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Department of Defense

DIRECTIVE

Cancelled effective by November 4, 1996

February 25, 1986
NUMBER 1332.18

ASD(HA)

SUBJECT: Separation from the Military Service by Reason of Physical Disability

References: (a) DoD Directive 1332.18, Uniform Interpretation of Laws Relative to Separation from the Military Service by Reason of Physical Disability, September 9, 1968 (hereby canceled)
(b) Deputy Secretary of Defense Memorandum, "Physical Disability Separations," January 29, 1973 (hereby canceled)
(c) Deputy Secretary of Defense Memorandum, "Physical Fitness Determinations," March 1, 1973 (hereby canceled)
(d) Deputy Secretary of Defense Memorandum, "Physical Disability Determinations," July 15, 1975 (hereby canceled)
(e) through (g), see enclosure 1

A. REISSUANCE AND PURPOSE

This Directive reissues reference (a), updating policies and procedures to consolidate into a single document the provisions of references (b) through (g) and to ensure that disability separations of military personnel from the Military Services, under the provisions of reference (e), are accomplished uniformly. References (a),(b),(c), and (d) are hereby superseded and canceled.

B. APPLICABILITY

The provisions of this Directive apply to the Office of the Secretary of Defense (OSD) and the Military Departments.

C. DEFINITIONS

The terms used in this Directive are defined in enclosure 2.

D. POLICY

1. General Rule Regarding Effect of Disability

Except as provided in subsection D.14., below, any military member on active duty or in active status who is found to be physically disabled will be retired, if eligible for retirement, or, if not so eligible, separated. Disciplinary separation from the Armed Forces is not precluded by this general rule.

2. Standard to be Used for Disability Determination

The sole standard to be used in making determinations of physical disability as a basis for retirement or separation shall be unfitness to perform the duties of office, grade, rank or rating because of disease or injury incurred while entitled to basic pay. Each case is to be considered by relating the nature and degree of physical disability of the service member concerned to the requirements and duties that service member may reasonably be expected to perform in his or her office, grade, rank or rating. In addition, there must also be findings that the disability is (a) of a permanent nature and (b) not the result of intentional misconduct or willful neglect and was not incurred during a period of unauthorized absence. To warrant retirement, the length of service and degree of disability requirements prescribed in clause (3) of 10 U.S.C. 1201, must be satisfied. To warrant separation, the degree of disability requirements prescribed in clause (4) of 10 U.S.C. 1203 must be satisfied and the military member must have less than 20 years of qualifying service, under the criteria of 10 U.S.C. 1208 (reference (e)).

3. Standards and Criteria Not to be Used

The following standards and criteria will not be used as bases for making determinations that a service member is unfit for continued military service by reason of physical disability:

a. Inability to perform the duties of his or her office, grade, rank, or rating in every geographic location and under every conceivable circumstance will not be the sole basis for a finding of unfitness. Where feasible, consideration should be given to reclassifying the service member to an office or military specialty for which he or she would be fit before disability separation or retirement is accomplished.

b. Inability to satisfy the standards for initial entry into military service, except as specified in subparagraph D.8.b.(1), below.

c. Lack of a special skill in demand by a Military Service.

d. Inability to qualify for specialized duties requiring a high degree of physical fitness, such as flying, diving, or submarine duty.

e. Inability to qualify for transfer to another Military Service or another component of the same Military Service because of medical disqualification.

f. The presence of one or more physical defects that are sufficient to require referral for evaluation or that may be unfitting for service members in a different office, grade, rank, or rating.

g. Pending voluntary or involuntary separation, retirement, or release to inactive status.

4. Authority to Make Determinations

a. Except with respect to the categories and circumstances specified in paragraph D.4.b., below, the Secretary of the Military Department concerned shall have delegable authority to make all determinations regarding (1) unfitness as a basis for retirement or separation by reason of physical disability, (2) the percentage of disability at the time of retirement or separation, and (3) entitlement to disability severance pay.

b. Officers in grade 0-7 or higher or medical officers in any grade who are processed for retirement by reason of age or length of service may not be retired for physical disability unless the initial unfitness determination of the Military Department concerned is approved by the Secretary of Defense on the recommendation of the Assistant Secretary of Defense (Health Affairs) (ASD(HA)). Further, officers in grade 0-7 or above or medical officers in any grade who are processed for retirement or separation by reason of physical disability may not be retired or separated for that reason until a recommendation therefor by the Military Department Secretary concerned is approved by the ASD(HA).

5. Applicability of Veterans Administration Schedule

a. The existence of a physical defect or condition that is ratable under the standard schedule of rating disabilities in use by the Veterans Administration (VA) does not of itself provide justification for, or entitlement to, separation or retirement from military service because of physical disability.

b. After entitlement to separation or retirement from military service has been determined under the provisions of this Directive, the VA schedule, as modified by the provisions of enclosure 4, shall be followed in rating disabilities. When the Secretary of the Military Department concerned determines that unfitness is the result of a condition not listed in the VA schedule, he or she may approve a rating applicable to a disease condition or injury in which the function or functions affected and anatomical location of symptomatology are closely analogous.

c. There is no legal requirement, in making disability retirement determinations, to rate a physical condition, not in itself considered to be disqualifying for military service, along with another condition that is determined to be disqualifying in arriving at the rated degree of incapacity incident to retirement from military service for disability. In making this professional judgment Military Department representatives will not rate those disabilities neither unfitting for military service nor contributing tc the inability to perform military duty.

6. Circumstances Not Justifying Referral for Disability Evaluation

a. Although disease and injury are bases for disability evaluation in proper circumstances, the presence of these conditions alone does not justify referral for disability evaluation.

b. A service member who is being processed for separation or retirement for reasons other than physical disability shall not be referred for disability evaluation unless the service member's physical condition reasonably prompts doubt that he or she is fit to continue to perform the duties of his or her office, grade, rank or rating.

7. Factors Governing Time of Processing

a. The time of processing a service member for disability separation or retirement shall be determined on an individual basis in the light of the interest of both the Military Service and the service member. Normally, service members who are not likely to return to duty will be processed as soon as this probability is ascertained.

b. Service members having a prognosis of imminent death or who are dead shall be evaluated and processed in a comparable manner and time sequence as all other service members. No procedures will be circumvented or omitted in the interest of timely processing.

8. Criteria for Making Unfitness Determination

a. All relevant evidence is to be considered in assessing service member fitness including the circumstances of referral.

(1) When a referral or physical evaluation immediately follows acute, grave illness or injury, the medical evaluation may stand alone, particularly if medical evidence establishes that continued service would be deleterious to the service member's health or not in the best interests of the parent service.

(2) When a service member is referred for physical evaluation under circumstances other than as described in (1) above, evaluation of his or her performance of duty by supervisors as indicated, for example, by letters, efficiency reports, credential reports or personal testimony may provide better evidence than a clinical estimate by a physician of the service member's physical ability to perform the duties of his or her office, grade, rank, or rating. Particularly in cases of chronic illness these documents may be expected to reflect accurately a member's capacity to perform.

(3) If the evidence establishes that the service member adequately performed the duties of his or her office, grade, rank, or rating until the time the service member was referred for physical evaluation, he or she might be considered fit for duty even though medical evidence indicates questionable physical ability to perform duty.

(4) Regardless of the presence of illness or injury, inadequate performance of duty, by itself, must not be considered as evidence of physical unfitness unless it appears that there is a cause and effect relationship between the two factors.

b. Pre-service medical conditions are to be considered in accordance with the following standards and limitations:

(1) A service member who entered military service with a waiver for a medical condition or physical defect that usually is cause for referral to a physical evaluation board shall normally not be considered unfit because of physical disability provided the condition has remained essentially unchanged and has not interfered with the performance of duty. If, however, based on accepted medical principles, the condition represents a decided medical risk which would probably prejudice the best interests of the Government were the individual to remain in military service, separation without benefits may be appropriate, if initiated within six months of initial entry on active duty. Entry physical standards will be used in separating individuals with pre-existing medical conditions.

(2) Standard in-service medical and surgical treatment to correct or improve diseases or conditions incurred before entry into military service, including postoperative scars and absent or poorly functioning parts or organs, is not necessarily evidence that those diseases or conditions have been aggravated by military service.

9. Presumptions

a. The following presumptions apply to line-of-duty determinations when service members are referred for disability evaluation:

(1) A service member is presumed to have been in sound physical and mental condition upon entering active service, except for medical impairments and physical disabilities noted and recorded at the time of entrance.

(2) Any disease or injury discovered after a service member enters active military service, with the exception of congenital and hereditary (genetically transmitted from parent to offspring) conditions, is presumed to have been incurred in line of duty and is not due to the service member's intentional misconduct or willful neglect.

(3) Even if the presumption set forth in (1) above is overcome by a preponderance of evidence to the contrary, any additional disability resulting from the preexisting disease or injury is presumed to have been caused by military service aggravation. Only specific findings of "natural progression" of the preexisting disease or injury based upon well-established medical principles, as distinguished from medical opinion alone, are sufficient to overcome the presumption of military service aggravation.

(4) Acute infections such as pneumonia, acute rheumatic fever (even though recurrent), acute pleurisy, and acute ear disease and sudden developments such as hemoptysis, lung collapse, perforated ulcer, decompensating heart disease, coronary occlusion, thrombosis, or cerebral hemorrhage occurring while in active military service will be presumed to be service-incurred or service-aggravated unless it can be shown by a preponderance of evidence that there was no permanent new or increased disability resulting therefrom during active military service.

b. The abnormalities, residual conditions and diseases listed below shall be presumed to have originated prior to entry into military service.

(1) Scars; fibrosis of the lungs; atrophy following disease of the central or peripheral nervous system; healed fractures; absent, displaced, or resected organs; supernumerary parts; congenital malformations and hereditary conditions; and similar conditions in which medical authorities are in such consistent agreement as to their cause and time of origin that no additional confirmation is needed to support the conclusion that they existed prior to military service.

(2) Manifestations of lesions or symptoms of chronic disease identified so soon after the date of entry on active military service that the disease could not have originated in that short a period will be accepted as proof that the disease existed prior to entrance into active military service.

(3) Manifestations of communicable disease within less than the minimum incubation period after entry on active service will be accepted as proof of inception prior to military service.

c. Continued performance of duty until a service member is scheduled for separation or retirement for reasons other than physical disability creates a presumption of fitness for duty. This presumption may be overcome if it is established by a preponderance of the evidence that (1) the service member, because of disability, was physically unable to perform adequately the duties of office, grade, rank or rating or that (2) acute, grave illness or injury, or other deterioration of the member's physical condition occurred immediately prior to or coincident with processing for separation or retirement for reasons other than physical disability which rendered the service member unfit for further duty.

10. Evidentiary Standards

a. A factual finding that a service member is unfit because of physical disability depends on the evidence that is available to support that finding. The quality of evidence is usually more important than quantity. All relevant evidence must be weighed in relation to all known facts and circumstances which prompted referral for disability evaluation. Findings will be made on the basis of objective evidence in the record as distinguished from personal opinion, speculation or conjecture. When the evidence is not clear concerning a service member's condition, an attempt will be made to resolve doubt on the basis of further objective investigation, observation, and evidence.

b. Findings with respect to fitness or unfitness for military service will be made on the basis of preponderance of the evidence. Thus, if a preponderance (that is, more than 50 percent) of the evidence indicates unfitness, a finding to that effect will be made. If, on the other hand, a preponderance of the evidence indicates fitness, the service member may not be separated or retired by reason of physical disability.

c. Similarly, with respect to any particular case the presumptions set forth in subsection D.9., above, may be overcome by a preponderance of evidence contrary to the premise of the presumption in issue, with the exception of line-of-duty/misconduct determinations which shall continue to be judged by their customary evidentiary standards.

11. Prohibition of Conclusion of Unfitness in Medical Reports

The presence of a disease or injury does not, of itself, justify a finding of unfitness by reason of physical disability. Therefore, medical reports referred for physical disability evaluation shall not reflect a conclusion of unfitness.

12. Counseling

a. Each service member (or, in appropriate cases, the next of kin or legal guardian) shall be carefully counseled in clearly understandable terms concerning the significance of action being proposed (1) when referral of his or her case for physical evaluation board consideration appears probable, (2) at each subsequent stage of processing, and (3) as questions are raised by the service member.

b. Counselors shall discuss such matters as the sequence of and nature of steps in processing, legal rights, effect of findings and recommendations, estimated retired or severance pay (only after Physical Evaluation Board (PEB) findings and recommendations are known), probable retired grade, potential veteran benefits, and recourse to and preparation of rebuttals. The counselor shall assist the service member in preparation of rebuttals when indicated. The service member will also be counseled regarding such other rights as post-retirement insurance programs and the Survivor Benefit Plan in accordance with DoD Directive 1332.27 (reference (g)) if appropriate.

13. Placement on Temporary Disability Retired List (TDRL)

a. Requirements for placement on the Temporary Disability Retired List (TDRL) are the same as for permanent retirement, except that a service member is placed on the TDRL when the degree of disability is determined to be of an impermanent nature as prescribed in 10 U.S.C. 1202 (reference (e)). When the service member's disability is unstable, he or she will be placed on the TDRL, if otherwise qualified.

b. The Military Departments may use reports of medical examinations from medical facilities of the various Military Services, the Veterans Administration and other Government agencies as part of required periodic physical examinations of members on the TDRL. Civilian medical facilities and physicians may be used for this purpose when it is likely that it will result in a saving for the service member or the Government.

c. Service members on the TDRL shall not be entitled to permanent retirement or separation with severance pay without a current medical examination acceptable to the Secretary of the appropriate Military Department, unless just cause is shown for failure to report for examination.

d. A report of medical examination shall be requested from the appropriate authorities in the case of a service member imprisoned by civil authorities. In the event no report, or an inadequate report, is received, disposition of the case shall be made in accordance with paragraph D.13.e., below.

e. As provided in 10 U.S.C. 1210 (reference (e)), if a service member on the TDRL refuses or fails to report for a required periodic physical examination, his or her disability retired pay may be terminated. If he or she later reports for the physical examination, retired pay will be resumed, retroactively, to the date the examination was actually performed. If the service member subsequently shows just cause for his or her failure to report, disability retired pay may be paid retroactively for a period not to exceed one year prior to the actual performance of the physical examination. If the service member does not undergo a periodic physical examination after disability retired pay has been terminated, he or she will be administratively removed from the TDRL on the fifth anniversary of placement on the list without entitlement to any of the benefits provided by 10 U.S.C. 61 (reference (e)), unless evidence shows just cause for failure to be examined.

14. Continuance on Active Duty of Physically Unfit

a. The general policy rule, as prescribed in subsection D.1., above, is that any service member who is found to be unfit by reason of physical disability to perform the duties of his or her office, grade, rank, or rating will be retired or separated. However, when the Secretary of the Military Department concerned determines that a particular service member's skill or experience justifies the continuance of that service member on active duty or in active status in a limited assignment, the service member may be retained on active duty or in active status as an exception to the general policy rule.

b. A service member who is continued on active duty or in active status under the discretionary authority of this subsection shall be reevaluated periodically to determine whether further continuance or, conversely, retirement or separation is in the best interests of the parent Military Service and the service member. Unless the disqualifying condition has progressed to a point at which the service member is no longer able to perform duty with limitations, the service member shall continue to be liable to complete any incurred service obligation.

c. A service member who is continued on active duty or in active status under subsection D.1., above, will be granted disability benefits upon final retirement or separation if the disability is still present to a disabling degree.

