors as marked interference with employment or frequent periods of hospitalization as to render impractical the application of the regular schedular standards."

### **2. DTM 14 Oct 2008**

#### **E7.4. Extra-Schedular Ratings.**

Extra-schedular evaluations for veterans are addressed in 38 CFR 3.321(b). The VASRD does not prevent the Secretary of the Military Department concerned from assigning ratings in unusual cases not covered by the VASRD. In such cases, extra-schedular ratings commensurate with the average earning capacity impairment due exclusively to service-connected disability may be assigned. The basis of the conclusion that the case presents such an exceptional or unusual disability picture that the regular VASRD standards do not apply must be documented.

#### **K. § 4.15 Total disability ratings.**

1. "The ability to overcome the handicap of disability varies widely among individuals. The rating, however, is based primarily upon the average impairment in earning capacity, that is, upon the economic or industrial handicap which must be overcome and not in individual success in overcoming it. However, full consideration must be given to unusual physical or mental effects in individual cases, to peculiar effects of occupational activities, to defects in physical or mental endowment preventing the usual amount of success in overcoming the handicap of disability and to the effect of combinations of disability. Total disability will be considered to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation;

*Provided*, that permanent total disability shall be taken to exist when the impairment is reasonably certain to continue throughout the life of the disabled person.

The following will be considered to be permanent total disability: ... becoming permanently helpless or permanently bedridden. Other total disability ratings are scheduled in the various bodily systems of this schedule."

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### *2. Examples Total Disability Ratings*

#### *a. VASRD DC 5104 - 5111*

*These codes award a 100% rating for anatomical loss of or Loss of use of two of any four extremities.*

- Loss of use of both hands or feet.*
- Anatomical Loss of both hands or feet.*
- Loss of use of a hand and anatomical Loss of a foot*
- Loss of use of a foot and anatomical Loss of a hand*

#### *b. Other Total Disability Ratings*

- i. Vision: Visual acuity of 5/200 in both eyes - or worse*
- ii. Hearing: Very severe hearing loss (I have never seen this)*
- iii. Respiratory: Permanent tracheostomy (see VASRD 6520, Laryngeal stenosis)*
- iv. Respiratory : Requires Outpatient oxygen therapy*
- v. Cardiovascular: METS of 3 or less*
- vi. GI: Complete loss of sphincter control; colostomy*
- vii. GU: Dialysis*
- viii. Heme/Lymphatic: During cancer treatment when stop date is indefinite. (ex. CML/Gleevec).*
- ix. Skin: Near constant requirement for systemic therapy including steroids and/or immunosuppressants*
- x. Mental Disorders: 100% rating under General Rating Formula*
- xi. Dental: Loss of mandible between angles*

### **L. §4.16 Total disability ratings for compensation based on unemployability of the individual.**

*This provision permits the PEB to award a total disability ratings based on unemployability when the Soldier does not meet the percentage standards.*

*Total disability ratings for compensation may be assigned, where the schedular rating is less than total, when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of service connected disabilities. Consult with 38 CFR § 4.16 for additional guidance in determining total disability ratings. [DTM 14 Oct 2008](#)*

*As stipulated in § 4.16, the PEB should include a full statement as to the Soldier's service-connected disabilities, employment history, educational and vocational attainment and all other factors having a bearing on the issue.*

### **M. § 4.18 Unemployability.**

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“A veteran may be considered as unemployable upon termination of employment which was provide on account of disability, or in which special consideration was given on account of the same, when it is satisfactorily shown that he or she is unable to secure further employment. ....

[C]onsideration is to be given to the circumstances of employment in individual claims, and, if the employment was only occasional, intermittent, tryout or unsuccessful, or eventually terminated on account of the disability, present unemployability may be attributed to the static disability.”

### **N. § 4.20 Analogous ratings.**

1. “When an unlisted condition is encountered it will be permissible to rate under a closely related disease or injury in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous. Conjectural analogies will be avoided, as will the use of analogous ratings for conditions of doubtful diagnosis, or for those not fully supported by clinical and laboratory findings. Nor will ratings assigned to organic diseases and injuries be assigned by analogy to conditions of functional origin.”

2. See 19 AUG 2009 Memorandum to PEB Presidents, “Analogous ratings”. <https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm>

3. §4.20 is a special regulatory provision. If the PEB uses an analogous code, the PEB should consider VASRD 4.7, Higher of two evaluations; and should explain how the unlisted condition is similar to the VASRD code selected based on anatomical and symptoms. For example: knee joint (periarticular); painful and limited range of motion (same symptom as that caused by VASRD diagnosis.)

### **O. § 4.23 Attitude of rating officers.**

1. “Fairness and courtesy must at all times be shown to applicants by all employees whose duties bring them in contact, directly or indirectly, with the Department’s claimants.”

2. *Do not let a Soldier’s attitude influence the Soldier’s due process.*

3. Prime Directive: We exist to support our Soldiers ...

### **P. § 4.25 Combined Rating Table.**

There is one problem - when you have the bilateral factor. Sometimes you end up with two numbers, neither of which are multiples of 10. Round to benefit the Soldier.

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### **Q. § 4.26 Bilateral factor.**

1. This provision applies to paired skeletal muscles. The bilateral factor does not apply for a 0% disability. However, rarely, if ever, be the PEB find an unfitting condition that rates at 0%. The bilateral factor applies to muscle injuries affecting paired skeletal muscles, i.e., VASRD 5319 - 5323.

