Ancillary Sep 1968 1332.1

DEPARTMENT OF DEFENSE
DIRECTIVES SYSTEM TRANSMITTAL

NUMBER	DATE	DISTRIBUTION
1332.18 - Ch 1	July 30, 1964	1300

ATTACHMENTS

Pages 5 and 6 of DoD Directive 1332.18, Dec 6, 62.

INSTRUCTIONS FOR RECIPIENTS

The following page changes to DoD Directive 1332.18, "Uniform Implementation of Laws Relating to Separation from the Military Departments by Reason of Physical Disability," dated December 6, 1962, have been authorized:

PAGE CHANGES

Remove: Pages 5 and 6
Insert: Attached replacement pages.

Change appears on Page 5 and is indicated by marginal asterisks.

IMPLEMENTATION

Two (2) copies of revised implementing documents will be forwarded to the Assistant Secretary of Defense (Manpower) within sixty (60) days.

MAURICE W. ROCHE
Administrative Secretary

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

FORM 1 MAR 62 106-1 PREVIOUS EDITIONS ARE OBSOLETE

C. Use of the Veterans Administration Schedule for Rating Disabilities.

1. The VA Schedule for Rating Disabilities does not relate to findings of unfitness for military duty. While a member may have physical disabilities ratable in accordance with the VA Schedule, such disabilities per se, regardless of degree, do not render him unfit by reason of physical disability within the meaning of paragraph VI.A. After a member's unfitness for military service has been established, however, the VA Schedule will be followed in rating disabilities.

2. Annex II clarifies certain points of the VA Schedule for Rating Disabilities and is prescribed for uniform use by the Military Departments.

3. In those cases in which the various evaluative agencies consider that the VA ratings, due to the circumstances of a particular case or situation in question, are excessive or inadequate or cannot be applied to members of the Military Departments and which are not covered by instructions contained in Annex II, appropriate ratings will be assigned by the Secretary of the Military Department concerned. In referring such cases to the Secretary of the Military Department concerned, the referring evaluative agency will include an explanation of why, in its opinion, the VA rating, if ordinarily applicable, is excessive or inadequate, or why it cannot be applied. Subsequent to final disposition, the case will be forwarded to the Assistant Secretary of Defense (Manpower) for review. This office will establish uniform criteria for disposition of similar cases in the future.

D. Length of Hospitalization.

It is not within the mission of the Military Departments to provide definitive medical care to members on active duty requiring prolonged hospitalization who are unlikely to return to duty. The time at which a member should be processed for disability separation must be determined on an individual basis, taking into consideration the interest of both the Government and the member. * However, members will neither be retained nor separated solely for the purpose of increasing their retirement or separation benefits. Members who are unfit and not likely to return to duty will be processed for disability separation when it is determined that they have attained "maximum hospital benefit". This is defined as that point during hospitalization when it can be anticipated that additional hospitalization will not contribute to any substantial recovery. *

#First amendment (Ch 1, 7/30/64)

E. Temporary Disability Retired List (TDRL).

1. Use of the Temporary Disability Retired List. The TDRL shall be used in the nature of a "pending list" for members unfit because of physical disability with conditions which may be permanently disabling and who meet the other requirements of Title 10 USC, Chapter 61, for disability retirement. The TDRL provides a safeguard for the Government against permanently retiring a member who subsequently fully recovers, or nearly so, from the disability which caused him to be unfit because of physical disability. Conversely the TDRL safeguards the member from being permanently retired with a condition which may reasonably be expected to develop into a more serious permanent disability. Therefore members whose disabilities have not stabilized to a degree where permanent disposition is warranted will be placed on the TDRL if otherwise qualified for retirement under the provisions of 10 U. S. Code, Chapter 61.

2. Use of Other Medical Facilities and Reports. To the maximum extent feasible, the Military Departments may utilize reports of medical examinations from, and the medical facilities of, the various armed services, VA, and other Government agencies for required periodic physical examinations of members on the TDRL.

3. Examination Prior to Permanent Retirement or Separation with Pay. Members on the TDRL shall not be entitled to permanent retirement or separation with severance pay without a current medical examination acceptable to the appropriate Departmental Secretary unless just cause is shown for failure to report for examination.