15. Special Rules Applicable to Flag and Medical Officers

a. An officer in pay grade 0-7 or higher or a medical officer in any grade will not be found to be unfit by reason of physical disability if he or she can be expected to perform satisfactorily in an assignment appropriate to his or her grade, qualifications, and experience.

b. An officer in pay grade 0-7 or higher or a medical officer in any grade who is processed for retirement by reason of age or length of service may not be retired for unfitness by reason of physical disability unless the procedural steps set forth in paragraph D.4.b., above, are followed. Officers in these two categories who are being processed for retirement or separation by reason of physical disability will not be so retired or separated until their cases have been reviewed by the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) in accordance with the authority provided in 10 U.S.C. and DoD

Directive 5136.1 (references (e) and (f)) and retirement for disability will not be authorized without the concurrence of the ASD(HA).

E. RESPONSIBILITIES

1. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) shall:

a. Make recommendations for a final decision by the Secretary of Defense with respect to retirement for physical disability of officers in grade 0-7 or higher and medical officers in all grades who are processed for retirement by reason of age or length of service. Review and approve or disapprove the disability retirement of all other officers in the grade of 0-7 or higher and medical officers in all grades.

b. Establish requirements for such reports as are necessary to aid in (1) determining whether the disability separation laws are being uniformly administered; (2) evaluating the effectiveness of this Directive in achieving uniformity; (3) amending or modifying the enclosures as required; and (4) identifying the areas in which additional guidance may be required.

c. Review substantive changes proposed by the Military Departments in their retention fitness standards and procedures for retention on active service which affect the uniformity of processing provided for in this Directive, and submit in accordance with subsection E.2., below.

d. Perform, on a periodic basis, individual after-the-fact case review of any designated category of cases to ensure that policies are applied in a fair and consistent manner.

e. Amend or modify the enclosures, as appropriate, after coordination of any proposed amendment or modification with the Secretaries of the Military Departments.

2. The Secretaries of the Military Departments shall:

a. Make determinations with respect to (1) unfitness by reason of physical disability; (2) percentage of disability at the time of retirement or separation because of unfitness; and (3) entitlement to disability severance pay.

b. Ensure that policies and procedures established by this Directive are interpreted uniformly so that a service member of one Military Service will be granted benefits substantially the same as a service member of another Military Service under similar conditions.

c. Review existing procedural practices (in particular, those contributing to delays in disposition of cases) and discontinue those that are duplicate efforts, as long as doing so does not jeopardize the rights of the service member or the interest of the Government to ensure expeditious processing of all cases arising under 10 U.S.C. 61 (reference (e)).

d. Following approval of a separation or retirement determination by the final reviewing authority, ensure that effective separation or retirement of the service member generally occurs within 20 days, on the average, of the date of the determination of unfitness by the Secretary.

e. Immediately upon the completion of the final disability determination notify the Veterans Administration (VA) of the names of all individuals who are being separated from the Armed Forces for physical disability. Each Military Service should establish a formal mechanism to forward these names to the VA. This will enable the VA to inform individuals promptly about available VA services and benefits.

f. Submit to the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) all proposed substantive changes, and reasons therefor, to the standards and procedures in use by a Military Department for determining whether a service member is unfit for further service and is entitled to disability benefits.

g. Submit to the ASD(HA) one copy of all retirement orders issued in the case of each general/flag rank officer (grades 07-010) retired because of physical disability.

F. AD HOC WORKING GROUPS

Ad hoc working groups may be appointed by the ASD(HA), either on his or her own initiative or upon the recommendation of the Secretary of a Military Department, to perform specific tasks in the review of implementing Military Department procedures. Each group will include representatives of the Office of the Secretary of Defense and each of the Military Departments, and will be established for a specific period of time, normally not to exceed 120 days.

G. EFFECTIVE DATE AND IMPLEMENTATION

This Directive is effective immediately. Forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 60 days.

William H. Taft, IV
Deputy Secretary of Defense

Enclosures - 5

1. References
2. Definitions
3. Background
4. Guidelines Regarding Medical Conditions and Physical Defects which Normally are Cause for Referral to a Physical Evaluation Board (PEB)
5. Application of the Veterans Administration Schedule for Rating Disabilities

REFERENCES, continued

(e) Title 10, United States Code, Sections 61, 133(b), 1201, 1203, 1208, 1210, 1216(d), 3010
(f) DoD Directive 5136.1, "Assistant Secretary of Defense (Health Affairs)," October 5, 1984
(g) DoD Directive 1332.27, "Survivor Benefit Plan," January 4, 1974

DEFINITIONS

1. Accepted Medical Principles. Fundamental deductions, consistent with medical facts, which are so reasonable and logical as to create a virtual certainty that they are correct.

2. Death. Either (1) irreversible cessation of circulatory and respiratory functions in an individual, or (2) irreversible cessation of all functions of his or her entire brain including the brain stem. A determination of death must be made in accordance with accepted medical standards.

3. Impairment of Function. Any disease or residual of an injury which results in a lessening or weakening of the capacity of the body or its parts to perform normally, according to accepted medical principles.

4. Manifest Impairment. That made evident by signs or symptoms.

5. Military Service. This term, as used herein, refers to the Army, the Navy, the Air Force and the Marine Corps.

6. Office, Grade, Rank, or Rating

a. Office. A position of duty, trust, authority to which an individual is appointed.

b. Grade. A step or degree in a graduated scale of office or military rank that is established and designated as a grade by law or regulation.

c. Rank. The order of precedence among members of the Armed Forces.

d. Rating. The name (such as "Boatswain's Mate") prescribed for members of an Armed Force in an occupational field.

7. Physical Disability. Any impairment due to disease or injury, regardless of degree, which reduces or precludes an individual's actual or presumed ability to engage in gainful or normal activity. The term "physical disability" includes mental disease, but not such inherent defects as behavioral disorders, personality disorders, and primary mental deficiency.

8. Preponderance of Evidence. That evidence which tends to prove one side of a disputed fact by outweighing the evidence on the other side. Preponderance does not necessarily mean a greater number of witnesses or a greater mass of evidence; rather, preponderance means a superiority of evidence on one side or the other of a disputed fact. It is a term which refers to the quality, rather than the quantity of the evidence.

9. Presumption. An inference of the truth of a proposition or fact, reached through a process of reasoning and based on the existence of other facts. Matters which are presumed need no proof to support them, but may be rebutted by evidence to the contrary.

10. Substantial Change. An alteration which would require a change in the Directive itself; the definitions, section A of enclosure (4); or sections A and B of enclosure (5).

BACKGROUND

Laws relating to the separation or retirement of military personnel because of physical disability were enacted primarily for the purpose of maintaining a vital and fit military organization with full consciousness of the necessity for maximum use of manpower. These laws are designed to provide for the retirement or separation of a service member who is determined to be unfit to perform the duties of his or her office, grade, rank, or rating because of physical disability; and to provide benefits due an eligible service member whose military service is terminated by disability. The laws are not intended to confer additional death benefits.

GUIDELINES REGARDING MEDICAL CONDITIONS AND PHYSICAL DEFECTS WHICH NORMALLY ARE CAUSE FOR REFERRAL TO A PHYSICAL EVALUATION BOARD (PEB)

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GUIDELINES REGARDING MEDICAL CONDITIONS AND PHYSICAL DEFECTS WHICH NORMALLY ARE CAUSE FOR REFERRAL TO A PHYSICAL EVALUATION BOARD (PEB)

A. GENERAL

1. This enclosure provides a listing of medical conditions and physical defects which normally are cause for referral to physical evaluation boards. The list is not all inclusive, and is not to be taken as a mandate that possession of one or more of the listed conditions or physical defects means automatic unfitness and subsequent disability separation or retirement. The major objective of the list is to achieve uniform disposition of cases arising under the law. Notwithstanding the foregoing, and in recognition of the differing missions and roles of the various component Military Services, the individual Secretaries of the Military Departments may modify these guidelines to fit their particular needs in light of their own requirements.

2. In developing additional guidelines, Service Secretaries should consider conditions and defects not listed in this Directive which justify referral of an individual to a physical evaluation board because the conditions or defects, individually or in combination:

a. Significantly interfere with the reasonable fulfillment of the purpose of the individual's employment in the Military Service;

b. May seriously compromise the health or well-being of the individual if he were to remain in the Military Service;

c. May prejudice the best interests of the Government if the individual were to remain in the Military Service.

3. Each case must be decided on the relevant facts and a finding of unfitness based on a factual finding that the service member is not physically capable of performing the duties of his or her office, grade, rank, or rating in such a manner as to reasonably fulfill the purpose of his or her assignment. Individuals with conditions and defects, individually or in combination, not elsewhere provided for in this enclosure, may be referred for physical evaluation board action when it appears that they are unable to perform duty as described above.

B. ABDOMEN AND GASTROINTESTINAL SYSTEM

1. Defects and Diseases.

a. Esophageal.

(1) Achalasia (cardiospasm) manifested by dysphagia not controlled by dilatation with frequent discomfort, or inability to maintain normal vigor and nutrition.

(2) Esophagitis, persistent and severe.

(3) Diverticulum of the esophagus of such a degree as to cause frequent regurgitation, obstruction, and weight loss, which does not respond to treatment.

(4) Stricture of the esophagus of such a degree as to require an essentially liquid diet, frequent dilation, and hospitalization, and which causes difficulty in maintaining weight and nutrition.

b. Amebic Abscess Residuals. Persistent abnormal liver function tests, and failure to maintain weight and normal vigor after appropriate treatment.

c. Cirrhosis of the Liver. Recurrent jaundice or ascites; or demonstrable esophageal varices or history of bleeding therefrom.

d. Gastritis. Severe, chronic gastritis with repeated symptoms requiring hospitalization and confirmed by gastroscopic examination.

e. Hepatitis, Chronic. When, after a reasonable time following the acute stage, symptoms persist, and there is objective evidence of impairment of liver function.

f. Hernia

(1) Hiatus hernia, with severe symptoms not relieved by dietary or medical therapy, or bleeding is recurrent in spite of prescribed treatment.

(2) Other hernias, if operative repair is contraindicated for medical reasons, or when not amenable to surgical repair.

g. Ileitis, Regional.

h. Pancreatitis, Chronic. Frequent abdominal pain requiring repeated hospitalization, or steatorrhea, or disturbance of glucose metabolism requiring insulin.

i. Peritoneal Adhesions. Recurring episodes of intestinal obstruction characterized by abdominal colicky pain and vomiting, and requiring frequent admissions to the hospital.

j. Proctitis, Chronic. Moderate to severe symptoms of bleeding, or painful defecation, or tenesmus and diarrhea, with repeated admissions to the hospital.

k. Ulcer, Peptic, Duodenal, or Gastric. Repeated incapacitations or absences from duty because of recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management, and supported by laboratory and X ray evidence of activity or severe deformity.

l. Ulcerative Colitis.

m. Rectum, Stricture of. Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, difficult bowel movements requiring the regular use of laxatives or enemas, or requiring repeated hospitalization.

n. Anus. Impairment of sphincter control with fecal incontinence.

o. Familial Polyposis.

2. Surgery.

a. Colectomy, Partial. When more than mild symptoms of diarrhea remain.

b. Colostomy. When permanent.

c. Enterostomy. When permanent.

d. Gastrectomy.

(1) Total

(2) Subtotal, with or without vagotomy, or gastrojejunostomy or pyloroplasty with or without vagotomy, when in spite of good medical management, the individual experiences any of the following:

(a) Develops incapacitating dumping syndrome. (Postoperative symptoms such as a moderate feeling of fullness after eating, or the need to avoid or restrict the ingestion of high carbohydrate foods, or the need for a daily schedule for a number of small meals should not be confused with dumping syndrome.)

(b) Develops frequent episodes of incapacitating epigastric distress with characteristic circulatory symptoms or diarrhea.

(c) Continues to demonstrate significant weight loss. (Preoperative weight representative of obesity should not be taken as a reference point in making this assessment.)

e. Gastrostomy. When permanent.

f. Pancreatectomy. Except for partial pancreatectomy for a benign condition which does not result in moderate residual symptoms.

g. Pancreaticoduodenostomy, Pancreaticogastrostomy, Pancreaticojejunostomy.

h. Proctopexy, Proctoplasty, Proctorrhaphy, or Proctotomy. If fecal incontinence remains after appropriate treatment.

C. BLOOD AND BLOOD-FORMING TISSUE DISEASES

1. Anemia. Symptomatic.

2. Hemolytic Disease, Chronic. Symptomatic, or with recurrent crises.

3. Leukopenia, Chronic.

4. Polycythemia. Symptomatic.

5. Purpura and Other Bleeding Diseases.

6. Thromboembolic Disease.

7. Splenomegaly, Chronic.

8. Other Such Diseases. When response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.

D. DENTAL

Diseases and abnormalities of the jaws or associated tissues when, following restorative surgery, there remain residuals which are incapacitating, or deformities which are severely disfiguring.

E. EARS AND HEARING

1. Ears.

a. Infections of the External Auditory Canal. Chronic and severe, resulting in thickening and excoriation of the canal, or chronic secondary infection requiring frequent and prolonged medical treatment.

b. Mastoiditis, Chronic. Constant drainage from the mastoid cavity, requiring frequent and prolonged medical care.

c. Mastoidectomy. Followed by chronic infection with constant or recurrent drainage requiring frequent or prolonged specialized medical care.

d. Meniere's Syndrome. Recurring attacks of sufficient frequency and severity as to require frequent or prolonged medical care.

e. Otitis Media. Moderate, chronic, supportive, resistant to treatment, and necessitating frequent or prolonged medical care.

2. Hearing. Ordinarily, a hearing defect is not sufficient reason for considering an individual unfit because of physical disability. When the unaided average loss in the better ear is 35 decibels ISO or more in the normal speech range (pure tone audiometric values at the 500, 1000, 2000 hertz), the individual will be evaluated at an audiology and speech center. Audiology specialists at the center will recommend referral to a Physical Evaluation Board (PEB) when appropriate. This recommendation may be based on the results of either pure tone audiometry or speech reception threshold and discrimination, whichever in the judgment of the specialists most accurately reflects the degree of the hearing loss.

F. ENDOCRINE AND METABOLIC CONDITIONS

1. Acromegaly.

2. Adrenal Hyperfunction. Not responding to therapy.

3. Adrenal Hypofunction. Requiring medication for control.

4. Diabetes Insipidus. Unless mild, with good response to treatment.

5. Diabetes Mellitus. When proven to require insulin.

6. Gout. With frequent acute exacerbations in spite of therapy, or with severe bone, joint, or kidney damage.

7. Hyperinsulinism. When caused by a malignant tumor, or when the condition is not readily controlled.

8. Hyperparathyroidism. When residuals or complications, such as renal disease or bony deformities, preclude the reasonable performance of military duty.