2. Examples:

- a. What is the "bilateral factor"
- b. What is the "bilateral factor"
- c. What is the combined rating for:

### **R. § 4.27 Use of diagnostic code numbers.**

Follow the VASRD.

E.g., 5003 Degenerative arthritis.

Analogous.

E.g., 5099 5003 Chondromalacia of right knee. This condition is rated analogous to 5003 IAW VASRD 4.20.

Residuals.

E.g., 8018 5110 Loss of use of both feet as a residual of multiple sclerosis.

### **S. § 4.28 Prestabilization rating from date of discharge from service.**

This provision permits a 100% rating where the condition is unstable with severe disability - Substantially gainful employment is not feasible or advisable.

It also provides a 50% rating where the Soldier has unhealed or incompletely healed wounds or injuries with material impairment of employability likely.

This provision is useful when the requirements for sending the case forward are met - but the PEB cannot assign a final rating because the condition is not sufficiently stable for final rating purposes. See OTSG Memo 09-037 MEB Processing.

### **T. § 4.30 Convalescent ratings.**

Assign a [single] 100% rating without regard to other provisions when the hospital discharge or outpatient release under the following three situations.

- Surgery requiring at least one month of convalescence.
- Surgery with severe postop residuals.
- Immobilization by cast, without surgery, of one or more major joints.

You will choose whether to apply the 100% rating for 1, 2, or 3 months (continuing for a period of 1, 2, or 3 months from the first day of the month following such hospital discharge or outpatient release.)

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Then assign a regular schedular rating - requesting an additional exam when necessary to ascertain Soldier's condition.

Even after the 1, 2, or 3 month period, you can extend the 100% rating for an additional 1, 2, or 3 month period provided there is a justification.

Extensions of 1 or more months up to 6 months may be made under (2) and (3)

### U. § 4.31 Zero percent evaluations.

"In every instance where the schedule does not provide a zero percent evaluation for a diagnostic code, a zero percent evaluation shall be assigned when the requirements for a compensable evaluation are not met."

## VI. Introduction to VASRD Subpart B (VASRD §4.40 - §4.150) [Back to Outline](#)

### A. General Organization

#### 15 Categories

1. [Musculoskeletal System](#)
2. [Organs of Special Sense \(Vision\)](#)
3. [Impairment of Auditory Acuity \(section also includes Olfaction \(sense of smell\) and Sense of taste\)](#)
4. [Infectious Diseases, Immune Disorders and Nutritional Deficiencies](#)
5. [Respiratory System](#)
6. [Cardiovascular System](#)
7. [Digestive System](#)
8. [Genitourinary System](#)
9. [Gynecological Conditions and Disorders of the Breast](#)
10. [Hemic and Lymphatic Systems](#)
11. [Skin](#)
12. [Endocrine System](#)
13. [Neurological Conditions and Convulsive Disorders](#)
14. [Mental Disorders](#)
15. [Dental and Oral Conditions](#)

### B. Relationship of VA worksheet to Disability Rating

So long as the examiner completes the correct VA worksheet, the correct disability determination should naturally follow. See Table of VA Worksheets within your training materials.

The PDA Website includes a document titled: 40-501, Ch. 3, Medical Retention Standards and Corresponding VA Worksheet. This document matches retention standards to appropriate VA Worksheet(s).

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### C. General DC Rating Scheme

DC Number (4 digits)	Diagnosis (except 5200s)	Percent rating
	U, V and W	
	X or Y	
	Z	

### D. DC Rating Scheme Variants

DC Number (4 digits)	Diagnosis (except 5200s) <b>GENERAL RATING FORMULA</b>	Percent rating	
	<b>Note 1:</b>		
	<b>Note 2:</b>		
	“Diagnostic Criteria”	<i>(Major)</i>	<i>(Minor)</i>
	Something very close to S PLUS q	Highest % (may or may not be 100%)	
	S or T	% (may be the same as below)	
	U, V AND W	% (may be the same as below)	
	X, Y, or Z	Lowest % (May be 0%)	
<b>Note 3:</b>			
<b>Note 4:</b>			

The *definition of the diagnostic criteria may be separated from the terms*. For example, the introductory language (at beginning of body section) may define the terms. E.g., neuralgia; neuritis. The notes may define the terms: major seizure; minor seizure.

Note may indicate the Soldier is rated based on “active” condition or “residuals,” whichever is higher. E.g., See VASRD 6350, Lupus erythematosus, systemic (disseminated):

Note may indicate rating is not to be combined with other ratings. See VASRD 6350, Lupus erythematosus, systemic (disseminated): Not to be combined with ratings under DC 7809. [This is discoid lupus erythematosus or subacute cutaneous lupus erythematosus.]

### E. “General Rating Formulas” (GRF)

- i. 5002 Arthritis rheumatoid, [“With the types of arthritis, diagnostic codes 5004 through 5009, rate the disability as rheumatoid arthritis.”]