4. Members on the TDRL Imprisoned by Civil Authorities. A report of medical examination will be requested from the appropriate authorities in those cases in which a member is imprisoned by civil authorities. In the event no report is received, or an inadequate report is received, disposition of the case shall be made in accordance with Paragraph VII.E.3 or 5.

5. Failure to Submit to Examination. If a member on the TDRL refuses, or otherwise fails to report for the required periodic physical examination, his eligibility to receive disability retired pay will be terminated. If he later reports, his eligibility to

S/S 9 Sep 68

December 6, 1962
NUMBER 1332.18

ASD(M)

Department of Defense Directive

SUBJECT Uniform Implementation of Laws Relating to Separation from the Military Departments by Reason of Physical Disability

References: (a) 10 United States Code, Chapter 61, and laws relating thereto
(b) DOD Directive 1332.11, "Application of Accepted Medical Principles to Determinations of Issue Involved in Application to Subsections (a) and (b), Title IV, Public Law 351, 81st Congress," dated 6 January 1954 (hereby cancelled)
(c) DOD Directive 1332.5, "Uniform Use of the Temporary Disability Retired List," dated 20 March 1952 (hereby cancelled)

I. PURPOSE

This Directive establishes policies to insure uniform administration of laws relating to separation from the Military Departments by reason of physical disability. Policies, principles, and procedures designed to insure that military personnel receive uniform disposition under 10 United States Code, Chapter 61 and laws relating thereto, are hereby established.

II. CANCELLATION

References (b) and (c) are cancelled on the effective date of this Directive.

III. APPLICABILITY

The policies set forth herein are applicable to the Military Departments.

IV. BASIC CONCEPTS

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 the maximum utilization of available manpower. With

the enactment of Title IV of the Career Compensation Act of 1949 (now codified in 10 United States Code (Chapter 61)) a single law was made applicable to all the services, for both officer and enlisted personnel. To become eligible for retirement or separation under this law, a primary requisite is that the member be unfit because of physical disability to perform military duty. While a member may have medical conditions or physical defects ratable under the Veterans Administration Schedule for Rating Disabilities, he will not be separated or retired because of those conditions or defects unless they render him unfit because of physical disability under the standard defined in Paragraph VI.A. Implementation by the Military Departments of disability laws must not deviate from these basic concepts.

V. REQUIRED ACTION

A. The Secretaries of the Military Departments are directed to implement uniformly those laws relating to retirement or separation of military personnel by reason of physical disability. Recognizing that there are basic organizational and procedural differences between the Military Departments, this directive does not intend to establish uniform procedures where procedures in effect do not result in decidedly different disposition of members among the services. Policies established herein primarily concern those areas in which it has been found that different interpretation, policies, and procedures result in a member of one service being granted, or denied, benefits decidedly different from those of another service under similar conditions.

B. The Assistant Secretary of Defense (Manpower) will insure uniform implementation of the disability separation laws within each military department by periodically reviewing their implementing regulations and procedures. He may accomplish this action through the use of temporary ad hoc working groups, as required, having representation from his office and each of the military departments. Such working groups will be established for a specific period of time, normally not more than 90 days, and will be assigned a specific task to be performed.

VI. DEFINITIONS

A. Unfit because of physical disability. A member is unfit because of physical disability when he is unable to perform the duties of his office, rank, grade or rating in such a manner as to reasonably fulfill the purpose of his employment on active duty.

B. Impairment of Function. Any lessening or weakening of the capacity of the body, or any of its parts, to perform that which is considered by accepted medical principles to be the normal activity in the bodily economy.

C. Manifest Impairment. Impairment which is manifested by signs and/or symptoms.

D. Latent Impairment. Impairment which is not manifested by current signs and/or symptoms, but which is of such a nature that there is reasonable certainty, according to accepted medical principles, that signs and/or symptoms will appear within a reasonable period of time.