9. Hyperthyroidism. Severe symptoms which do not respond to treatment.

10. Hypoparathyroidism. With objective evidence and severe symptoms not controlled by maintenance therapy.

11. Osteomalacia. When residuals after therapy are of such degree or nature as to limit physical activity to a significant degree.

G. EXTREMITIES.

1. Upper Extremities.

a. Amputations. Amputation of part or parts of an upper extremity which results in impairment equivalent to the loss of use of a hand.

b. Joint Ranges of Motion. Motion which does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to methods illustrated in Plate I.

(1) Shoulder:

(a) Forward elevation to 90°.

(b) Abduction to 90°.

(2) Elbow:

(a) Flexion to 100°.

(b) Extension to 45°.

(3) Chronic Dislocation. When not repairable or surgery is contraindicated.

MEASUREMENT OF ANKYLOSIS AND JOINT MOTION

Upper Extremities

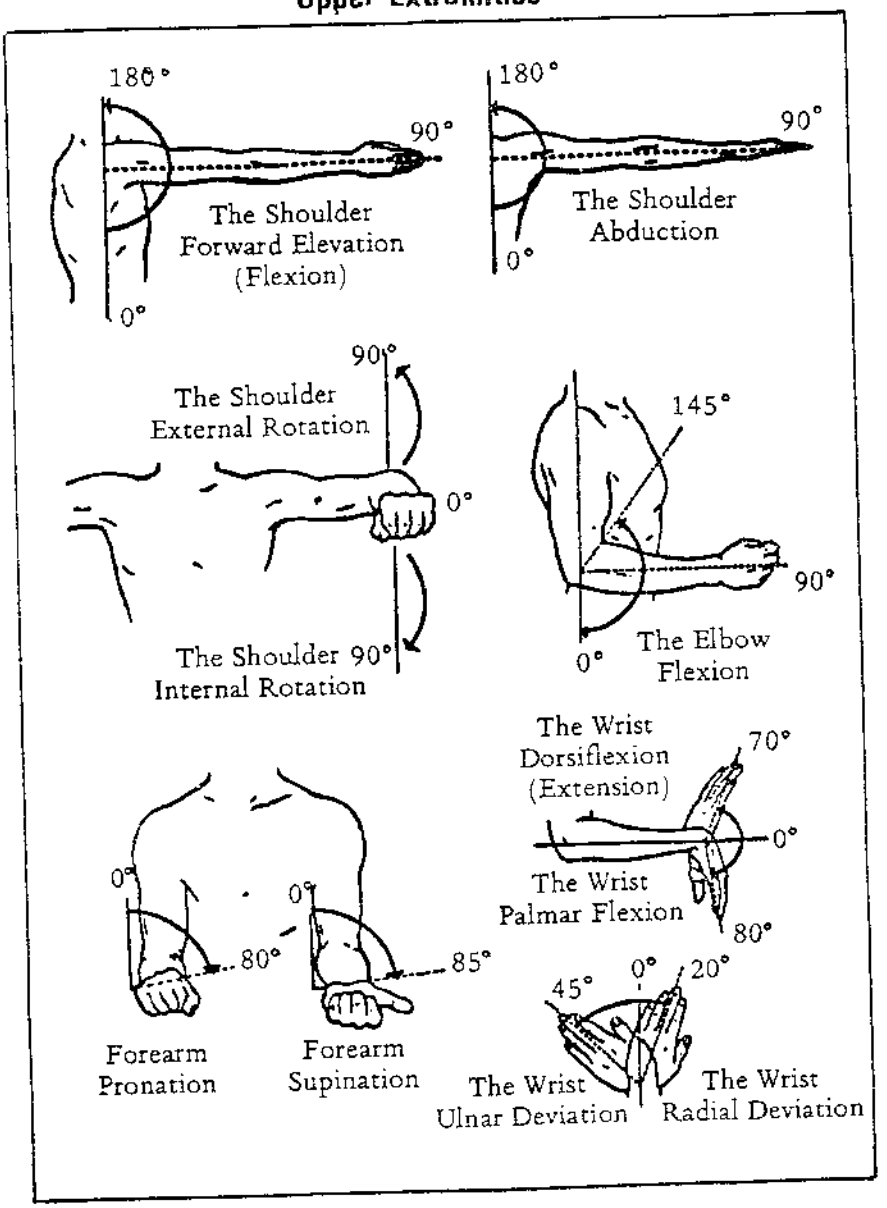


PLATE I

This plate provides a standardized description of ankylosis and joint motion measurement of the upper extremities. The anatomical position is considered as 0° with two major exceptions: (1) in measuring shoulder rotation, the arm is abducted to 90° and the elbow is flexed to 90° so that the forearm reflects the midpoint (0°) between internal and external rotation of the shoulder; and (2) in measuring pronation and supination, with the arm next to the body and the elbow flexed to 90° , the forearm is in mid-position (0°) between pronation and supination when the thumb is uppermost.

2. Lower Extremities.

a. Amputations.

(1) Loss of a toe or toes which precludes the ability to run or walk without a perceptible limp, or to engage in fairly strenuous jobs.

(2) Any loss greater than that specified above to include foot, leg, or thigh.

b. Feet.

(1) Hallux valgus. When moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.

(2) Pes Planus, Symptomatic. When more than moderate, with pronation on weight bearing that prevents the wearing of a military shoe, or when associated with vascular changes.

(3) Talipes Cavus. When moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, that prevents the wearing of a military shoe.

c. Internal Derangement of the Knee.

(1) Residual instability following remedial measures if more than mild in degree; or with recurring episodes of effusion, or locking, resulting in frequent incapacitation.

(2) If complicated by arthritis, see paragraph 3.a., below.

d. Joint Ranges of Motion. Motion which does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated in Plate II.

(1) Hip:

(a) Flexion to 90°.

(b) Extension to 0°.

(2) Knee:

(a) Flexion to 90°.

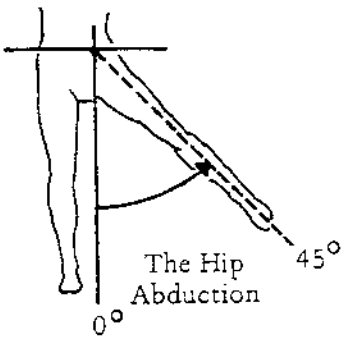
(b) Extension to 15°.

e. Shortening of an Extremity. When shortening exceeds two inches.

MEASUREMENT OF ANKYLOSIS AND JOINT MOTION

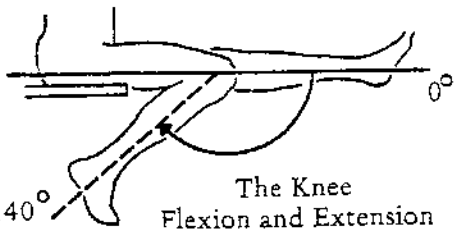
Lower Extremities

The Hip
Flexion

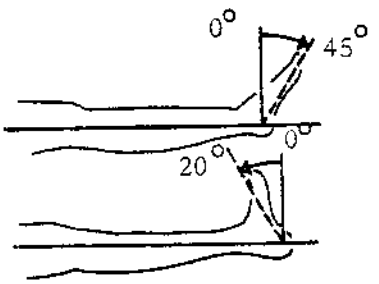


The Hip
Abduction

The Hip
EXTENSION



The Knee
Flexion and Extension



The Ankle
PLANTAR FLEXION AND DORSI FLEXION

PLATE II

This plate provides a standardized description of ankylosis and joint motion measurement of the lower extremities. The anatomical position is considered as 0° .

3. Miscellaneous.

a. Arthritis.

(1) Arthritis due to infection associated with persistent pain and marked loss of function, with X ray evidence, and documented history of recurrent incapacity.

(2) Arthritis due to trauma. When surgical treatment fails or is contraindicated and there is functional impairment of the involved joint so as to preclude the satisfactory performance of duty.

(3) Osteoarthritis. When severe symptoms are associated with impairment of function, supported by X ray evidence and documented history of recurrent incapacity for prolonged periods.

(4) Rheumatoid arthritis or rheumatoid myositis. If the history of repeated incapacitating episodes is supported by objective and subjective findings.

b. Chondromalacia or Osteochrondritis Dessicans. Severe, manifested by frequent joint effusion, more than moderate interference with function or with severe residuals from surgery.

c. Fractures.

(1) Malunion. When, after appropriate treatment, there is more than moderate malunion with marked deformity or there is more than moderate loss of function.

(2) Nonunion. When it persists after an appropriate healing period with more than moderate loss of function.

(3) Bone fusion defect. When manifested by more than moderate pain or loss of function.

(4) Callus, excessive, following fracture. When functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

d. Joints.

(1) Arthroplasty with severe pain, limitation of motion and limitation of function, joint prosthesis or total joint replacement.

(2) Bony or fibrous ankylosis with severe pain involving major joints or spinal segments, or ankylosis in unfavorable position, or ankylosis with marked loss of function.

(3) Contracture joint with marked loss of function and the condition is not remediable by surgery.

(4) Loose bodies within a joint with marked functional impairment complicated by arthritis to such a degree as to preclude favorable results of treatment.

e. Muscles. Flaccid paralysis, spastic paralysis, or loss of substance of one or more muscles producing loss of function that precludes satisfactory performance of duty.

f. Myotonia Congenita. Significantly symptomatic and precluding the satisfactory performance of duty.

g. Osteitis Deformans. Involvement of single or multiple bones with resultant deformities, or symptoms severely interfering with function.

h. Osteoarthropathy, Hypertrophic, Secondary. More than moderate pain present in one or multiple joints and with at least moderate loss of function.

i. Osteomyelitis, Chronic. Recurrent episodes not responsive to treatment, and involving the bone to a degree which interferes with stability and function.

j. Tendon Transplant. Unsatisfactory restoration of function, significantly interfering with the satisfactory performance of duty.

H. EYES

1. Diseases and Conditions.

a. Active Eye Diseases. Active eye disease, or any progressive organic disease regardless of the stage of activity, which is resistant to treatment and affects the distant visual acuity or visual field so that:

(1) Distant visual acuity does not meet the standard stated in paragraph 2. e., below, or

(2) The field of vision in the better eye is less than 20°.

b. Aphakia, Bilateral.

c. Chronic Congestive (Closed Angle) Glaucoma or Chronic Non-congestive (Open Angle) Glaucoma. If well established with demonstrable changes in the optic disk or visual fields, or not amenable to treatment.

d. Diseases and Infections of the Eye. When chronic, more than mildly symptomatic, progressive and resistant to treatment after a reasonable period.

e. Ocular Manifestations of Endocrine or Metabolic Disorders. Not disqualifying per se; however, residuals or complications, or the underlying disease may render a service member unfit.

f. Residuals or Complications of Injury. When progressive, or when reduced visual acuity or fields do not meet the criteria of paragraph 2. e. or f., below.

g. Retina, Detachment of.

(1) Unilateral Detachment.

(a) When visual acuity does not meet the standard of paragraph 2. e.

(b) When the visual field in the better eye is constricted to less than 20°.

(c) When uncorrectable diplopia exists.

(d) When detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.

(2) Bilateral Detachment, regardless of etiology or results of corrective surgery.

2. Vision.

a. Aniseikonia. Subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances and difficulties in form sense, and not corrected by iseikonic lenses.

b. Binocular Diplopia. Which is severe, constant, and in zone less than 20° from the primary position.

c. Hemianopsia. Of any type, if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not normally considered to render an individual unfit.

d. Night Blindness. Of such a degree that the individual requires assistance in any travel at night.

e. Visual Acuity.

(1) When visual acuity cannot be corrected with spectacle lenses to at least: 20/60 in one eye and 20/60 in the other eye; or 20/50 in one eye and 20/80 in the other eye; or 20/40 in one eye and 20/100 in the other eye; or 20/30 in one eye and 20/200 in the other eye; or 20/20 in one eye and 20/300 in the other eye.

(2) When an eye has been enucleated, or

(3) When vision is correctable only by the use of contact lenses or other specified corrective devices (telescopic lenses, etc.).

f. Visual Fields. When the visual field in the better eye is constricted to less than 20 .

I. GENITOURINARY SYSTEM

1. Genitourinary Conditions.

a. Cystitis. When complications or residuals of treatment themselves preclude satisfactory performance of duty.

b. Dysmenorrhea. Symptomatic, not amenable to treatment, and incapacitating.

c. Endometriosis. Symptomatic and incapacitating.

d. Hypospadias. Accompanied by chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings, and the condition is not amenable to treatment.

e. Incontinence of Urine. Due to disease or defect not amenable to treatment.

f. Kidney.

(1) Calculus in kidney, symptomatic and incapacitating, significantly interfering with the satisfactory performance of duty.

(2) Congenital renal anomaly, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(3) Cystic kidney (polycystic kidney), if the focus of frequent infection or when renal function or is impaired.

(4) Hydronephrosis, more than mild and causing continuous or frequent symptoms not responding to medical or surgical treatment.

(5) Hypoplasia of the kidney, associated with elevated blood pressure, frequent infections, or reduction in renal function.

(6) Nephritis, chronic, with renal functional impairment.

(7) Nephrosis, other than mild, with renal functional impairment.

(8) Pyelonephritis or pyelitis, chronic, which has not responded to medical or surgical treatment, with evidence of persistent hypertension or reduction in renal function.

g. Menopausal Syndrome, Physiologic or Artificial. With mental and constitutional symptoms significantly interfering with the satisfactory performance of duty.

h. Strictures of the Urethra or Ureter. Severe, not amenable to treatment, and significantly interfering with the satisfactory performance of duty.

i. Urethritis, Chronic. Not responsive to treatment and necessitating frequent absences from duty.

2. Genitourinary and Gynecological Surgery.

a. Cystectomy.

b. Cystoplasty. If reconstruction is unsatisfactory or if residual urine persists in excess of 50cc or if refractory symptomatic infection persists that significantly interferes with the satisfactory performance of duty.

c. Nephrectomy. When, after treatment, there is infection or pathologic change (anatomic or functional) in the remaining kidney.

d. Nephrostomy. If drainage persists.

e. Oophorectomy. When following treatment and convalescent period, there remain incapacitating mental or constitutional symptoms significantly interfering with the satisfactory performance of duty.

f. Penis, Amputation of. When urine is voided in such a manner as to soil clothing or surroundings, or result in severe mental symptoms.

g. Pyelostomy. If drainage persists.

h. Ureterocolostomy.

i. Ureterocystostomy. When both ureters are markedly dilated with irreversible changes.

j. Ureteroileostomy, Cutaneous.

k. Ureteroplasty.

(1) When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for a nephrectomy.

(2) When bilateral, evaluate residual obstruction or hydronephrosis and consider unfitness on the basis of the residuals involved.

l. Ureterosigmoidostomy.

m. Ureterostomy. External or cutaneous.

n. Urethrostomy. When a satisfactory urethra cannot be restored.

J. HEAD

Loss of substance of the skull with or without prosthetic replacement when accompanied by moderate residual signs and symptoms.