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- ii. 5003 Arthritis, degenerative. [“The diseases under diagnostic codes 5013 through 5024 will be rated on limitation of motion of affected parts, as arthritis, degenerative, except gout which will be rated under diagnostic code 5002.”]
- iii. GRF for Diseases and Injuries of the Spine (cervical spine; thoracolumbar spine).
- iv. GRF for sinusitis (DC’s 6510 through 6514).
- v. GRF for Inactive Pulmonary Tuberculosis.
- vi. GRF for interstitial lung disease (diagnostic codes 6825 through 6833).
- vii. GRF for restrictive Lung Disease (diagnostic codes 6840 through 6845). [See Notes (1), (2), and (3).]
- viii. GRF for Disease, Injury, or Adhesions of Female Reproductive Organs (diagnostic codes 7610 through 7615).
- ix. GRF for Major and Minor Epileptic Seizures.
- x. GRF for Mental Disorders.

### VII. VASRD: Subpart B (By Body System)

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#### A. Musculoskeletal System VASRD §4.40 – § 4.73:

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- 1. Range of Motion
  - a. Joints
  - b. Spine
- 2. DeLuca v. Brown
- 3. Muscle Injuries
- 4. Pyramiding
- 5. Loss of Use
- 6. Dominant hand

1. Range of Motion: More than the goniometer reading.

#### § 4.45 The joints.

(f) ... for the purpose of rating disability from arthritis, the *shoulder, elbow, wrist, hip, knee, and ankle* are considered **major joints**; *multiple involvements of the interphalangeal, metacarpal and*

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*carpal joints of the upper extremities, the interphalangeal, metatarsal and tarsal joints of the lower extremities, ... are considered groups of minor joints, ratable on a parity with major joints.*

§ 4.46 Accurate measurement. Instructs examiner to use a goniometer for range of motion.

### § 4.71 Measurement of ankylosis and joint motion.

Ankylosis refers to a joint that does not move, i.e., it is fixed.

Plate I: Normal ROMs for Shoulder, Elbow, Forearm, Wrist

Plate II: Normal ROMs for Hip, Knee, Ankle. Hip extension 30° is not in the Plate but is inferred from VA worksheet.

Plate III: Bones of the hand

Plate IV: Bones of the foot

### The Spine

§ 4.46 Accurate measurement. As with measuring joint ROM, the examiner must use a goniometer to measure spine ROM.

§ 4.71 Measurement of ankylosis and joint motion.

Plate V: ROM of the cervical and thoracolumbar spine.

Spine: General Rating Formula General Rating Formula for diseases and injuries of the spine

Considers ROM Forward flexion

Considers "combined ROMS"

Considers other physical findings such as tenderness and gait

The notes explain how to use the general rating formula

**Note (1)** Evaluate objective neurologic abnormalities separately under an appropriate code

**Note (2)** Referencing Plate V, this note provides the normal range of motion.

Cervical spine: forward flexion 0-45°; extension: 0-45°; left and right lateral flexion: 0-45°; and left and right lateral rotation: 0-80°. Combined ROM refers to the sum of the above ROMs and is 340°

Thoracolumbar spine: forward flexion 0-90°; extension 0-30°; left and right lateral flexion 0-30°; and left and right lateral rotation 0-30°. Combined ROM refers to the sum of the above ROMs and is 240°

Normal ROMs for each component of spinal motion are **the maximum** to be used for calculation of the combined ROM.

**Note (3)** provides an exception to norms so long as the examiner includes a reason. Examples include age, body habitus, neurologic disease, or other factors not the result of disease or injury of the spine.

**Note (4)** instructs that each range of motion measurement is rounded to the nearest five degrees.



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**Note (5)** Provides a definition of unfavorable ankylosis. (This is a rare condition.) Favorable ankylosis is defined as a spinal segment in neutral position (zero degrees).

**Note (6)** This note instructs to separately evaluate disability of the thoracolumbar and cervical spine segments, except when there is unfavorable ankylosis of both segments, which will be rated as a single disability.

### **Summary of General Rating Formula**

Note the introductory language: With or without symptoms such as pain (whether or not it radiates), stiffness, or aching in the area. (See DeLuca Discussion).

a. Cervical spine: Unfavorable ankylosis of entire cervical spine; or, b. Thoracolumbar spine: Forward flexion 30° or less; or, favorable ankylosis of the entire thoracolumbar spine	40%
a. Cervical spine: Forward flexion 15° or less; or, favorable ankylosis of the entire cervical spine	30%
a. Cervical spine: Forward flexion > 15° but not > 30°; or combined ROM not > 170°; or c. b. Thoracolumbar spine: Forward flexion > 30° but not > 60°; or combined ROM not > 120°; or, c. c. Muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis	20%
a. Cervical Spine: Forward flexion > 30° but not > 40°; or combined ROM > 170° but not > 335°; or c. b. Thoracolumbar spine: Forward flexion > 60° but not > 85°; or combined ROM > 120 ° but not > 235 ° c. Muscle spasm, guarding, or localized tenderness not resulting in abnormal gait or abnormal spinal contour; or vertebral body fracture with loss of 50% or more of the height	10%

### Muscle Injuries

VASRD § 4.55 and § 4.56 and DC 5300 series.

Muscle Injuries: IED Explosion Injuries and GSWs

VASRD 4.55 Principles of combined ratings for muscle injuries.

§ 4.55 (a) A muscle injury will not be combined with a peripheral nerve rating of the same body part, unless the injuries affect entirely different functions.