E. Physical Disability. Any manifest or latent impairment of function 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. Physical disability is not synonymous with unfit because of physical disability for military duty. The term "physical disability" includes mental disease but not such inherent defects as behavior disorders, personality disorders, and primary mental deficiency.

F. Accepted Medical Principles. Fundamental deductions consistent with medical facts and based upon the observation of a large number of cases. To constitute accepted medical principles, the deductions must be so reasonable and logical as to create a virtual certainty that they are correct.

G. Optimum Hospital Improvement (for disposition purposes). The point during hospitalization when, following administration of essential initial medical treatment, the patient's medical fitness for further active service can be determined, and it is considered probable that further treatment for a reasonable period will not result in material change in the patient's condition which would alter his ultimate type of disposition or amount of separation benefits.

VII. POLICIES

A. Standards of Unfitness by Reason of Physical Disability.

1. Normally, members with conditions listed in Annex I will be considered unfit by reason of physical disability. However, this Annex is established to provide general guidelines and is not to be taken as a mandate to the effect that possession of one or more

of the listed conditions means automatic retirement or separation from the service. Each case must be decided upon the relevant facts and a determination of fitness or unfitness must be made dependent upon the ability of the member to perform the duties of his office, grade, rank or rating in such a manner as to reasonably fulfill the purpose of his employment on active duty.

2. The various medical conditions and physical defects which may render a member unfit for military duty by reason of physical disability are not all listed in this Annex. Under such procedures as may be adopted, it shall be the responsibility of the Assistant Secretary of Defense (Manpower) to amend and revise Annex I with the view toward compilation of a more complete list of disabilities which normally render members unfit by reason of physical disability within the meaning of paragraph VI.A. In this connection it should be noted that a major objective in the preparation and use of such a list is to achieve uniform disposition of cases arising under the law.

3. A member will not be declared unfit for military service because of disabilities which were known to exist at time of his acceptance for military service, and which have remained essentially the same in degree since acceptance and have not interfered with his performance of effective military service.

B. Application of Accepted Medical Principles.

The fact that a member is determined to be unfit for duty while on active duty is not sufficient to entitle him to disability retirement or severance pay. There must be a determination that this unfitness is due to a disability incurred while entitled to receive basic pay. The fact that such member was accepted physically for active duty is not conclusive that the disability was incurred after such acceptance. It is one piece of evidence to be considered with all of the medical evidence. In addition to and in conjunction with all pertinent medical evidence, due consideration and weight must be given to accepted medical principles authenticated by medical authorities in arriving at a final determination. It is not proper nor shall the practice be followed of excluding such accepted medical principles in making the aforesaid determination even in cases where there is no other evidence that the disability existed prior to entrance upon active duty. In applying the policies with respect to aggravation, due consideration will be given to the length of service particularly where the period is in excess of 8 years of active duty.

C. Use of the Veterans Administration Schedule for Rating Disabilities.

1. The VA Schedule for Rating Disabilities does not relate to findings of unfitness for military duty. While a member may have physical disabilities ratable in accordance with the VA Schedule, such disabilities per se, regardless of degree, do not render him unfit by reason of physical disability within the meaning of paragraph VI.A. After a member's unfitness for military service has been established, however, the VA Schedule will be followed in rating disabilities.

2. Annex II clarifies certain points of the VA Schedule for Rating Disabilities and is prescribed for uniform use by the Military Departments.

3. In those cases in which the various evaluative agencies consider that the VA ratings, due to the circumstances of a particular case or situation in question, are excessive or inadequate or cannot be applied to members of the Military Departments and which are not covered by instructions contained in Annex II, appropriate ratings will be assigned by the Secretary of the Military Department concerned. In referring such cases to the Secretary of the Military Department concerned, the referring evaluative agency will include an explanation of why, in its opinion, the VA rating, if ordinarily applicable, is excessive or inadequate, or why it cannot be applied. Subsequent to final disposition, the case will be forwarded to the Assistant Secretary of Defense (Manpower) for review. This office will establish uniform criteria for disposition of similar cases in the future.