K. HEART AND VASCULAR SYSTEM

1. Heart.

a. Arteriosclerotic Disease. Associated with congestive heart failure, repeated anginal attacks or objective evidence of myocardial infarction.

b. Atrial Fibrillation and Flutter. Associated with organic heart disease, or if not adequately controlled by medication.

c. Endocarditis. Resulting in myocardial insufficiency.

d. Heart Block. Associated with other signs and symptoms of organic heart disease or syncope (Stokes-Adams syndrome).

e. Myocarditis and Degeneration of the Myocardium. Myocardial damage producing symptoms such as fatigue, palpitation and dyspnea with ordinary physical activity.

f. Paroxysmal Ventricular Tachycardia.

g. Paroxysmal Supraventricular Tachycardia. If associated with organic heart disease or if not adequately controlled by medication.

h. Pericarditis.

(1) Chronic constrictive pericarditis unless successful surgery has been performed.

(2) Chronic serous pericarditis.

i. Rheumatic Valvulitis. Associated with cardiac insufficiency producing symptoms such as fatigue, palpitation, dyspnea or anginal-type pain with ordinary physical activity.

j. Ventricular Premature Contractions. Frequent or continuous attacks, whether or not associated with organic heart disease, such as to interfere with the satisfactory performance of duty.

2. Vascular System.

a. Arteriosclerosis Obliterans. When any of the following pertain:

(1) Intermittent claudication of sufficient severity to produce pain and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest, or

(2) Objective evidence of arterial disease with symptoms of claudication, ischemic rest pain or with gangrenous or ulcerative skin changes of a permanent degree in the distal extremity, or

(3) Involvement of more than one organ system or anatomic region (the lower extremities are considered one region for this purpose) with symptoms of arterial insufficiency.

b. Congenital Anomalies. Coarctation of aorta and other congenital anomalies of the cardiovascular system unless satisfactorily treated by surgical correction.

c. Aneurysms. Aneurysm of any vessel not correctable by surgery and producing limiting symptomatic conditions which preclude satisfactory performance of duty. Aneurysm corrected by surgery but with residual limiting symptomatic conditions which preclude satisfactory performance of duty. Satisfactory performance of duty is precluded because of underlying recurring or progressive disease producing pain, dyspnea or similar symptomatic limiting conditions.

d. Reconstructive Surgery, Including Grafts. When:

(1) The individual is being evaluated for separation or retirement and the observation period following surgery is deemed inadequate to determine the patient's ability to perform duty as evidenced by a cardiovascular surgical consultation.

(2) Prosthetic devices are attached to or implanted in the heart.

(3) Unproven procedures have been accomplished and the patient is unable to satisfactorily perform duty or cannot be returned to duty under circumstances permitting close medical supervision of his activities.

e. Periarteritis Nodosa.

f. Chronic Venous Insufficiency (Postphlebitic Syndrome). When symptomatic despite elastic support, significantly interfering with the satisfactory performance of duty.

g. Raynaud's Phenomenon. Manifested by trophic changes of the involved parts characterized by scarring of the skin, or ulceration.

h. Thromboangiitis Obliterans. Intermittent claudication of sufficient severity to produce pain and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without rest, or other equally significant complications.

i. Thrombophlebitis. When repeated attacks requiring treatment are of such frequency as to interfere with the satisfactory performance of duty.

j. Varicose Veins. Severe and symptomatic despite therapy, significantly interfering with the satisfactory performance of duty.

3. Miscellaneous Vascular Conditions.

a. Hypertensive Cardiovascular Disease and Hypertensive Vascular Disease.

(1) Diastolic pressure consistently more than 110 millimeters of mercury following an adequate period of therapy on an ambulatory status, or

(2) Any documented history of hypertension regardless of the pressure values if associated with one or more of the following:

(a) More than minimal demonstrable changes in the brain.

(b) Heart disease related to the hypertension.

(c) Kidney involvement, manifested by unequivocal impairment of renal function.

(d) Grade III (Keith-Wagner-Barker) changes in the fundi.

(e) Multiple drug therapy with the requirement for an inordinate amount of medical supervision that significantly interferes with the satisfactory performance of duty.

b. Residual of Surgery of the Heart, Pericardium or Vascular System. When surgery results in inability of the individual to perform duties without significant discomfort or dyspnea.

L. LUNGS AND CHEST WALL

1. Tuberculous Conditions. See pertinant Service Pubications.

a. Pulmonary Tuberculosis (to Include Tuberculous Pleurisy).

b. Tuberculous Lesions.

2. Nontuberculous Conditions. These conditions must be evaluated in terms of pulmonary function; clinically by exertional tolerance, and in the laboratory by measurements which reflect exertional or altitudinal tolerance. Recurrent infections and symptoms such as cough and pain should be considered when they limit a member's activity.

a. Atelectasis. Of a functionally significant degree.

b. Bronchial Asthma. Associated with more than mild irreversible reduction in pulmonary function (ventilatory tests) and symptoms of such severity as to interfere with the satisfactory performance of duty.

c. Bronchiectasis. Cylindrical or saccular type which is moderately symptomatic, with productive cough at frequent intervals throughout the day, or with moderate other associated lung disease to include recurrent pneumonia, or with residuals or complications which require repeated hospitalization.

d. Bronchitis. With chronic, severe cough, or with moderate associated asthma or emphysema producing dyspnea at rest or on slight exertion, or with residuals or complications which require repeated hospitalization.

e. Cystic Disease of the Lung and Bullous Emphysema. If producing significant functional impairment.

f. Hemopneumothorax, Hemothorax, Pyopneumothorax or Chronic Fibrotic Pleurisy. More than moderate restriction of respiratory excursions and chest deformity, or weakness and fatigability on slight exertion.

g. Histoplasmosis and Other Pulmonary Mycoses. With significant residuals or failure to respond to treatment.

h. Pneumothorax, Spontaneous. Repeated episodes of pneumothorax not correctable by surgery.

i. Pneumoconiosis. Severe with dyspnea on mild exertion.

j. Pulmonary Emphysema. Resulting in dyspnea on mild exertion and supported by demonstrable moderate reduction in pulmonary function or when present, to at least a moderate degree, as a complication of any other respiratory condition.

k. Pulmonary Fibrosis. Linear fibrosis or fibrocalcific residuals of such a degree as to cause dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

l. Pulmonary Sarcoidosis. Complicated by demonstrable moderate reduction in pulmonary function.

m. Stenosis, Bronchus. Severe stenosis associated with repeated attacks of bronchopulmonary infections requiring frequent hospitalization.

3. Surgery of Lungs and Chest. If surgery results in impairment of pulmonary function to a moderate degree or more, as demonstrated by ventilatory tests.

M. MOUTH, NOSE, PHARYNX, LARYNX, AND TRACHEA

1. Larynx.

a. Paralysis of the Larynx. Characterized by vocal cord paralysis seriously interfering with speech or adequate airway.

b. Stenosis of the Larynx. Of a degree causing respiratory embarrassment.

c. Obstructive Edema of Glottis. If recurrent.

2. Nose, Pharynx, Trachea.

a. Rhinitis. Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting, concomitant severe headaches, and foul, fetid odor.

b. Sinusitis. Severe and chronic which is suppurative, complicated by polyps, or does not respond to treatment.

c. Trachea. Stenosis of a degree causing respiratory embarrassment.

N. NEUROLOGICAL DISORDERS

1. Amyotrophic Lateral Sclerosis.

2. Chorea. Chronic and progressive.

3. Freidreich's Ataxia.

4. Hepatolenticular Degeneration.

5. Migraine. Manifested by frequent incapacitating attacks or attacks which last for several consecutive days, and unrelieved by treatment.

6. Multiple Sclerosis.

7. Myasthenia Gravis.

8. Myelopathic Muscular Atrophy. Includes severe residuals of poliomyelitis.

9. Narcolepsy. When attacks are not controlled by medication.

10. Paralysis Agitans.

11. Peripheral Nerve Conditions.

a. Neuralgia. When symptoms are severe, persistent, and not responsive to treatment.

b. Neuritis. When manifested by more than moderate, permanent functional impairment.

c. Paralysis due to Peripheral Nerve Injury. When manifested by more than moderate, permanent functional impairment.

12. Progressive Muscular Atrophy.

13. Syringomyelia.

14. Transverse Myelopathy.

15. General Neurological Disorders. Any other neurological condition, regardless of etiology, when, after adequate treatment, residual symptoms such as persistent severe headaches, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance of consciousness, speech or mental defects, or personality changes definitely interfere with the performance of duty.

O. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

1. Psychoses. One or more psychotic episodes, existing symptoms or residuals thereof, or a recent history of psychotic reaction sufficient to interfere with performance of duty or social adjustment.

2. Psychoneuroses. Persistent or recurrent symptoms requiring hospitalization or the need for continuing psychiatric support. (Incapacity because of neurosis must be distinguished from weakness of motivation or underlying personality disorder.)

3. Personality Disorders.

a. Personality Disorders. Personality disorders are considered to render an individual administratively unfit rather than unfit because of physical disability. Interference with performance of effective duty will be dealt with through appropriate administrative channels.

b. Transient Personality Disruptions. Transient personality disruptions of a nonpsychotic nature or situational maladjustments due to acute or special stress are generally self-limited conditions and do not render an individual unfit because of physical disability.

4. Disorders of Intelligence. Individuals determined to have primary mental deficiency or special learning defect(s) of such degree as to interfere with the satisfactory performance of duty are administratively unfit or unsuitable and should be recommended for administrative separation.

P. SKIN AND CELLULAR TISSUES

Conditions listed below are cause for referral to a Physical Evaluation Board (PEB) when they are severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or use of military equipment.

1. Acne. Severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or use of military equipment.

2. Atopic Dermatitis. More than moderate or requiring frequent hospitalization.

3. Cysts and Tumors. See section S., below.

4. Dermatitis Herpetiformis. Which fails to respond to therapy.

5. Eczema, Chronic. Regardless of type, when there is more than minimal involvement or when there are repeated exacerbations in spite of continuing treatment.

6. Elephantiasis or Chronic Lymphedema. Not responsive to treatment.

7. Epidermolysis Bullosa.

8. Erythema Multiforme. More than moderate and chronic or recurrent.

9. Exfoliative Dermatitis. Chronic.

10. Fungus Infections, Superficial. If not responsive to therapy and resulting in frequent absences from duty.

11. Hidradenitis, Suppurative, and Folliculitis Decalvans.

12. Hyperhydrosis. Of the hands or feet, when severe or complicated by a dermatitis or infection, either fungal or bacterial, and not responsive to treatment.

13. Leukemia Cutis and Mycosis Fungoides.

14. Lichen Planus. Generalized and not responsive to treatment.

15. Lupus Erythematosus. Chronic discoid variety with extensive involvement or when the condition does not respond to treatment.

16. Neurofibromatosis. If repulsive in appearance or when associated with manifestations of other organ system involvement.

17. Parapsoriasis. Extensive and not controlled by treatment.

18. Pemphigus. Not responsive to treatment, and with moderate constitutional or systemic symptoms.

19. Psoriasis. Extensive and not controllable by treatment.

20. Radiodermatitis. If resulting in malignant degeneration at a site not amenable to treatment.

21. Scars and Keloids. So extensive or adherent that they seriously interfere with the function of an extremity or body area involved, or if repulsive in appearance.

22. Tuberculosis of the Skin. If not responsive to therapy.

23. Ulcers of the Skin. Not responsive to treatment after an appropriate period of time or if resulting in frequent absences from duty.

24. Urticaria. Chronic, severe and not amenable to treatment.

25. Other Skin Disorders. If chronic, or of a nature which requires frequent medical care or interferes with the satisfactory performance of military duty.

Q. SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS (See also subsection G.3., above)

1. Congenital Anomalies. Presenting functional impairment of a degree sufficient to preclude the satisfactory performance of duty.

2. Coxa Vara. More than moderate with pain, deformity, and arthritic changes.

3. Herniation of Nucleus Pulposus. When symptoms and associated objective findings are of such a degree as to require repeated hospitalization or frequent absences from duty.

4. Deviation or Curvature of Spine. More than moderate, or interfering with function, or causing unmilitary appearance.

R. SYSTEMIC DISEASES

1. Acquired Immune Deficiency Syndrome (AIDS). Service members confirmed to be HTLV-III antibody positive who manifest evidence of progressive clinical illness or immunological deficiency. (See enclosure 5, paragraph B.3.)

2. Amyloidosis. Generalized.

3. Dermatomyositis.

4. Leprosy. Any type.

5. Lupus Erythematosus, Disseminated, Chronic.

6. Myasthenia Gravis.

7. Mycoses. Active, not responsive to therapy or requiring prolonged treatment, or when complicated by residuals that in themselves render a Service member unfit.

8. Panniculitis. Relapsing, febrile, nodular.

9. Porphyria.

10. Sarcoidosis. Progressive, with severe or multiple organ involvement and not responsive to therapy.

11. Scleroderma. Generalized or of the linear type, which seriously interferes with the function of an extremity or body area involved.

12. Tuberculosis, Generalized. Not responsive to therapy.

S. TUMORS AND MALIGNANT DISEASES

1. Malignant Neoplasms. Malignant neoplasms or residuals of treatment which are of such a nature as to preclude satisfactory performance of duty.

2. Neoplastic Conditions of Lymphoid and Blood-Forming Tissues. Normally grounds for referral to a Physical Evaluation Board (PEB).

3. Benign Neoplasms. When the condition prevents the satisfactory performance of duty and is not remediable, or a remedial operation is refused.

T. VENEREAL DISEASES

1. Symptomatic Neurosyphilis. In any form.

2. Complications or Residuals of Venereal Diseases. When chronicity or degree of severity is such that the individual is incapable of performing useful duty.

APPLICATION OF THE VETERANS ADMINISTRATION SCHEDULE FOR RATING DISABILITIES

A. GENERAL RATING POLICIES

1. Use of the Veterans Administration Schedule for Rating Disabilities. Congress established the VA Schedule for Rating Disabilities (hereafter cited as the VASRD or the VA Schedule) as the standard under which percentage determinations are to be made, pursuant to Title IV of the Career Compensation Act of 1949 (now principally codified in 10 U.S.C. 61 (reference (e)). However, not all the General Policy provisions, 10 U.S.C. 61 as set forth in paragraphs 1-31 of the VA Schedule, are applicable to the Military Departments. Many of these policies were written primarily for VA rating boards in the field, and are intended to provide guidance under laws and policies applicable only to the VA. Section A. (General Rating Policies) of this enclosure replaces paragraphs 1 through 31 of the VA Schedule. The remainder of the VA Schedule (paragraph 40 et seq.) is applicable except those portions that (1) pertain to VA determinations of Service connection, or (2) refer to internal VA procedures or practices, or (3) are otherwise specifically identified in attachment 1 to this enclosure as being inapplicable.

2. Essentials of Evaluative Rating.

a. The VA Schedule is primarily a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. 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. Conditions which do not render a service member unfit for military service will not be considered for determining the compensable disability rating unless they contribute to the finding of unfitness.