§ 4.55(b) Skeletal muscles divided into 5 anatomical regions and include 23 *muscle groups*

1. Torso and Neck (5 muscle groups)
2. Shoulder Girdle and Arm (6 muscle groups)
3. The Forearm and Hand (3 muscle groups)
4. Pelvic Girdle and Thigh (6 muscle groups)
5. The Foot and Leg (3 muscle groups)

§ 4.55 (c). Instruction for rating a muscle injury and an *ankylosed* joint

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§ 4.55 (d). Instruction for rating two or more muscle group injuries acting on a single joint

§ 4.55 (e). Instruction for rating two or more compensable muscle group injuries *not* acting on the same joint

§ 4.55 (f). Instruction for rating two or more muscle group injuries in *different anatomical locations* which do not act on *ankylosed joints*

### VASRD 4.56 Evaluation of muscle disabilities.

(a) An open comminuted fracture with muscle or tendon damage is generally rated as severe unless evidence establishes minimal muscle damage.

(b) Through and through injury rated at no less than moderate for each injured muscle group.

(c) The six cardinal signs and symptoms of muscle disability are: 1. loss of power; 2. Weakness; 3. lowered threshold of fatigue; 4. fatigue-pain; 5. impairment of coordination; and 6. uncertainty of movement.

(d) Under DC 5301-5323 [muscle injuries are] classified as slight [(d) (1)]; moderate [(d) (2)]; moderately severe [(d) (3)]; or severe [(d) (4)]; based on the following three considerations:

- (i) Type of injury
- (ii) History and complaint
- (iii) Objective findings

Example: (ii) History and complaint

(ii) *History and complaint*. This category considers the nature and severity of the cardinal signs and symptoms of muscle injury

*Slight*: No cardinal signs or symptoms of muscle injury

*Moderate*: Record of consistent complaint of one or more of the cardinal signs and symptoms of muscle disability... particularly lowered threshold of fatigue after average use, affecting the particular functions controlled by the injured muscles.

*Moderately severe*: Record of consistent complaint of cardinal signs and symptoms of muscle disability ... and, if present, evidence of disability to keep up with work requirements.

*Severe*: Record of consistent complaint of cardinal signs and symptoms of muscle disability ... worse than those for moderately severe and, if present, evidence of inability to keep up with work requirements.

### VASRD 4.73 Schedule of ratings - muscle injuries.

The numerical designation of each muscle group, its function and names each muscle comprising each muscle group is included within the 5300 series of the rating schedule. The VA muscle worksheet does not include this information. However, this information is included within the Guidance for MEB Examiners CME.

<https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm>

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### VASRD § 4.14, Avoidance of Pyramiding: Importance of finding most favorable rating scheme

Some conditions, particularly injuries, cause disability to the muscles, nerves, and joints. This provision instructs not to “count” the same disability, e.g., joint motion, to support multiple ratings based on joint motion. However, it is important to choose the most favorable rating.

Example A: A Soldier sustains a through and through injury to the dominant hand from an IED explosion. (See VASRD 5309.) Treatment requires multiple surgeries. The Soldier has documented severe nerve injuries of the radial and ulnar nerve. These rate at 70%. The Soldier also has multiple fused joints (favorable ankylosis) in the hand that rate at 30%. It would constitute pyramiding to separately rate the ankylosed joints if the (rated) nerves (when intact) act on the fused joints.

Example B: A Soldier sustains a crush injury and has documented nerve injuries that appear to combine only to 60%. The Soldier also has traumatic arthritis of multiple interphalangeal joints with limitation of motion rating at 20 + 10%. However, the evidence indicates the Soldier has no effective function of the hand because the Soldier cannot grasp or manipulate objects. The Soldier cannot hold a cup to drink from, use the hand to eat or to hold a hair brush or toothbrush. In this situation the adjudicator would rate the Soldier with reference to VASRD 5125, loss of use of hand.

### VIII. § 4.63 Loss of use of hand or foot.

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Loss of use of a hand or a foot ... will be held to exist when no effective function remains other than that which would be equally well served by an amputation stump at the site of election below elbow or knee with use of a suitable prosthetic appliance.

The determination will be made on the basis of the actual remaining function of the hand or foot, whether the acts of grasping, manipulation etc., in the case of the hand, or of balance and propulsion, etc., in the case of the foot, could be accomplished equally well by an amputation stump with prosthesis.

Loss of Use Codes can be used for disability due to any cause including musculoskeletal or neurological conditions - to include burn injuries.

These are rated at 100%:

- 5109 Loss of use of both hands
- 5110 Loss of use of both feet
- 5111 Loss of use of one hand and one foot

These are rated as follows:

- 5125 Loss of use of hand (70% major; 60% minor)
- 5167 Loss of use of foot (40%)

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Dominant Hand

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§ 4.69 Dominant hand.

Disabilities affecting use of the dominant upper extremity is often rated higher than that affecting use of nondominant extremity. If Soldier is ambidextrous, the injured extremity is considered the dominant extremity.

DC 5051 - 5053; 5120 - 5156, etc.