D. Length of Hospitalization.

It is not within the mission of the Military Departments to provide definitive medical care to members on active duty requiring prolonged hospitalization who are unlikely to return to duty. The time at which a member should be processed for disability separation must be determined on an individual basis, taking into consideration the interest of both the Government and the member. Members will not, however, be retained solely for the purpose of increasing their retirement or separation benefits. Members who are unfit, and not likely to return to duty, will be processed for disability separation upon receiving optimum military hospital improvement.

E. Temporary Disability Retired List (TDRL).

1. Use of the Temporary Disability Retired List. The TDRL shall be used in the nature of a "pending list" for members unfit because of physical disability with conditions which may be permanently disabling and who meet the other requirements of Title 10 USC, Chapter 61, for disability retirement. The TDRL provides a safeguard for the Government against permanently retiring a member who subsequently fully recovers, or nearly so, from the disability which caused him to be unfit because of physical disability. Conversely the TDRL safeguards the member from being permanently retired with a condition which may reasonably be expected to develop into a more serious permanent disability. Therefore members whose disabilities have not stabilized to a degree where permanent disposition is warranted will be placed on the TDRL if otherwise qualified for retirement under the provisions of 10 U. S. Code, Chapter 61.

2. Use of Other Medical Facilities and Reports. To the maximum extent feasible, the Military Departments may utilize reports of medical examinations from, and the medical facilities of, the various armed services, VA, and other Government agencies for required periodic physical examinations of members on the TDRL.

3. Examination Prior to Permanent Retirement or Separation with Pay. Members on the TDRL shall not be entitled to permanent retirement or separation with severance pay without a current medical examination acceptable to the appropriate Departmental Secretary unless just cause is shown for failure to report for examination.

4. Members on the TDRL Imprisoned by Civil Authorities. A report of medical examination will be requested from the appropriate authorities in those cases in which a member is imprisoned by civil authorities. In the event no report is received, or an inadequate report is received, disposition of the case shall be made in accordance with Paragraph VII.E.3 or 5.

5. Failure to Submit to Examination. If a member on the TDRL refuses, or otherwise fails to report for the required periodic physical examination, his eligibility to receive disability retired pay will be terminated. If he later reports, his eligibility to

receive retired pay will be resumed, retroactive to the date he actually undergoes the examination. If just cause for failure to report on time and as required is shown subsequent to the time of such late reporting, his eligibility to receive retired pay will be made retroactive, but not to exceed one year. If he does not undergo a periodic physical examination after his eligibility to receive disability retired pay has been terminated, he 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. Code, Chapter 61, and laws relating thereto, unless evidence shows just cause for failure to be examined.

F. <u>Continuance on Active Duty of Members Unfit Because of Physical Disability for Military Duty</u>.

1. With the consent of the member, particularly one with over 18 years active service, the appropriate Secretary may defer the disposition of a member who, although unfit because of physical disability, can still serve with appropriate assignment limitations.

2. Members continued on active duty in accordance with the provisions of this section must be unfit because of physical disability with a basically stabilized condition, or one in which accepted medical principles indicate slow progression. They must be able to maintain themselves in a normal military or naval environment, without adversely effecting their health, or requiring an inordinate amount of medical care.

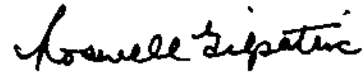
3. Members who are unfit because of physical disability will not be continued on active duty solely to increase benefits, nor will they be continued unless their employment is justified as being of value to the military service. A member continued under these provisions will be re-evaluated periodically to assure that further continuance, or conversely, separation, is consonant with the best interests of the Government and the member. Unless the disqualifying condition has progressed to a point where the member becomes unable to perform duty with limitations, the member remains liable to complete any service obligation he has incurred.

VIII. ADMINISTRATIVE PRACTICES

To insure expeditious processing of cases arising under 10 U. S. Code, Chapter 61, the Secretaries of each Department shall review existing procedural practices with the view toward eliminating any duplication of effort. In particular, practices and procedures contributing to delays in disposition shall be discontinued in any cases in which the rights of the party or the interest of the Government would not be jeopardized by such discontinuance.

IX. IMPLEMENTATION

This Directive will become effective upon date of issuance. Two copies of implementing regulations of the Military Departments shall be provided to the Assistant Secretary of Defense (Manpower), within 60 days of the date of this Directive.