3. Higher of Two Evaluations. In a number of atypical instances, it is not expected that all cases will show all the findings specified in the VA Schedule. Where there is a question as to which of two percentage evaluations shall be applied, the higher evaluation will be assigned if the service member's disability more nearly approximates the criteria for that rating. Otherwise the lower rating will be assigned. When after careful consideration of all reasonably procurable and assembled data, there remains a reasonable doubt as to which rating shall be applied, such doubt will be resolved in favor of the member.

4. Pyramiding. Pyramiding is the term used to describe the application of more than one rating to any area or system of the body when the total functional impairment of that area or system is adequately reflected under a single appropriate code. Disability from injuries to the muscles, nerves, and joints of an extremity may overlap to a great extent and special rules for their evaluation are included in appropriate sections of the VA Schedule and in Attachment 1 of this enclosure. Related diagnoses should be merged for rating purposes when the VA Schedule provides a single code covering all their manifestations. This prevents pyramiding and reduces the chance of over-rating. For example, disability from fracture of a tibia with malunion,

limitations of dorsiflexion, eversion, inversion, and traumatic arthritis of the ankle would be evaluated under one diagnostic code 5262, in accordance with the effect upon ankle function, with no separate evaluation for the limitation of motion or traumatic arthritis.

5. Total Disability Ratings. Total disability will be considered to exist when the member's impairment is sufficient to render it impossible for the average person to follow a substantially gainful occupation. Accordingly, in cases in which the VASRD does not provide a 100 percent rating under the appropriate (or analogous) VA Code, a member may be assigned a disability rating of 100 percent if his impairment is sufficient to render it impossible for him to follow a substantially gainful occupation.

6. Convalescent Ratings. Under certain diagnostic codes, the VA Schedule provides for convalescent rating to be awarded for specified periods of time without regard to the actual degree of impairment of function. Such ratings do not apply to the Military Departments since the purpose of convalescent ratings is accomplished by other means under disability laws. Convalescence will ordinarily have been completed by the time optimum hospital improvement (for disposition purposes) has been attained. The ratings for observation periods, as distinguished from convalescence, such as those "for one year" following treatment for a malignant neoplasm, are not affected by this policy.

7. Analogous Ratings. When an unlisted condition is encountered, it will be permissible to rate it under a closely related disease or injury in which not only the functions, 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 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.

8. Zero Percent Ratings and Minimum Ratings.

a. Occasionally a medical condition which causes or contributes to unfitness for military service is of such mild degree that it does not meet the criteria for even the lowest rating provided in the VA Schedule under the applicable code number. A 0 percent rating may be applied in such cases even though the lowest rating listed is 10 percent or more, except when "minimum ratings" are specified (b., below). It should be noted that the 0 percent rating does not preclude the award of compensation as prescribed by law for ratings of less than 30 percent. The bilateral factor will be applied when a disability is present in two paired extremities, but one is rated at 0 percent.

b. In some instances the VA Schedule provides a "minimum rating," without qualification as to residuals or impairment. Syringomyelia, code 8024, is an example. Diagnosis alone is sufficient to justify the minimum rating. Higher ratings may be awarded in consonance with degree of severity, but no rating lower than the "minimum" may be used if the diagnosis is satisfactorily established.

c. The VA Schedule provides for minimum rating for "residuals" in certain medical conditions. The instructions may be "rate residuals, minimum ___%," or may specify what impairment to rate and give a minimum rating for

that impairment. Examples are code 8011, anterior poliomyelitis, and 6015, benign new growth of eyeball and adnexa, other than superficial. To justify the minimum rating for residuals, a functional impairment or other residual caused by the condition must exist. Otherwise, a 0 percent is appropriate.

9. Extra-Schedule Ratings in Exceptional Cases. The requirement to use the VA Schedule in rating disabilities vests in the Secretary of the Military Department the same administrative power to assign ratings in unusual cases, not covered by the Schedule, as that exercised by the Central Office of the Veterans Administration. Therefore, in exceptional cases where the Schedule evaluations are found to be inadequate, extra-Schedule ratings commensurate with the average earning capacity impairment due exclusively to Service-connected disability may be assigned in accordance with procedures to be established by the Secretary of the Military Department concerned. In such a case, the recommending agency must fully document the basis of the conclusion 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 Schedule standards.

10. Rating of Disabilities Aggravated by Active Service. In cases involving aggravation by active service, the rating will reflect only the degree of disability over and above the degree existing at the time of entrance into the active service, whether the particular condition was noted at the time of entrance into the active service or is determined upon the evidence of record to have existed at that time. It is necessary, therefore, in all cases of this character to deduct from the present degree of disability, the degree, if ascertainable, of the disability existing at the time of entrance into active service, in terms of the rating schedule, except that if the disability is total (100 percent), the Existed Prior to Service (EPTS) factor will be recorded, and no deduction in compensable rating will be made. The resulting difference will be recorded on the rating sheet. If the degree of disability at the time of entrance into the Military Service is not ascertainable in terms of the schedule, no deduction will be made.

11. Assignment of Aggravation Factors When Prescribed Treatment is Refused or Omitted. A service member's degree of disability may have been aggravated or increased by an unreasonable failure or refusal to submit to medical or surgical treatment or therapy, to take prescribed medications, or to observe prescribed restrictions on diet, activities, or the use of alcohol, drugs, or tobacco. The compensable disability rating may be reduced to compensate for such aggravation or increased when the existence and degree of aggravation are ascertainable by application of accepted medical principles, and where it is clearly demonstrated that:

a. The service member was advised clearly and understandably of the medically proper course of treatment, therapy, medication or restriction; and

b. The member's failure or refusal was willful or negligent, and not the result of mental disease or of physical inability to comply.

12. Combined Ratings Table. When a member has more than one compensable disability, the percentages are combined rather than added (except when a "Note" in the VASRD indicates otherwise). This results from the consideration

of the individual's efficiency, as affected first by the most disabling condition, then by the less disabling conditions in the order of their severity. Thus a person having a 60 percent disability is considered to have a remaining efficiency of 40 percent. If he has a second disability rated at 20 percent, then he is considered to have lost 20 percent of that remaining 40 percent, thus reducing his remaining efficiency to 32 percent. Hence, a 60 percent disability combined with a 20 percent disability results in a combined rating of 68 percent. The combined rating for any combination of disabilities can be determined by first arranging the disabilities in their exact order of severity and then referring to the combined ratings table on pages 10 and 11 of the VA Schedule in acordance with the following instructions:

a. Combining Two Percentages. Enter the table by locating the highest percentage in the left-hand column and reading across to where that horizontal line intersects with the vertical column headed by the second percentage. (Example: 40 combined with 20 equals 52.)

b. Combining Three or More Percentages. First, combine the first two percentages as above. Second, re-enter the table by locating that combined value in the left-hand column and reading across to where that horizontal line intersects with the vertical column headed by the third percentage. (Example: 50 combined with 30 equals 65. 65 combined with 20 equals 72.) If there are additional percentages, the second step is repeated using the new combined value and the next percentage.

c. Converting Combined Ratings. After all percentages have been combined, the resulting combined value is converted to the nearest number divisible by 10, and combined values ending in 5 will be adjusted upward. If the combined value included a decimal fraction of 0.5 or more as a result of applying the bilateral factor, the fraction is converted to the next higher whole number; otherwise the decimal fraction is disregarded. (Example: If the combined value is 64.5, first round off the fraction to make the combined value 65, which in turn is rounded off to 70. If the combined value is 64.4, the decimal fraction is disregarded and the combined value of 64 rounded off to 60.)

13. Bilateral Factor. When a partial disability results from injury or disease of both arms, or both legs, or of paired skeletal muscles, the rating for the disabilities of the right and left sides will be combined as usual, and 10 percent of this value (called the Bilateral Factor) will be added (i.e., not combined) before proceeding with further combinations, or converting to degree of disability. The Bilateral Factor will be applied to such bilateral disabilities before other combinations are carried out, and the rating for such disabilities, including the Bilateral Factor as above, will be treated as one disability for the purpose of arranging in order of severity and for all further combinations.

a. The terms "arms" and "legs" are not here intended to distinguish between the arm, forearm, and hand, or the thigh, leg, and foot, but to describe to the upper extremities and lower extremities as a whole. Thus with a compensable disability of the right thigh (for example, amputation), and one of the left foot (for example, pes planus), the Bilateral Factor applies, and similarly whenever there are compensable disabilities affecting use of paired

extremities regardless of location or specified type of impairment. (Except as noted in c. below).

b. The correct procedures when applying the Bilateral Factor to disabilities affecting both upper extremities and both lower extremities is to combine the ratings of the disabilities affecting the four extremities in order of their individual severity and apply the Bilateral Factor by adding, not combining, 10 percent of the combined value thus attained.

c. The Bilateral Factor is not applicable unless there is partial disability of compensable degree in each of two paired extremities or paired skeletal muscles. Special instructions regarding the applicability of the Bilateral Factor are provided in various parts of the VA Schedule - Code 7114-7117, Code 8205-8412, etc. The Bilateral Factor is not applicable in skin disabilities rated under VASRD Code 7806.

14. Use of VA Code Numbers. The VA code numbers appearing opposite the listed ratable disabilities are arbitrary numbers for the purpose of showing the basis of the evaluation assigned and for statistical analysis. Great care will be exercised in the selection of the applicable code number and in its citation on the rating sheet. Each rated disability is assigned its VA code number unless a hyphenated code is expressly authorized. It is not proper to use additional VA codes as a means of further describing defects. The written diagnosis entered on the rating form should include any description considered necessary to indicate the extent, severity or etiology of the condition. In the selection of code numbers, injuries generally will be represented by the number assigned to the residual condition on the basis of which the rating is determined. With diseases, preference is to be given to the number assigned to the disease itself; if the rating is determined on the basis of residual conditions, the number appropriate to the residual condition will be added, preceded by a hyphen. Thus atrophic (rheumatoid) arthritis rated as ankylosis of the lumbar spine would be coded "5002-5289." In this way, the exact source of each rating can be easily identified. In the citation of disabilities on rating sheets, the diagnostic terminology may be any combination of the medical examiner's or VA Schedule terminology which accurately reflects the degree of disability. Residuals of diseases or therapeutic procedures will not be cited without reference to the basic disease. Hyphenated codes are used only in these circumstances:

a. When the VA Schedule provides that a listed condition is to be rated as some other code, e.g., myocardial infarction rated as arteriosclerotic heart disease (7005-7006) or nephrolithiasis rated as hydronephrosis (7508-7509).

b. When the schedule provides a minimum rating and the disability is being rated on residuals, e.g., multiple sclerosis rated as incomplete paralysis of all radicular groups (8018-8513).

c. When an unlisted condition is rated by analogy, e.g., spondylolisthesis rated as sacroiliac injury and weakness (5294-5299). When an unlisted disease, injury, or residual condition is encountered, requiring rating by analogy, the diagnostic code number will be "built-up" as follows: The first two digits will be selected from that part of the schedule most closely identifying the part, or system, of the body involved; the last two

digits will use "99" for all unlisted conditions. This procedure will facilitate a close check of new and unlisted conditions, rated by analogy.

B. RATING PRINCIPLES

1. Modification of Specific Parts of the VA Schedule. Instructions and explanatory notes which follow are listed according to paragraphs and code numbers in the VASRD. Only those portions which require special comment, or those which have been the cause of misunderstanding in the past, are included.

2. New Growths, Malignant.

a. This guidance applies to rating malignancies listed in VASRD Codes 5012, 6014, 6208, 6819, 7343, 7528, 7627, 7818, 7914, 8002 and 8041. Guidance which is obviously inappropriate to rating of a specific malignancy (e.g., rules for skin cancer do not affect ratings for bone tumors) shall be disregarded.

b. Application of this guidance requires a prior finding of unfitness because of physical disability.

c. An individual in whom a malignant tumor was diagnosed which has not responded to therapy, will be permanently retired.

d. An individual with minor new growth, malignant, skin, if found unfit, will be rated as "scars-disfiguring" or on the extent of constitutional symptoms, physical impairment and/or other contributing causes.

3. The VASRD does not now have a code for the Acquired Immune Deficiency Syndrome (AIDS). Service members meeting the requirement for Physical Evaluation Board (PEB) referral in paragraph R.1. of enclosure (4) will be given a minimum of a 30% rating. Additional ratings may be given for specific diagnoses such as pneumonia or Kaposi's sarcoma.

Attachment
1. Special Instructions and Explanatory Notes, VASRD

SPECIAL INSTRUCTIONS AND EXPLANATORY NOTES, VASRD

5000, Osteomyelitis.

a. Note (1) following Code 5000 in the VASRD may appear to be ambiguous in its instructions concerning application of the amputation rule. It means that in rating active osteomyelitis of any part, the amputation of which would be ratable at less than 20 percent (ordinarily the minimum rating for active osteomyelitis), a rating of 10 percent may be assigned. This constitutes disregard of the amputation rule in those instances where the rating for amputation would be 0 percent. Example: A case of active osteomyelitis of the little finger distal to the proximal interphalangeal joint may be rated at 10 percent even though amputation at that level is ratable at 0 percent (Note (b), page 33R and VA Code 5227). However, a ratable disability exists only so long as distal phalanx with its active osteomyelitis remains.

b. Osteomyelitis should not be considered cured simply because saucerization or sequestrectomy has been performed. Cures sometimes may be effected, however, by removal or radical resection of the bone.

c. Under Note (2), a rating may be assigned only when the disease is active clinically or by X ray.

d. Osteomyelitis extending into a major peripheral joint will not be rated higher than the elective amputation level that would remove the involved joint.

5002, Rheumatoid Arthritis. A distinction is made between active disease and chronic residuals. VASRD Codes 5002, 5004 to 5009 and 5017 will be rated by the same criteria and the VASRD guidance on page 28-2R.

a. As an active process: Ratings assigned under these codes will be based primarily on clinical and laboratory evidence. X ray changes are not required.

b. For chronic residuals: Ratings will be based on limitation of motion in accordance with the VASRD Code 5200 series. X ray evidence, alone, will not support a rating in any of these conditions.

c. The bilateral factor will apply as appropriate.

d. These ratings under VASRD Code 5200 will not be combined with ratings for active process.

5003, Arthritis, Hypertrophic.

a. This is one of the more frequently encountered conditions in the field of disability evaluation, and one of the more difficult to adjudicate. The difficulty stems from the fact that it occurs in some degree in all individuals beyond age 40, and from its wide variability in rate of progression and severity of manifestations. Symptomatology is frequently disproportionate to demonstrable pathology, and in this area the effect of such intangibles as motivation and other psychogenic components must be considered.

b. Ratings under this code can be assigned in either of the following situations: In the absence of limitation of motion with only X ray evidence of

involvement of two or more major joints or two or more joint groups; or, when there is objective evidence of some limitation of motion combined with X ray findings of arthritis of one or more major joints or minor groups.

c. When the limitation of motion of the involved specific joint or joints is of sufficient degree, the rating assigned will be under one of the appropriate limitation of motion codes (the 5200 or 9900 series of codes of the VASRD).

d. When a rating is assigned under a limitation of motion code (5200 series), it will not be combined with a rating under code 5003 for other joint involvement on the basis of X ray findings.

e. It is emphasized that separate rating of specific joints or joint groups are not intended for application to the fluctuating types of impairments which tend to improve or disappear.