Examples of 199 Musculoskeletal write-ups:

For each rated condition:

- (1) VASRD number and diagnosis
- (2) Brief history statement when relevant for combat-related issues
- (3) VASRD Rating criteria: i.e., medical/surgical history; physical findings/clinical data/ subjective complaints or performance data (if applicable) to support finding.
- (4) Reason unfit

Example: Spine Disability

NARSUM: 21 B, combat engineer with onset of back pain while running with LBE when under attack while in Iraq. Back pain associated with intermittent pain radiating down left leg. Feels sometimes the left leg is weak. MRI shows disc disease of L4-L5 without encroachment of disc on nerve root. EMGs are normal. Neuro exam including MMST & sensory exam is normal. Pain does not respond adequately to NSAIDS. Physical therapy has helped, but not enough to permit Soldier's return to duty.

Forward flexion onset of pain 70° gets to 90°

Extension 35°

Left lateral flexion 27°

Right lateral flexion 30°

Left lateral rotation 40°

Right lateral rotation 30°

Normal gait.

Spasm and localized tenderness

Examiner indicates, "Soldier's lumbar disc disease causes pain with forward flexion, onset at 70° (as measured with a goniometer).

Therefore, in my opinion, Soldier is functionally limited to 70° forward flexion and this is due to pain on repeated use. Soldier does not have any additional functional loss in other range of motions or due to other factors such as weakness, fatigability, etc."

5243 Intervertebral disc syndrome described as lumbar disc disease. Onset while Soldier in Iraq wearing LBE during combat operations. Soldier limited to forward flexion of 70°; combined 215°. Normal gait. Tenderness and spasm noted on exam. This condition is unfitting for

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this 13B because he is unable to wear LBE. (MEB Dx 1, NARSUM, Commander statement) 10%, 10A. SWSP

### B. Organs of Special Sense: Eye [Back to Outline](#)

Rating based on: field loss; decreased visual acuity (best corrected); and diplopia. Minimums for medication use.

Goldmann Bowl Perimetry Testing

<https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm>

[Kinetic Visual Field Testing](#)

[Performing Diplopia Fields](#)

See also: <http://www.vba.va.gov/bln/21/Benefits/exams/index.htm>

VA Worksheets

Ear Diseases; Sense of Taste; Smell

DC 6204 Peripheral vestibular disorders

(dizziness - could be residual of TBI)

6207 Loss of auricle (could be from a burn injury)

\*\*\*\*

6275 Sense of smell

6276 Sense of taste

### C. Impairment of Auditory Acuity (Hearing) plus ... [Back to Outline](#)

A Audio worksheet: CNC Maryland word recording and puretone thresholds  
Speech Recognition in Noise Test (SPRINT) cannot be translated into useful rating data.

VASRD DC 6100 Hearing Impairment

§ 4.85 Evaluation of hearing impairment

**Table VI** Numeric designation of hearing impairment based on puretone threshold average and speech discrimination.

**Table VIA** Numeric designation of hearing impairment based only on puretone threshold average

**Table VII** Percentage evaluation for hearing impairment

VASRD DC 6100 Hearing Impairment

§ 4.86 Exceptional patterns of hearing impairment.

(a)

(b)

### D. Infectious Disease, Immune Disorders and Nutritional Deficiencies

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HIV-Related Diseases

Chronic Fatigue Syndrome (CFS)

Other (e.g., Lupus).

6350 Lupus. Ratings for 60% and 100% are based on frequency of exacerbations. The VA worksheet asks the examiner to describe exacerbations with reference to their frequency and duration. For the

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100% rating there is an associated requirement the condition produce severe impairment of health. DC 6350 provides an alternate rating scheme - based on residuals under the appropriate system. Choose the rating scheme that permits the highest rating. Note that 6350 instructs not to rate with reference to 6350 and 7809, discoid lupus erythematosus or subacute cutaneous lupus erythematosus.

### E. Respiratory

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Ratings are based on postbronchodilator Pulmonary Function Testing (PFTs). See § 4.96 (d) (4). USAPDA and VA policy is to include 6602, asthma as being included within § 4.96 (d) (4).

DLCO - very important for some respiratory conditions (not asthma though). A rating based on DLCO may permit higher rating than PFTs. (The rating criteria within the respiratory system are generally "ors.")

§ 4.96 (a) Avoid multiple ratings for 6600-6817 and 6822 - 6847. Elevate to next higher when "disability warrants."

VASRD 6602, Asthma. The requirements for the 30% rating based on medication usage are met when the evidence supports the Soldier uses: daily inhalational or (daily) oral bronchodilator therapy; or (daily, or less than daily) inhalational anti-inflammatory medication. If the Soldier was prescribed daily anti-inflammatory medication and the evidence indicates the Soldier is not using this medication daily, consider whether the case should be returned to the MTF for OTSG review. See AR 40-400. See 5 MAY 2009 Memorandum to PEB Presidents, "Asthma (DC 6602): Requirements for 30% Rating."

<https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm>.

Asthma, when rated based on PFTs, generally should be rated with reference to the postbronchodilator PFTs. See Policy/Guidance Memo 19: Asthma and postbronchodilator PFTS.

[https://www.hrc.army.mil/site/Active/TAGD/Pda/policy\\_refs\\_Updated\\_062207.htm](https://www.hrc.army.mil/site/Active/TAGD/Pda/policy_refs_Updated_062207.htm)

### F. Cardiovascular System

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Many rating schemes for cardiac disability use "ors"

...or cardiac *hypertrophy or dilation on CXR, ekg or echo* = 30%

Exercise stress test important for METS

E.g., 5-7 METS (30%) = 5 = walking 15 min mile; 7 METs = jogging

Might get a higher rating based on presence of cardiac hypertrophy vs. METS

History of Deep Vein Thrombosis

VASRD 7121 Post-phlebotic syndrome

Note 10% vs. 20% can hinge on whether elevation completely or incompletely relieves edema.