Deputy Secretary of Defense

Inclosures - 2
1. ANNEX I
2. ANNEX II

MEDICAL CONDITIONS AND PHYSICAL DEFECTS WHICH NORMALLY RENDER A MEMBER MEDICALLY UNFIT FOR FURTHER MILITARY DUTY

Section I. ABDOMEN AND GASTROINTESTINAL SYSTEM

1. ABDOMINAL AND GASTROINTESTINAL DEFECTS AND DISEASES

a. Achalasia (Cardiospasm): Dysphagia not controlled by dilatation, with continuous discomfort, or inability to maintain weight.

b. Amebic abscess residuals: Persistent abnormal liver function tests and failure to maintain weight and normal vigor under appropriate treatment.

c. Biliary dyskinesia: Frequent abdominal pain not relieved by simple medication, or with periodic jaundice.

d. Cirrhosis of the liver: Recurrent jaundice, ascites, or demonstrable esophageal varices or history of bleeding therefrom.

e. Gastritis: Severe, chronic hypertrophic gastritis with repeated symptomatology and hospitalization and confirmed by gastroscopic examination.

f. Hepatitis, chronic: When after a reasonable time (1 to 2 years) following the acute stage, symptoms persist, and there is objective evidence of impairment of liver function.

g. Hernia:

(1) Hiatus hernia: Severe symptoms not relieved by dietary or medical therapy or recurrent bleeding in spite of prescribed treatment.

(2) Other: If operative repair is contraindicated for medical reasons or when not amenable to surgical repair.

h. Ileitis, regional: Confirmed diagnosis thereof.

i. Pancreatitis, chronic: Frequent abdominal pain of a severe nature, steatorrhea or disturbance of glucose metabolism requiring insulin.

j. Peritoneal adhesions: Recurrent episodes of intestinal obstruction characterized by abdominal colicky pain, vomiting, and intractable constipation requiring frequent admissions to the hospital.

k. Ulcer, peptic; duodenal and gastric: Frequent recurrence of symptoms (pain, vomiting, or bleeding, etc.) requiring repeated hospitalization in spite of good medical management and supported by laboratory and x-ray evidence.

l. Ulcerative colitis: Except when responding well to treatment.

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.

2. GASTROINTESTINAL AND ABDOMINAL SURGERY

a. Colectomy partial: When moderate symptoms of diarrhea remain or if complicated by colostomy.

b. Colostomy: Per se, when permanent.

c. Enterostomy: If permanent.

d. Gastrostomy: Permanent.

e. Ileostomy: Permanent.

f. Pancreatectomy.

g. Pancreaticoduodenostomy and pancreaticogastrostomy: Moderate symptoms of digestive disturbance or requiring insulin.

h. Pancreaticojejunostomy: If for cancer in the pancreas or with moderate symptoms of digestive disturbance and requiring insulin.

i. Proctectomy.

j. Proctopexy, proctoplasty, proctorrhaphy, and proctotomy: If fecal incontinence remains after an appropriate treatment period.

Section II. BLOOD AND BLOOD-FORMING TISSUE DISEASES

1. BLOOD AND BLOOD-FORMING TISSUE DISEASES
When response to therapy is unsatisfactory, or when therapy is such as to require prolonged intensive medical supervision:

a. Anemia.

b. Hemolytic crisis, chronic and symptomatic.

c. Leukopenia, chronic and not responsive to therapy.

d. Polycythemia.

e. Purpura and other bleeding diseases.

f. Thrombo-embolic disease.

g. Neoplastic conditions of the hemic and lymphatic systems.

Section III. EARS

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 or hospitalization.

b. Mastoiditis, chronic, following mastoidectomy: Constant drainage from the mastoid cavity which is resistant to treatment, requiring frequent dispensary care or hospitalization.

c. Meniere's syndrome: Severe recurring attacks requiring repeated hospitalization.

d. Otitis media: Moderate, chronic, suppurative, resistant to treatment, and necessitating frequent hospitalization.