5010, Arthritis Due to Direct Trauma. When an affected joint merits a rating higher than 10 percent, the analogy appropriate to the impairment must be used. Diagnosis alone is insufficient for the 10 percent rating. With an affected joint, the assignment of a 10 percent rating requires the presence of objective evidence of limitation of motion in addition to X ray findings.

5054, Total Hip Replacement. Convalescent ratings and ratings for specified periods of time will not be used. In uncomplicated cases the member is usually ambulatory and disposition is possible approximately one month after the procedure has been performed. TDRL, with an appropriate rating, is usually required prior to permanent disposition.

5055, Knee Replacement (Prosthesis).

a. The provision that a member will be rated at 100 percent for one year following implantation of the prosthesis does not apply.

b. If, after maximum hospital benefit has been achieved, a member remains unfit, rate for residual impairment. If the member's condition has not stabilized for rating purposes, placing on the TDRL should be considered.

c. The VASRD footnote to Code 5055 does not apply.

5126-5151, Multiple Finger Disability. The difficulty frequently encountered in rating multiple finger amputations at different levels has been simplified by a convenient method of computation. By the assignment of graded values for each finger according to the level at which it was amputated, or for the severity of its ankylosis, it is possible to calculate an "average amputation level" for the fingers involved. (See Plate III.) The disability may then be rated in accordance with the notes of instruction in the VASRD. The method is as follows:

Step One: Determine the grade value of each of the affected fingers from the chart below.

Defect of individual finger	Rated as	Grade Value
Amputation through distal phalanx[1] or distal joint. (Other than negligible tip losses.)	Favorable ankylosis (Note c, page 33-R VASRD).	Grade 1
Amputation through middle phalanx.	Unfavorable ankylosis (Note b).	Grade 2
Amputation through proximal phalanx or proximal I-P joint.	Amputation (Note a).	Grade 3
Amputation of entire digit with amputation or resection of more than one half of metacarpal.	Single finger amputation with metacarpal resection (Codes 5152-5156).	Grade 4

Step Two: Find the average grade value by dividing the total of values for the individual fingers by the number of fingers involved. Round off fractions to the nearest whole number.

Step Three: From the second and third columns of the chart above, determine the appropriate category of the defects (favorable ankylosis, unfavorable ankylosis, amputation, etc.) for the average grade of the disabled hand. The proper code number and rating can then be determined within the category according to the number of fingers involved. Example: Service member has had his thumb amputated through the distal phalanx, the long and ring finger through the middle phalanges, and the entire small finger, including more than half of the metacarpal.

Grade value for the thumb 2
Grade value for the long finger 2
Grade value for the ring finger 2
Grade value for the little finger, including more than half of metacarpal..... 4
Total value 10

[1]For rating purposes the thumb will be regarded as having no distal phalanx. Amputation of the thumb at the interphalangeal joint or distal thereto will be graded as unfavorable ankylosis (Grade 2). The VASRD is ambiguous in this regard, no such distinction being made in the notes following 5151 of the VASRD, yet VA Code 5152 shows 20 percent for application at the distal joint or distal thereto, and VA Code 5224 also shows 20 percent for application to unfavorable ankylosis of the thumb.

$$\frac{\text{Total Value}}{\text{Number of fingers involved}} = \text{Ratable Value}$$

$$\frac{10}{4} = 2\tfrac{1}{2} = 3$$

Referring to the chart above, Grade 3 is ratable as amputation. Amputation of four fingers - thumb, index, ring and little - is ratable under VA Code 5130 at 70 percent (for major hand) or 60 percent (for minor hand).

5171, Amputation of Great Toe. Must be through the proximal phalanx to warrant a 10 percent rating.

5200-5295, Ratings Involving Joint Motion.

a. In the measurement and assessment of joint motion it is incumbent upon the medical examiner to utilize the standardized descriptions portrayed in Plates I and II, enclosure 3, of this Directive.

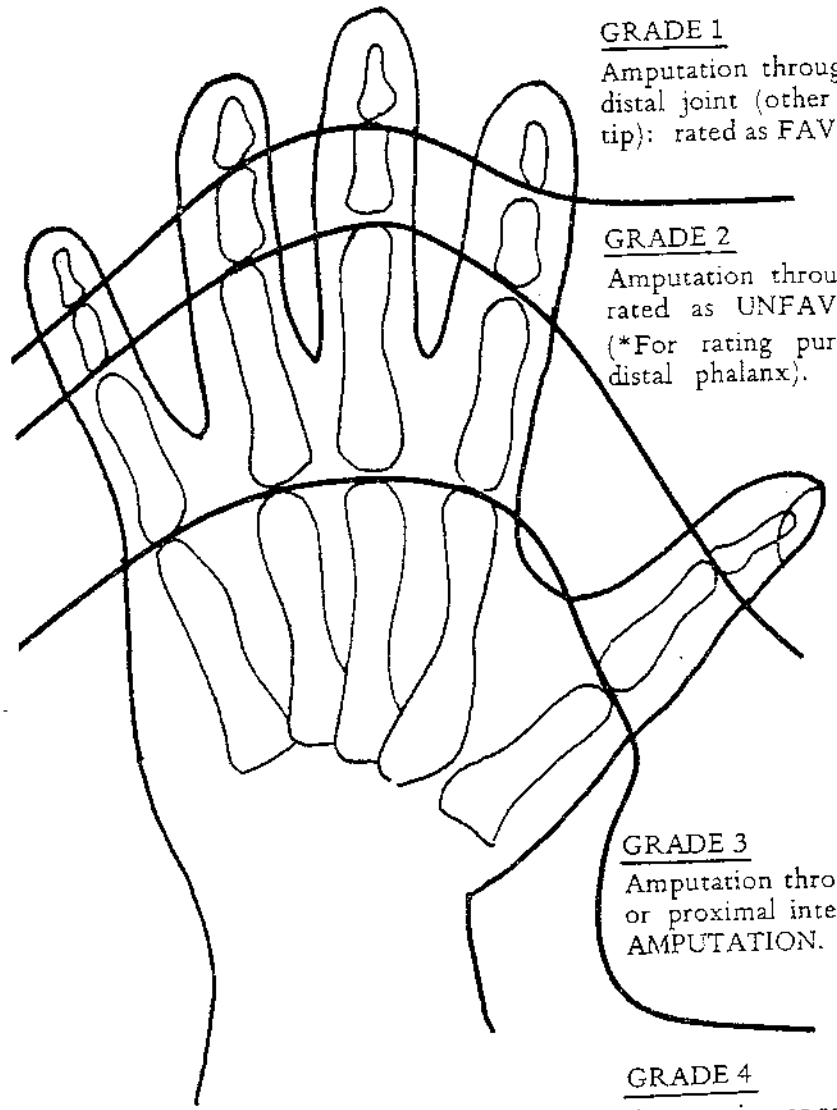
b. When the reported limited range of motion falls between two points specified in the VASRD, the higher percentage of disability will apply.

c. Ankylosis is the absence of motion of a joint. In application, it is complete fixation, or a limitation of motion so severe in degree that the amount of movement is negligible.

d. The inclination, usually encountered when an analogous rating of an extremity is necessary, to use an analogy such as "other impairment of" elbow or knee (Code 5209 or 5257), is to be avoided when the actual impairment is a limitation of motion of the joint, properly ratable as limitation of flexion or extension of the part distal to the joint.

e. In some cases of limitation or of other abnormal joint motion, the basic cause is injury to muscle or tendon rather than to bone or joint. A careful distinction must be made for appropriate rating.

RATING OF MULTIPLE FINGER DISABILITIES



GRADE 1

Amputation through the distal phalanx or distal joint (other than loss of negligible tip): rated as FAVORABLE ANKYLOSIS.

GRADE 2

Amputation through the middle phalanx* rated as UNFAVORABLE ANKYLOSIS (*For rating purposes, thumb has NO distal phalanx).

GRADE 3

Amputation through the proximal phalanx or proximal interphalangeal joint rated as AMPUTATION.

GRADE 4

Amputation or resection of metacarpal bones, more than one-half of the bone lost.

PLATE III

(See the VASRD for principles on the "Musculo-Skeletal System" in connection with rating problems resulting from injuries to extremities.)

5205-5208, Absence or Limitation of Motion of Elbow and Forearm.

a. 5205. Where a rating for unfavorable ankylosis is not based upon the additional finding of complete loss of supination or pronation, it may be combined with 5213 subject to the amputation rule. If there is less than complete loss of supination or pronation, 5205 may be combined with 5213 but not to exceed the rating for unfavorable ankylosis under 5205.

b. 5206-5208. These will combine with 5213, but not to exceed the rate for unfavorable ankylosis under 5205.

5209-5212, Other Impairments of Elbow, Radius and Ulna. These codes are not to be combined with Code 5213.

5213, Impairment of Pronation and Supination.

a. Limitation of either pronation or supination may be rated, but never both in the same arm. Full pronation is the position of the hand flat on the table. Full supination is the position of the hand palm up In rating limitation of pronation the "arc" is from full supination to full pronation. The "middle" of the arc is the position of hand, palm vertical to the table.

b. There is an inconsistency in the schedule for the ratings for the major arm, where "hand fixed near the middle of the arc or moderate pronation" is rated 20 percent, while limitation of pronation with "motion lost beyond middle of arc" is rated 30 percent. Cases in which this conflict arises shall be resolved in the member's favor.

c. "Motion lost beyond last quarter of arc" means that the forearm can be pronated from 0 through 45 , but no further. (See paragraph 71 of the VASRD and the illustration of forearm pronation, Plate I, enclosure (3) of this Directive.)

5214, Wrist, Ankylosis of.

a. Ankylosis of the wrist in 10 degrees to 30 degrees of dorsiflexion will be considered favorable and rated accordingly.

b. Wrist replacement prosthesis. Rate according to functional impairment.

5251-5253, Limitation of Extension and Flexion of the Thigh. Ratings allowable under these codes may not realistically reflect the degree of disability because of basic or related disability of the sacroiliac region, pelvis, acetabulum, or head of femur. More appropriate ratings may be selected from VA Code 5250 (hip, ankylosis of), VA Code 5255 (femur, impairment of, with hip disability) or VA Code 5294 (sacroiliac injury). (See paragraph 67 of the VA Schedule for comments on pelvic skeletal fractures.)

5255-5262, Defects of Long Bones of the Lower Extremity. Apply these codes (malunion with adjacent joint disability) when appropriate to avoid multiple codes and ratings, but, when both a proximal and a distal major joint are

affected, an additional rating may be indicated for the less disabled joint. These codes are often appropriate when joint surfaces are included in the fracture lines.

5270 Ankle prosthesis may be rated under this number. Maximum disability is 40 percent in keeping with amputation rule. Place on TDRL if appropriate and rate on residual disability after stabilization.

5272, Subastragalar or Tarsal Joint Ankylosis. The assignment of a rating under this code is proper only in the absence of motion of the subtalar joint which is manifested by the lack of inversion or eversion of the foot.

5285-5295, Spine.

a. The joints of the cervical, dorsal and lumbar segments of the spine and the combination of sacroiliac and lumbosacral joints are each regarded as a group of minor joints. Each is ratable as one major joint only when separate ratings are justified by X ray evidence of pathology in addition to limitation of motion or muscle spasm or other evidence of painful motion of the individual segments involved. Otherwise, rate as for osteoarthritis.

b. Arthritic impingement on nerve roots which produces degeneration of the nerve function or frequent, prolonged attacks of neuralgia, as distinguished from brief episodes of radiating pain, should be rated as one entity under codes for neurological conditions, unless limitation of spinal motion justifies an additional rating.

5285, Residuals of Fracture of Vertebra.

a. The need for a member to wear some type of brace for the restriction of lumbar or dorsolumbar movement is not analogous to the requirements for a jury mast type of neck brace for abnormal mobility following cervical fracture. Where there is no cord involvement, the disability should be rated in accordance with the degree of limited motion with brace in place.

b. When there is significant demonstrable (objective findings and X ray) deformity of one or more vertebral bodies, 10 percent is to be added to, not combined with, the rating for each spinal segment in which such deformity appears. Instructions contained in the italicized note under Code 5285 (VASRD), pertaining to ratings for ankylosis and limited motion, apply also to the addition of 10 percent for demonstrable deformity of a vertebral body. The 10 percent is to be added to the rating for the segment before that rating is combined with the others. Example: If, as residuals of vertebral fractures, a

member were to have moderate limitation of motion in cervical and lumbar segments, and substantial deformities of the bodies of C5, D12, and L1, the rating would be:

Line:			
	1.	Code 5285-5290	20%
	2.	Demonstrable deformity of C5----------	10
	3.	(Subtotal)	30
	4.	Code 5285-5292	20%
	5.	Demonstrable deformity of L1	10
	6.	(Subtotal)	30
	7.	Combining lines 3 and 6	51%

(Since there is no associated finding, there can be no addition because of deformity in D12)

c. The addition to the rating of 10 percent for demonstrable deformity of a vertebral body is intended only for a substantial degree of deformity. It should not be added in those instances of insignificant deformity such as slight shortening of the anterior vertical dimension of the body. Where a successful spinal fusion has been performed because of the deformity of a vertebral body, the potential of the deformity for increasing the degree of disability has usually been removed or so far reduced that the addition of 10 percent to the rating is not justified.

5287-5289, Ankylosis of a Spinal Segment.

a. A rating for ankylosis requires a condition of absent or negligible range of motion for the whole segment. Ankylosis of part of a segment still may leave some degree of useful motion for the segment as a whole, so that the appropriate rating would be for limitation of motion.

b. Separate ratings for ankylosis of segments of the spine shall not exceed 60 percent when combined, if the combined effect of such separate disabilities is complete ankylosis of the spine at a favorable angle.

5296, Skull.

a. Diagnostic burr holes and other bony defects are ratable only when there is loss of both inner and outer tables of bone. Where there is more than one, add the areas of each and rate the total. The following may be helpful as a reference in determining appropriate ratings:

1 centimeter - 0.3937 inch

1 inch - 2.54 centimeters

1 square centimeter = 0.1550 square inch

2 square centimeters = 0.3100 square inch

3 square centimeters = 0.4650 square inch

Diameter of Circle	Area of Circle	
	Square centimeters	Square inches
1 centimeter	0.7854	0.1216
2 centimeters	3.1416	0.4869
3 centimeters	7.0686	1.0956
4 centimeters	12.5664	1.9478
1/2 inch		0.19635
1 inch		0.7854
1 1/2 inches		1.76715
2 inches		3.1416

b. Considering total bone loss for multiple areas, such as in trephining, the rating should not be assigned based upon "coin measurement" but on the basis of the aggregate area loss in terms of square inches. Attention is directed to the fact that approximately 50 percent of diagnostic burr holes heal within five years.

c. Loss of part of the skull is not ratable if the defect has been successfully repaired with a prosthetic plate. Residual neurological deficit or cosmetic deformity will be rated separately if appropriate. Burr holes, to be ratable, must be contiguous.

d. Areas of loss where bone regeneration has taken place are not ratable. If regeneration has partially closed the defect, only the remaining area of loss is to be rated.

e. The rating problem created by the disparity in the criteria for area measurement (50-cent piece = 1.140 square inches; 25-cent piece = 0.716 square inches) shall be resolved in favor of the member.