VA Worksheet

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Arteries, Veins, Miscellaneous

4 (b) Are symptoms or edema relieved by elevation of the extremity, compression hosiery, or other measures?

Arterial Disease of Lower Extremities:

Ankle Brachial Index (ABI): This is the ratio of ankle/arm BP. Easy test.

Claudication *and* physical findings including trophic changes (thin skin, absence of hair, dystrophic nails)

E.g., VASRD 7114/7115

### G. Digestive System

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The VA Worksheets

[Digestive Conditions, Miscellaneous](#)

[Esophagus and Hiatal Hernia](#)

[Intestines \(Large and Small\)](#)

[Liver, Gallbladder, and Pancreas](#)

[Mouth, Lips, and Tongue](#)

[Rectum and Anus](#)

[Stomach, Duodenum, and Peritoneal Adhesions](#)

Digestive System

Rating Issues:

§ 4.114 Pyramiding provision: 7301 – 7329, 7331, 7342, and 7345 -7348.

Lab findings in conditions associated with weight loss are important

§ 4.112 defines Weight loss.

### H. Genitourinary System

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5 GU rating schemes. The PEB assigns one (the highest) rating, i.e., the PEB rates the “predominant area of dysfunction.”

1. Urinary Frequency
2. History of UTIs
3. Requirement for Catheterization
4. Urinary Leakage
5. Abnormal Kidney Function

Ref: § 4.115a

### I. Gynecological Conditions

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VASRD DC 7610 – 7615

General rating formula for Disease, Injury, or Adhesions.

30 % Symptoms not controlled by continuous meds

10% Symptoms that require continuous treatment

0% Symptoms that do not require continuous treatment

Gyn VA Worksheet

B. Report of Medical History

3. Treatments

...

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c. Detail hormonal and other medications and whether continuous medication is required, response, and side effects.

### J. Hemic and Lymphatic

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7703 Leukemia and 7715 (Non Hodgkin's) Lymphoma.

Chronic Myelogenous Leukemia (CML) treated with Gleevec. Rate at 100% because we consider it a treatment phase.

### K. Skin

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**VASRD 7800, Burn scars; scars due to other causes; or other disfigurement of the head, face, or neck.**

Note (3) Pictures useful.

Scheme: Rate on # characteristics of disfigurement or visible or palpable tissue loss and gross distortion or asymmetry.

8 Characteristics of Disfigurement

1. Scar 5 or more inches
2. Scar at least  $\frac{1}{4}$  wide at widest part
3. Surface contour elevated or depressed on palpation
4. Adherent to underlying tissue
5. Hypo- or hyper-pigmented  $> 6$  sq. in.
6. Abnormal texture  $> 6$  sq. in.
7. Missing underlying soft tissue  $> 6$  sq. in.
8. Induration and inflexible  $> 6$  sq. in.

(CAVEAT: If you have #1, 5, 6, 7 or 8, you will also have #2.)

Visible or palpable tissue loss *and* gross distortion or asymmetry of:  
**Features:** Nose, chin, forehead **Paired sets of features:** eyelids, ears, lips, cheeks

Counting Characteristics

Example 1:

Two scars, each with: #1, #3, and #4.  
= 4 characteristics  
(#2: at least  $\frac{1}{4}$  inch wide at widest)

Example 2:

Two scars:  
one: #1, #3, and hypopig. 5 sq in.  
second: #3, hypopig. 2 sq in.  
= 4 characteristics  
(#2 plus - combine the hypopig areas to  $>6$  sq. in.)

See Note (5)

May also rate under 7804 and 7805 ratings



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7804 Scar(s), unstable or painful

Note (1) Unstable means frequent loss of covering of skin over the scar.

5 or more 30%

3-4 20%

1-2 10%

Note (2) If *one or more* scars both unstable and painful, add 10%

E.g., 5 painful scars, one unstable = 40%

7801 Deep & 7802 Superficial

Based on sq. inches.

Divides body into portions:

Anterior vs. Posterior trunk (divided by mid axillary line)

Individual extremities

Combine the ratings for the different areas

May combine with 7804 (unstable/painful) ratings

### L. Endocrine System

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7913, Diabetes

100% 60% and 40% ratings reference:

Regulation of Activities (avoidance of strenuous occupational and recreational activities) PLUS ...

NOTE (1): Unless used to support the 100% rating, rate compensable residuals/complications separately.

Other Endocrine Conditions

Not very common. Not often unfitting. E.g., thyroid conditions.

Some with "unfitting" potential, e.g., 7911, Addison's disease

### M. Neurological Conditions & Convulsive Disorders [Back to Outline](#)

Organic Diseases of the Central Nervous System

8000 Encephalitis, epidemic, chronic

Brain, new growth of:

8002 Malignant

8003 Benign, minimum

...

8045 Residuals of traumatic brain injury (TBI)

Three main areas of dysfunction:

1. Cognitive
2. Emotional/behavioral
3. Physical

1. Cognitive impairment. Rate based on Table: "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" (This is the facet scheme.)

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Cognitive Impairment: "Decreased memory, concentration, attention, and executive function." "Executive function includes goal setting, speed of information processing ..."