5297, Removal of Ribs.

a. For removal of ribs, the VASRD requires the complete removal from the vertebral angle to the costo-cartilaginous junction. Removals to a lesser degree are rated as rib resections.

b. The presence of certain conditions precludes the assignment of an additional rating under Code 5297; exceptions are allowed in specific situations. Notes (1) and (2) under this Code in VASRD provide pertinent guidance.

5299-52xx, Dupuytren's Contracture. Rate on the basis of limitation of motion of finger movement.

5301-5326, Muscle Injuries.

a. There are specific limits to the permissible combination of ratings of muscle injuries in the same anatomical segment, and of muscle injuries in which the movements of a single joint are affected. (See paragraphs 55 (page 20-R) and 72 (page 45-3R), VASRD.)

b. When a joint is ankylosed, the muscles acting on that joint may not also be rated.

6000-6092, Diseases of the Eye.

a. The adjudication of disabilities of the visual apparatus is often extremely difficult. In some cases, involving a combination of defects, it may be possible to arrive at an equitable percentage rating through literal application of the terms of the VA Schedule. The complexity of these conditions does not permit the construction of a schedule that is adequate for the infinite variety of defects and the resulting types and degrees of impairment which may occur. Here the concept of "visual efficiency" may be helpful. Visual efficiency is the product of the interdependent relationship of all the functions of the ocular apparatus, of which the three principal ones are central visual acuity, field of vision, and muscle function. Since the estimation of visual efficiency, as such, is not provided by the VA Schedule as a means of determining degree of disability it is useful only to help create a mental image of the service member's real handicap so that an equitable rating in terms of the schedule may be recommended.

b. The VA Schedule makes several references to the effect that the combined rating for disabilities of the same eye is not to exceed the amount for total loss of vision of that eye, unless there is an enucleation or a serious cosmetic defect added to the total loss of vision. Accordingly, where there is a cosmetic defect, even though limited to the eye with the visual loss, representing a separate and distinct entity, namely, facial disfigurement, a separate rating of 10, 30, or 50 percent depending on the facts in the case is permitted under Code 7800 to be combined with the rating for the visual loss or rating for enucleation.

c. It is mandatory that visual field defects be examined and reported in accordance with the method prescribed in paragraph 76 of the VA Schedule. Attach copies of the records showing visual field defects to the medical board report. Make and report muscle function examinations in accordance with paragraph 77 of the VA Schedule.

6000-6009, Conditions Involving Structures of the Globe.

a. Rate disabilities resulting from these conditions, as follows:

Step One:

(1) Rate impairment of visual acuity.
(2) Rate impairment of field of vision.
(3) Rate active pathology, if present, at 10 percent.
(4) Combine the rating in (1) or (2) above, whichever is higher, with (3).

Step Two. Rate pain, rest requirement and/or episodic incapacity from 10 to 100 percent. This rating, when only one eye is involved, is not necessarily limited to the 30 percent rating for total loss of vision of one eye, since pain or rest requirements may be incapacitating in any degree, including total. Assign this rating under the code which covers the basic condition (i.e., Code 6000 through Code 6009). Analogy to another code number is not required. It is an estimate based as nearly as possible upon the actual impairment of social and industrial function which is imposed by the pain experienced, the time lost because of the requirement for rest, the frequency of incapacitating episodes, or any combination thereof.. Do not combine an additional rating of 10 percent during continuance of active pathology with this rating.

Step Three. Award the higher of the two ratings resulting from Steps One and Two, above.

b. Retained Foreign Body. Rate as active pathology under Step One, if in a critical area or not stabilized, or rate for residuals under Step Two.

6013, Glaucoma, Simple, Primary, Noncongestive. The minimum rating is applicable if the diagnosis is satisfactorily established, whether or not visual acuity or field of vision has been affected. The rating is for the disease, rather than for functional impairment of an individual organ, and applied whether the disease process involves one or both eyes.

6081, Scotoma, Pathological. The rating is 10 percent whether unilateral or bilateral. Combine, of course, with other ratings, with the reservation that the rating for one eye may not exceed 30 percent, unless there is enucleation or a serious cosmetic defect. Central scotoma cannot, however, be combined with central visual loss.

6090-6092, Diplopia. To determine rating, substitute the 6090 reading for the visual acuity of the poorer eye and read percentage in the 6071-6079 series. If vision is same in both eyes, pick one as an arbitrary choice. Example: Member has 20/50 vision bilaterally with diplopia in 20 of 20 rectangles; rate as 5/200 one eye and 20/50 other eye under 6073 at 40 percent.

6200, Otitis Media, Suppurative, Chronic. The 10 percent rating during the continuance of the suppurative process is intended as compensation for the existence of active pathology rather than for additional impairment of the individual sense organ. This rating is therefore limited to 10 percent, whether the pathological process is unilateral or bilateral.

6207, Deformity of Auricle. If associated with disfiguring scars of face or head, Code 7800 may be appropriate. Apply the rule against pyramiding.

6300-6317, Systemic Conditions. Convalescent ratings of 6 or 12 months provided under certain of these codes are not to be applied by the Military Departments.

6309, Rheumatic Fever. Rate residual impairments under the appropriate code. When a member is determined to be unfit due to recurrence of disease, and there is no residual functional impairment, consider use of the 0 percent rating.

6350, Lupus Erythematosus, Systemic. Rate connective tissue diseases under this code.

6519, Aphonia, Organic. Impairment of ability to speak may be ratable under more than one code, depending upon the cause and severity of the impairment. In such instances, award the highest applicable rating. This instruction does not apply to speech impairment due to loss of whole or part of the tongue; rate under Code 7202.

6600-6603, Diseases of the Trachea and Bronchi, and Pulmonary Emphysema. Pulmonary function studies must be included in clinical records to support the diagnosis and degree of severity in these pulmonary diseases.

6725-6728, Inactive Pulmonary Tuberculosis.

a. Determining Inactivity. Pulmonary tuberculosis is considered to be inactive:

(1) When these criteria are met: No symptoms of tuberculous origin. Serial roentgenograms must show stability or very slow shrinkage of the tuberculous lesion. No evidence of cavity. Sputum or gastric washings show negative on culture or guinea pig inoculation. These conditions shall have existed at least six months.

(2) When inactivity established is by evaluation. This is usually, but not always, at the time the patient is declared to have received the maximum benefits of hospitalization.

(3) Six months after surgical excision of an active lesion during which time there shall have been no evidence of tuberculous activity in any body system, or upon discharge from the medical treatment facility, whichever is later.

b. Chemotherapy. Treatment by medication is frequently continued beyond the date when the disease becomes inactive according to the above criteria. Do not confuse the ending date of such treatment schedule with that of a beginning of the inactive status.

c. Rating Residuals. A rating of 100 percent for one year after the date of attaining inactivity will not be used. After the condition becomes inactive, rate residuals (e.g., impairment of pulmonary function, surgical removal or resection of a part, etc.) under the appropriate VA Code, subject to the limitations contained in paragraph 96a, of the VA Schedule, except for the reference to Public Law 90-493.

6800-6801, 6802, 6811, 6812, and 6818, Non-Tuberculous Diseases. Appropriate pulmonary function studies must be included in clinical records to support the diagnosis and degree of severity of any of these pulmonary diseases.

6814, Pneumothorax. Do not apply the "100 percent for six months" rating. Rate the underlying condition, if known, or consider rating by analogy to emphysema (Code 6603) or pneumoconiosis (Code 6802).

6815, Pneumonectomy. The 60 percent rating is applied for pneumonectomy, regardless of the number of ribs removed at the time of the operation. If, at a later date, thoracoplasty becomes necessary for obliteration of space within the thorax, the rating for pneumonectomy will be combined with a rating for removal of ribs. Note (2) which follows Code 5297 in VASRD provides rating guidance in a case of this type.

6816, Lobectomy. An entire lobe other than the right middle lobe must be removed for the defect to be ratable. Excision of the right middle lobe, segmental resection or lingulectomies are not ratable.

6899, Sarcoidosis. This disease is difficult to rate because of its unpredictable course and the number of body systems that may be involved. It is usually rated by analogy to coccidiomycosis (Code 6821) or pneumoconiosis (Code 6802) when the predominant manifestation is in the lungs. With other organ or more generalized involvement and manifestations such as lymphadenopathy, transient joint pains and occasional febrile episodes, assignment of the Disability Code 6399 and rating under Code 6316 may be appropriate.

7000 series, Cardiovascular Disease.

a. To avoid pyramiding, give only one rating for all manifestations of cardiovascular-renal disease when, according to accepted medical principles, the conditions are etiologically related. For example, hypertension, arteriosclerosis, and end-organ nephropathy are so closely associated that they may be regarded as one clinical entity. Rate the disability under the code representing the predominant signs and symptoms. Occasionally the related manifestations in another body system will be so severe as to increase the member's overall impairment to the point that the next higher percentage under the selected code will be justified. The note in the VASRD under Code 7507 is pertinent in this respect.

b. Rate valvular heart disease, when not of arteriosclerotic or hypertensive origin, as rheumatic heart disease, Code 7000.

7000, Rheumatic Heart Disease.

a. Assumption of the existence, prior to service, of a ratable degree of rheumatic heart disease is sometimes justified even though its presence was not previously recorded. Such an assumption, of course, will depend upon its compatibility with the interpretation of medical history and findings in the light of accepted medical principles. A stenotic valvular lesion, discovered early in military service, is an example of such a condition.

b. A "definitely" enlarged heart is one in which there is positive evidence of enlargement beyond the doubtful or borderline enlargement that is sometimes reported when the presence of enlargement is uncertain. Voltage criteria alone are not acceptable as electrocardiographic evidence of definite enlargement.

c. The 100 percent rating for active rheumatic heart disease for six months is not applicable.

d. Following valvulotomy or other corrective cardiovascular procedures, rate as discussed in 7005-7006e., below.

7005-7006, Arteriosclerotic Heart Disease, Myocardial Infarction.

a. Do not combine a rating for arteriosclerotic heart disease with one for hypertensive heart or hypertensive vascular disease (Code 7007 or 7101).

b. A rating of 100 percent under this code solely on the basis of the acute attack occurring within a six month period will not be applied.

c. In assigning percentages under these codes the criteria are as follows:

(1) The 100 percent rating. Following a myocardial infarction in which complications are so severe (i.e., intractable angina or intractable congestive heart failure) as to generally confine the individual to his home or comparable environment.

(2) The 60 percent rating. Following a myocardial infarction with substantiated repeated attacks of angina pectoris at rest or with normal activity. Also, substantiated repeated attacks of angina pectoris without antecedent myocardial infarction. More than light manual labor is precluded. The term "substantiated" as it is used here means the existence of a clinical and/or medical history, or other documentation, which tends to support the diagnosis. Cases forwarded with such diagnosis which do not contain supporting documentation, and which are marginal with respect to disability, will be returned by the adjudicative or review agencies to the appropriate medical authority for inclusion or preparation of such documentation.

(3) The 30 percent rating. Following a myocardial infarction manifested by a definite clinical history and expected laboratory evidence and/or characteristic electrocardiographic changes; or electrocardiographic evidence which is diagnostic of a previous myocardial infarction without continuing symptoms indicative of complications of arteriosclerotic heart disease. Also, angina pectoris where ordinary activity does not cause frequent pain, but where strenuous activity is precluded.

d. When an infarction or other acute conditions evaluated under these codes has occurred within approximately six months preceding evaluation or when the member's condition does not appear to have stabilized sufficiently to permit evaluation, place on the Temporary Disability Retired List (TDRL) and remove as soon as clinically stabilized.

e. Injuries, surgical procedures:

(1) Wounds, retained fragments or surgical procedures that disrupt the integrity of the myocardium or the conduction system, are rated for residual impairments raised to the next higher level.

(2) Ratings for heart injuries may be assigned in conjunction with disabilities rated as residuals of pleural injuries under VASRD Code 6818. Since these ratings are for separate injuries, ratings under both codes will not be considered pyramiding.

(3) Coronary bypass procedures, valve reconstruction or prosthesis, pacemakers and other significant procedures must be individually evaluated as the case merits. Place a member who is found unfit, following one of these procedures, on the TDRL with a minimum rating of 60 percent, if retired within six months of surgery. On removal from the TDRL, if still considered unfit because of physical disability, the rating assigned will be for residual impairment raised to the next higher level, with the exception of coronary bypass procedures, which ordinarily will be rated on residuals alone. In all such conditions the minimum residual impairment will be rated as 30 percent.

f. Definition of terms, as used in VASRD:

(1) "Ordinary manual labor" includes work not involving sustained heavy energy expenditure, and includes most skilled laborers, mechanics, and drivers.

(2) "Strictly sedentary employment" involves low energy expenditure and minimal body movement.

7007-7101, Hypertensive Heart Disease and Hypertensive Vascular Disease.

a. Obtain blood pressure reading, to be used in determining disability rating percentages, under normal circumstances and during usual activities. When antihypertensive medication is required for control, base the rating on the pressures obtained during usual activities, while under medication. It is emphasized that hypertension brought under control through optimum conditions (that is, during hospitalization under a regimen of medication and enforced rest) will not be used as a basis for evaluation, unless it is established that such control continues upon resumption of normal activity. Similarly, readings obtained during periods when indicated medication is withheld for purposes of medical observation, diagnostic study, etc., are not used as the basis for evaluation. A minimum of 10 readings taken on at least 5 days, on treatment, and under conditions as close as possible to normal duty performance, will be necessary. Also, correlate blood pressure levels with other evidence of end organ change, such as eyeground, neurologic, etc. It should be appreciated that the member, while in a hospital status, may be engaged in activities which for adjudicative purposes, are considered as unrestricted and comparable to "outside of the hospital environment." For example, he is ambulatory to the mess hall, receives weekend passes, engages in ward housekeeping duties. The level of hypertension is not to be determined by an average of all readings, but rather the predominant readings are to be the basis for determination of the level of hypertension.

b. When a combination of 7007 or 7101 exists with 7005, rate the individual under the code that most accurately reflects the disability. The presence of stigmata of hypertensive disease does not warrant rating at a higher level, unless there is clinically significant secondary organ involvement, such as renal impairment. When significant changes are present, consider raising the rating one step.

c. Careful evaluation is necessary in making the frequently tenuous distinction between hypertensive heart disease and hypertensive vascular disease, especially for the minor degrees of severity. Generally, to justify the 30 percent rating for hypertensive heart disease, all of the criteria

mentioned in the VASRD for that rating shall be met. "Definite enlargement of the heart" means certain left venticular hypertrophy by ECG criteria, other than voltage alone, with allowance for T-wave changes which may reflect medication more than pressure. The X ray appearance of the heart is deceptive in concentric hypertrophy, but must be at least consistent with that diagnosis.

7015, 7016, 7017, 7110, Surgical Procedures Associated with AV Block, Heart Valve Replacement, Aneurisms. Convalescent ratings and ratings for specified periods of time following surgery do not apply. Rate on the basis of functional impairment. However, maximum ratings do apply.

7114-7117, Peripheral Vascular Disease.

a. Consider the symptoms and signs of each of these conditions as manifestations of a systemic disease entity, wherein bilateral involvement of extremities is natural and expected. They are distinct from local mechanisms affecting peripheral circulation (for example, varicose veins or phlebitis) in which bilateral involvement is more nearly equivalent to coincidental duplication of the disease, rather than its direct extension.

b. When manifestations are limited to the extremities, base the percentage of disability upon the most severely affected extremity. Use the rating of that extremity as the total percentage, unless each of the two or more extremities separately meets the requirements for evaluation in excess of 20 percent. In the latter case, 10 percent only will be added to (not combined with) the evaluation for the more severely affected extremity, except where the disease has resulted in amputation. When both upper and lower extremities are involved, apply the above procedure to the upper extremities, then to the lower extremities. These ratings will be combined if each group has a total rating in excess of 20 percent.

c. Apply the bilateral factor in all cases of an amputation of one extremity with any compensable degree of disability of the other extremity.

d. Do not combine a peripheral vascular disease rating of 20 percent or less with any other peripheral vascular disease rating.

e. Peripheral vascular disease rating chart for Codes 7114 through 7117:

One extremity involved:	Combined rating
20	20
40	40
60	60
Two extremities, not paired (one arm and one leg):	
20 and 20	20
40 and 20	40
40 and 40	60

60 and 20	60
60 and 40	80
60 and 60	80

Two paired extremities, (two arms or two legs):

20 and 20	20
40 and 20	40
40 and 40 (40+10)	50
60 and 20	60
60 and 40 (60+10)	70
60 and 60 (60+10)	70

Three extremities involved:

Paired extremities:	Other	Combined rating
20 and 20	20	20
20 and 20	40	40
20 and 20	60	60
40 and 20	20	40
40 and 20	40	60
40 and 20	60	80
40 and 40	20	50
40 and 40	40	70
40 and 40	60	80
60 and 40	20	70
60 and 40	40	80
60 and 40	60	90
60 and 60	20	70
60 and 60	40	80
60 and 60	60	90

All extremities involved: Paired extremities:	Paired extremities	Combined rating
20 and 20	20 and 20	20
40 and 20	20 and 20	40
60 and 20	20 and 20	60
40 and 40	20 and 20	50
40 and 20	40 and 20	60
40 and 40	40 and 20	70
40 and 40	40 and 40	80
60 and 40	40 and 40	90
60 and 40	60 and 40	90
60 and 60	40 and 40	90
60 and 60	60 and 40	90
60 and 60	60 and 60	90

7307, Gastritis, Hypertrophic. Identification by gastroscopic examination is required to establish this diagnosis.

7308, Postgastrectomy Syndrome. In evaluating and rating, take care to differentiate between nondisabling symptoms or minor discomfort which sometimes result from overindulgence, such as that experienced from overeating by a person without a gastrectomy, and discomfort symptomatic of a true postgastrectomy syndrome. Circulatory symptoms, even though mild or intermittent, or comparable symptoms such as a need for rest regularly after meals are indicative of disability which may be a basis for rating.

7328-7329, Intestinal Resections. Where portions of both intestines have been removed, rate under the code which is most representative of the clinical manifestations.

7332-7336, Ano-Rectal Conditions. Pilonidal cyst or sinus is primarily a disorder of ectoderm and shall be rated as a skin condition, except when an active process is present when it shall be rated by analogy to Code 5000.

7338, Hernia, Inguinal. If correctible, hernia is not ratable even though operation is refused, unless complicated by circumstances contra-indicating surgery, such as poor muscular or fascial structure, senility, psychosis, or serious disease which would interfere with healing or be aggravated by surgery, and the presence of other disabilities so serious or advanced that herniorrhaphy would serve no useful purpose.

7345, Hepatitis, Infectious.

a. Acute Infectious Hepatitis may be associated with "A", "B", or variant antigens and will usually resolve without residual impairment at the time liver function tests return to normal.

b. Chronic Persistent Hepatitis is a condition exhibiting minimally disturbed histology and liver function tests. It causes no, or minimal, persistent disability or progression and rating for residuals is seldom justified. However, placement on the TDRL may be appropriate when the clinical and laboratory course, particularly in the presence of persistent antigenemia, indicate a need for continued observation to rule out chronic active hepatitis. This problem is not always resolved by liver biopsy and both time and supporting evidence may be needed.

c. Chronic Active Hepatitis is a serious, frequently progressive condition that may or may not readily be associated with a demonstrable antigen. Since the course of the disease is often difficult to predict, placement on the TDRL may be appropriate prior to permanent disposition.

d. Other forms of inflammatory liver disease will be rated by analogy to infectious hepatitis or to other specific VASRD codes if applicable.

7347, Pancreatitis. Rate diabetes mellitus, if present, separately.

7500-7531, The Genitourinary System. Sterility and impotence are not ratable entities. Anatomical loss of procreative organs will not be rated.

7600 Gynecological Conditions. Anatomical loss of procreative organs will not be rated.

7524, 7617, 7618, 7619 Procreative Organs. Do not rate loss of procreative organs unless there are significant disqualifying residuals.

7703, Leukemia. If the use of chemotherapeutic agents is required, rate the same as leukemia requiring irradiation or transfusion.

7706, Splenectomy. Do not rate separately. Rate the residuals, if any, of the basic condition.

7709, Lymphogranulomatosis (Hodgkin's Disease). Cases in remission with minimal residuals may not be unfitting. Staging is the basis for clinical management of Hodgkin's Disease under treatment. Rating and disposition may be carried out according to the following guide:

Stage	(Stage A) Rating	(Stage B) Rating	Disposition (if unfit)
I	30	60	TDRL
II	30	60	TDRL
III	60	--	TDRL
III	--	100	TDRL
IV	100	100	TDRL

7714, Sickle-Cell Anemia. The VASRD rates all the manifestations of sickle-cell disease and its variants. Individuals with the more severe hemoglobinopathies are not acceptable for entry into the military services and appropriate policies concerning line of duty and service aggravation apply.

7801, Scars, Burns, Third Degree. These instructions supplement the criteria in the VASRD to permit a realistic rating of actual impairment of function:

a. Rate third degree burn scars, which cause limitation of function of underlying structure, by analogy to other codes which reflect the functional impairment.

b. Rate unsuccessful healed or grafted areas according to Code 7801. Footnotes to code 7801 in the VASRD apply.

c. Rate successfully grafted third degree burn areas as second degree burns under Code 7802. The footnote to code 7802 in the VASRD applies.

d. In calculating burn area, the following may be of assistance:

Average 70 kgm (150 lb) male body surface = $1.7M^2$
2636 in^2 = 18.3 ft^2
1 $meter^2$ = 39.37 inches
1 $meter^2$ = 1550.6 $inches^2$

Also use the diagram and Conversion Table in Plate IV on page 5-1-21 of this attachment.

7802, Scars, Burns, Second Degree. VA Code 7802 limits rating to 10 percent of second degree burns affecting an area or areas approximately one square foot. When there are widely separated areas and each area is approximately one square foot or more, 10 percent may be assigned for each scar.

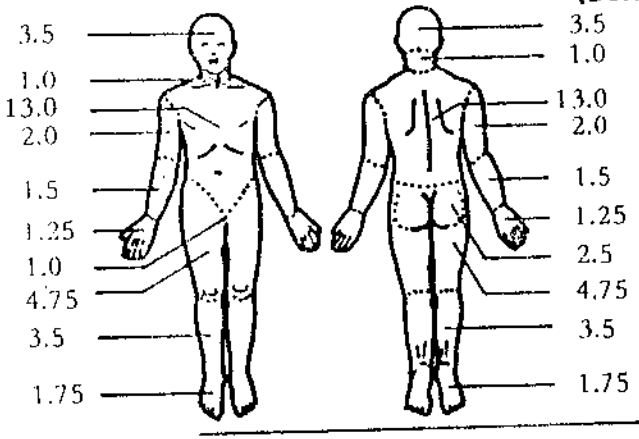
7804, Scars, Superficial, Tender and Painful. This rating of 10 percent may be assigned whenever the requirements are met for the area of involvement even though the rating may exceed the amputation rating, but only if the amputation rating is 0 percent. Do not combine a rating assigned for a scar under these circumstances, with any other rating for disability which involves the same area or digit.

7809, Lupus Erythematosus. This applies to the localized (discoid) type involving only the skin. Rate systemic lupus erythematosus, and the other so-called collagen diseases, under VA Code 6350.

7913, Diabetes Mellitus.

a. The severity of each case is to be individualized, taking into consideration complications, age of the member, and ease or difficulty in the control of blood sugar levels. By established practice, "large" insulin dosage has come to be regarded as "more than 40 units daily."

* ESTIMATION OF BODY SURFACE AREA
(Berkow)



The diagram at the left provides the basic scheme for estimation of body surface area The table below is for convenient conversion to actual surface area measurement, based upon application to the average 70 kgm. man with a body surface area of 2,636 sq. in. (18.3 sq. ft.).

Body Surface	Percent of body surface	Area	
		Square Inches	Square Feet
Anterior or posterior head	3.5	92	0.64
Anterior or posterior neck	1.0	26	.18
Anterior or posterior trunk	13.0	343	2.38
Anterior or posterior arm	2.0	53	.37
Anterior or posterior forearm	1.5	40	.27
Dorsal or palmar hand & fingers	1.25	33	.23
Buttock	2.5	66	.46
Genitalis	1.0	26	.18
Anterior or posterior thigh	4.75	125	.87
Anterior or posterior calf	3.5	92	.64
Dorsal foot or sole, incl toes	1.75	46	.32

PLATE IV

This may be used as a general guide, but not as the determining factor in assigning percentage ratings. It is quite possible for a member whose average insulin dosage is 30 to 35 units, but with unstable control requiring frequent hospital observation to be more disabled in fact than one on 45 units with steady blood sugar levels on a regimen of normal activity.

b. Care must be taken that ratings reflect the severity of the diabetes, as such, and that undue importance is not given to early or questionable complications. This is particularly true in considering ratings of 60 percent or above. In most instances, a lower rating shall be given with complications, such as vascular insufficiency, visual defects, pruritis and neuropathies, rated separately. The presence of early or questionable complications in otherwise less than severe diabetes mellitus does not automatically warrant a higher rating.

8000-8046, Organic Diseases of the Central Nervous System. Careful correlation of the footnote under Code 8046 in the VASRD with the italicized introduction to Codes 8000-8046 should enable boards to select the proper rating approach. In some of these conditions, the minimum rating may be awarded on the basis of the diagnosis alone, whether or not there are residuals. In others, the minimum rating may be awarded only if there are residuals. If the latter have neither residuals capable of objective verification nor subjective residuals which are credible, consistent with the disease, and are not more likely attributable to other diseases, the condition should be ratable at 0 percent.

8007-8009, Brain Vessels. Do not apply the six month convalescent rating. In many of these cases, the danger of disastrous recurrences justifies a rating of residuals sufficiently liberal to provide temporary retirement and subsequent reevaluations.

8017, 8018, 8023-8025, Degenerative Disorders of the Central Nervous System. Combined ratings may be assigned under these codes with the bilateral factor added.

8205-8412, Diseases of the Cranial Nerves. Notice the provision for combined ratings under these codes when there is bilateral involvement, but without addition of a bilateral factor.

8510-8730, Diseases of the Peripheral Nerves. In cases where the rating is made on residuals, observe the general principle of adjudicating on the basis of impairment of function rather than on anatomical diagnosis. For example, a complete paralysis of the circumflex nerve of the major extremity carries a 50-percent rating under VA Code 8518. In many cases, however, abduction of the arm when the circumflex nerve is paralyzed occurs by virtue of other muscles taking over the function of the paralyzed muscles. To warrant the 50-percent rating, the member's residual loss of function must actually include all the defects listed under VA Code 8518. When other muscles have, in fact, taken over the function of the circumflex-innervated deltoid, the residual loss of function is properly ratable under VA Code 5201, Limitation of Arm Motion or 5303, muscle injury, Group III, whichever best reflects the predominant impairment. Rate cases of paralysis of the common peroneal nerve with foot drop, VA Code 8521, in terms of loss of function, rather than topographically. Amputation below the knee, VA Code 5165, is ratable at 40 percent. In order to warrant a similar rating for peroneal palsies, there must be sufficiently

severe symptoms, such as trophic and circulatory changes and other concomitants to make the functional impairment reasonably equivalent to actual loss of the foot.

8599, Scalenus Anticus Syndrome. Rate this syndrome by analogy with the lower radicular group (VA Code 8512), or less commonly, with either erythromelalgia (VA Code 7119) or Raynaud's Disease (VA Code 7117), depending upon predominant symptoms and overall functional impairment.

8910-8914, Epilepsies. Attacks following omission of prescribed medication or the ingestion of alcoholic beverages are not indicative of the controllability of the disease, and shall not be included in the determination of the disability percentage.

9200-9210, Psychoses. Loss of function, reflected in impaired social and industrial adaptability, is the principal criterion for establishing the level of impairment resulting from mental illness. Specifically included are those disorders manifesting disturbances of perception, thinking, emotional control and behavior sufficiently severe to limit capacity to perform military duties or otherwise earn a living. Reference should be made to member's social and industrial adjustment prior to diagnosed psychiatric illness as a baseline for assessing loss of function. All pertinent data provided by the medical board, TDRL examining physicians, and other competent medical authorities must be carefully reviewed before arriving at a final determination. When this material is conflicting, the problem issues should be resolved before a rating decision is made, and the action taken to resolve them clearly shown in the record of preceedings. It is often difficult to properly assess the degree of permanent impairment resulting from a psychotic process during the weeks immediately following an acute episode. On occasion, a member's period of intensive in-hospital treatment has not been completed at the time of the initial medical board action. With the passage of time, the clinical picture tends to stabilize and the degree of permanent impairment may then be more accurately estimated. For purposes of assessment of impairment resulting from most schizophrenias and the major affective psychoses placement on the TDRL is warranted.

a. Complete. Service members receiving this rating on either a temporary or permanent basis will most often be declared incompetent and if not transferred to a Veterans Administration Hospital, be discharged to the care of a relative or guardian. Infrequently a Service member, though not declared incompetent, may still be entitled to this rating.

b. Severe. The severely impaired category includes service members discharged to their own care or the care of relatives when manifesting marked degrees of mental deterioration, emotional impairment, permanent disintegration and poor judgment that does not completely impair social and industrial adaptability.

c. Considerable. This category should be reserved for service members who require frequent outpatient treatment and medication to maintain employment and avoid rehospitalization, and who despite treatment, exhibit extensive job instability and experience periodic relapses requiring hospitalization.

d. Definite. The service member requires occasional outpatient treatment and medication to maintain employment and avoid rehospitalization, and may do well on this treatment program, though he or she may experience some job instability and often the illness may interfere with his or her advancement.

e. Slight. Appropriate to service members after experiencing psychotic episodes with or without residuals when none of the foregoing are applicable.

f. Full Remission. This category will be used when a psychosis is in full remission and has had little permanent effect on the service member's personality. The member will not be in need of medication, followup, or medical supervision. Rate as "0 percent."