### The Ten Facets

1. Memory, attention, concentration, executive functions
2. Judgment
3. Social Interaction
4. Orientation
5. Motor Activity (with intact motor and sensory system)
6. Visual spatial orientation
7. Subjective symptoms
8. Neurobehavioral effects
9. Communication
10. Consciousness

### 5 levels of impairment:

- |     |       |
|-----|-------|
| (1) | 0     |
| (2) | 1     |
| (3) | 2     |
| (4) | 3     |
| (5) | TOTAL |

Find highest facet.

Facet level: 0 = 0%

Facet level: 1 = 10%

Facet level: 2 = 40%

Facet level: 3 = 70%

Facet level: Total = 100%

2. Physical Dysfunction. Use DC other than TBI facet scheme to evaluate: motor and sensory dysfunction (including pain) of the extremities and face; visual impairment; hearing loss; tinnitus; loss of sense of smell and taste.

### Note (1): Overlapping Manifestations

If manifestations can be clearly separated, assign separate evaluation for each condition. If manifestations cannot be clearly separated, assign single evaluation under which ever set of diagnostic criteria allow better assessment of overall impaired functioning due to both conditions

Note (2): Examples not Exhaustive List. See Subjective Symptom List: headaches, mild anxiety, tinnitus, insomnia, hypersensitivity to sound and light, fatigability, blurred or double vision.

Note (3): Defines Instrumental activities (used in "subjective symptom" facet) as activities (other than self-care) that are needed for independent living. Examples: meal preparation, doing housework and

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other chores, shopping, traveling, doing laundry, being responsible for one's medication, using a telephone.

**See VA Training Letter in Compilation.**

### Neurologic Conditions and Convulsive Disorders

§4.120 Evaluations by comparison. Consider impairment of: motor; sensory; (and) mental function; psychotic manifestations; complete or partial loss of use of one or more extremities; speech disturbances; impairment of vision; disturbances of gait; tremors; visceral manifestations; injury to the skull; etc.

In rating disability refer to the appropriate schedule.

In rating peripheral nerve injuries consider the site and character of the injury, the relative impairment in motor function, trophic changes, or sensory disturbances.

### Peripheral Nerves: General Format

85XX Paralysis of:

**Complete;** description of complete paralysis.

**Incomplete:**

        Severe

        Moderate

        Mild

86XX Neuritis.

87XX Neuralgia.

§4.123 Neuritis, cranial or peripheral.

Neuritis, cranial or peripheral, characterized by loss of reflexes, muscle atrophy, sensory disturbances, and constant pain, at time excruciating, is to be rated on the scale provided for injury of the nerve involved, with a maximum equal to severe, incomplete, paralysis. See nerve involved for diagnostic code number and rating. The maximum rating which may be assigned for neuritis not characterized by organic changes referred to in this section will be that for moderate, or with sciatic nerve involvement, for moderately severe, incomplete paralysis.

§4.124 Neuralgia, cranial or peripheral.

Neuralgia, cranial or peripheral, characterized usually by a dull and intermittent pain of typical distribution so as to identify the nerve, is to be rated on the same scale with a *maximum* equal to *moderate incomplete paralysis*. See nerve involved for diagnostic code number and rating. *Tic douloureux*, or trifacial neuralgia, *may be rated up to complete paralysis* of the affected nerve.

Incomplete Paralysis. The VASRD provides that "incomplete paralysis" ... indicates a degree of lost or impaired function *substantially less* than the *type pictured for complete paralysis given with each nerve*, whether due to *varied level of the nerve lesion* or to *partial regeneration*. When the involvement is *wholly sensory*, the rating should be for the

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*mild, or at most, the moderate* degree. The following ratings for the peripheral nerves are for unilateral involvement; when bilateral, combine with application of the *bilateral factor*.

**TABLE: Nerve ratings: Discerning different ratings.**

Complete Paralysis	Severe Incomplete Paralysis	Moderately Severe Incomplete Paralysis	Moderate Incomplete Paralysis	Mild Incomplete Paralysis
	Neuritis (\$ 4.123) (when characterized by organic changes.)	Neuritis (\$ 4.123) (when characterized by organic changes)	Neuritis (\$ 4.123) (when characterized by organic changes)	Neuritis (\$ 4.123) (when characterized by organic changes)
		Neuritis (\$ 4.123) not characterized by organic changes when <b>Sciatic nerve</b>	Neuritis (\$ 4.123) not characterized by organic changes	Neuritis (\$ 4.123) not characterized by organic changes
<b>Tic douloureux</b> (Trifacial Neuralgia) (\$ 4.124)	<b>Tic douloureux</b> (Trifacial Neuralgia) (\$ 4.124)	<b>Tic douloureux</b> (Trifacial Neuralgia) (\$ 4.124)	Neuralgia (\$ 4.124)	Neuralgia (\$ 4.124)

### Manual Muscle Strength testing (Motor)

0/5: No contraction

1/5: Muscle flicker, but no movement

2/5: Movement possible, but not against gravity (test the joint in its horizontal plane)

3/5: Movement possible against gravity, but not against resistance by the examiner

4/5: Movement possible against some resistance by the examiner

(sometimes this category is subdivided further into 4-/5, 4/5, and

4+/5)

5/5: Normal strength

Incoordination (Motor): impaired ability to execute skilled movements smoothly. See 4.45.

MS and other diseases affecting the cerebellum may cause incoordination.

### Sensory

Facets of sensory include -

2 point discrimination

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numbness  
paresthesias  
pain (varies in severity, frequency)

EMG/NCV (electromyography/nerve conduction velocity) can help identify nerve injury. Ideally the report should identify which nerves are injured and should discuss the significance of the findings.

### Complete paralysis of Median Nerve

Complete; the hand inclined to the ulnar side, the index and middle fingers more extended than normally, considerable atrophy of the muscles of the thenar eminence, the thumb in the plane of the hand (ape hand); pronation incomplete and defective, absence of flexion of index finger and feeble flexion of middle finger, cannot make a fist; index and middle fingers remain extended; cannot flex distal phalanx of thumb, defective opposition and abduction of the thumb at right angles to palm; flexion of wrist weakened; pain with trophic disturbances.

Good Anatomy Website

<http://home.comcast.net/~wnor/homepage.htm>

### VASRD Leg Nerves

Sciatic  
Femoral  
Internal saphenous  
Obturator  
External cutaneous  
(lateral femoral cutaneous)  
Ilio-inguinal

### 8520 Sciatic Nerve

Branches:

8521 Common peroneal (ext. popliteal)  
8522 Superficial peroneal (musculocutaneous)  
8523 Deep peroneal (ant. tibial)  
8524 Internal Popliteal nerve (Tibial)  
8525 Posterior tibial nerve - branches into lateral and medial plantar nerves

### Dorsiflexion vs. Plantar Flexion

Dorsiflexion: Common Peroneal (VASRD 8521 and (8522)/8523)

Plantar Flexion: Tibial (VASRD 8524 or (distal) 8525).

Both dorsiflexion and plantar flexion: Sciatic

### Seizure Disorders

Count all seizures - including "index" seizure except "noncompliance"

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General rating Formula references many different “or” time frames.  
E.g., weekly; monthly; six months; one year; two years.

Description of Seizure important (**Major vs. minor seizures**).

Minimum rating 10% for continuous medication required for control

Major vs. Minor Seizure

Note (1): A *major* seizure is characterized by the generalized tonic-clonic convulsion with unconsciousness

Note (2): A *minor* seizure consists of a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head ...

General Rating Formula

Excerpt:

40% = At least 1 major seizure in the last 6 months or 2 in the last year; or averaging at least 5 to 8 minor seizures weekly

20% = At least 1 major seizure in the last 2 years; or at least 2 minor seizures in the last 6 months

Unemployability & Seizure Disorders

Rating Schedule specifically addresses this issue of unemployability related to seizure disorders.

**N. Mental Disorders: VASRD §§ 4.125 - 4.130** [Back to Outline](#)

### **§4.126 Evaluation of disability from mental disorders**

(a) When evaluating a mental disorder, the rating agency shall consider the frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the veteran’s capacity for adjustment during periods of remission. The rating agency shall assign an evaluation based on all the evidence of record that bears on occupational and social impairment rather than solely on the examiner’s assessment of the level of disability at the moment of the examination.

(b) When evaluating the level of disability from a mental disorder, the rating agency will consider the extent of social impairment, but shall not assign an evaluation solely on the basis of social impairment.

(c) Delirium, dementia, and amnestic and other cognitive disorders shall be evaluated under the general rating formula for mental disorders; neurologic deficits or other impairments stemming from the same etiology (e.g., a head injury) shall be evaluated separately and combined with the evaluation for delirium, dementia, or amnestic or other cognitive disorder (see §4.25).

### **§4.127 Mental retardation and personality disorders.**

Mental retardation and personality disorders are not diseases or injuries for compensation purposes, and, except as provided in §3.310(a) of this chapter, disability resulting from them may not be service-connected. However, disability resulting from a mental disorder that is superimposed upon mental retardation or a personality disorder may be service-connected.

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Current as of 30 MAR 2010

### § 4.129 Mental disorders due to traumatic stress

When a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veteran's release from active military service, the rating agency shall assign an evaluation of not less than 50 percent and schedule an examination within the six month period following the veteran's discharge to determine whether a change in evaluation is warranted.

#### VASRD Organization of Mental disorders

Schizophrenia and Other Psychotic Disorders

Delirium, Dementia, and Amnestic and Other

Cognitive Disorders

Anxiety Disorders (PTSD is in this category)

Dissociative Disorders

Somatoform Disorders

Chronic Adjustment Disorder

\*\*\*

Eating Disorders (Anorexia and Bulimia)

#### **O. Dental & Oral**    [Back to Outline](#)

##### Three VASRD DCs

9901 Complete loss of mandible between angles 100%

9905 Temporomandibular articulation

Temporomandibular articulation, LOM

Inter-incisal range:

0 - 10 mm            40%

11 to 20 mm        30%

21 to 30 mm        20%

31 to 40 mm        10%

Lateral excursion:

0 to 4 mm10%    10%

Note: Do not combine inter-incisal & lat. exc.

VASRD DC 9913

Loss of teeth due to loss of substance of maxilla or mandible without loss of continuity:

Where chewing surface cannot be restored by suitable prosthesis

Loss of all teeth 40%

Upper teeth 30%

...

Note: ...loss due to periodontal disease is "not considered disabling."