Section IV. ENDOCRINE AND METABOLIC DISORDERS

1. ENDOCRINE AND METABOLIC DISORDERS

a. Acromegaly: With severe functional impairment.

b. Adrenal hyperfunction: Which does not respond to therapy satisfactorily or therapy presents serious problems in management.

c. Diabetes insipidus: Unless mild and patient shows good response to treatment.

d. Diabetes mellitus: When proven to require hypoglycemic drugs in addition to restrictive diet for control.

e. Goiter: With symptoms of obstruction to breathing with increased activity, unless correctible.

f. Gout: Advanced cases with frequent acute exacerbations requiring repeated hospitalization and severe bone, joint, or kidney damage.

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

h. Hyperthyroidism: Severe symptoms of hyperthyroidism, with or without evidence of goiter, which do not respond to treatment.

i. Hypofunction, adrenal cortex: Requiring medication for control.

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

k. Hypothyroidism: With objective evidence and severe symptoms not controlled by medication.

l. Pituitary basophilism.

Section V. EXTREMITIES

1. UPPER EXTREMITIES

a. Amputations: Amputation of hand or of fingers resulting in a loss of function of a hand.

b. Joint ranges of motion:

Joint ranges of motion which do not equal or exceed the measurements listed below:

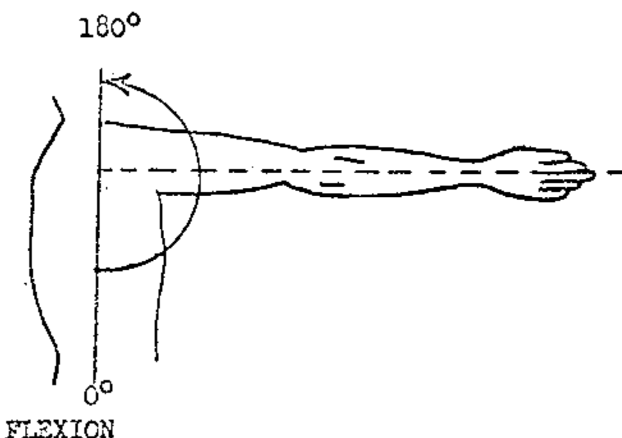
(1) Shoulder

(a) Forward elevation to 90°.
(b) Abduction to 90°.

(2) Elbow

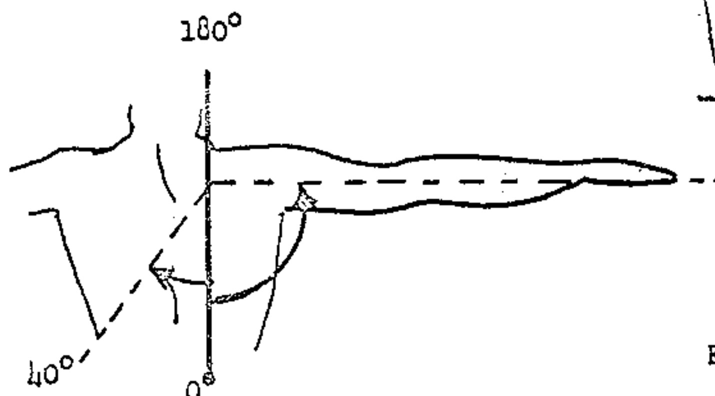
(a) Flexion to 100°.
(b) Extension to 60°.

The Shoulder



FLEXION

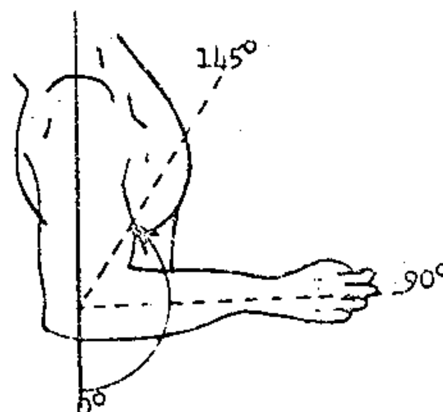
a Position - Standing, sitting, or supine with elbow extended. Palm facing medially. Measure from lateral aspect of body.
b Stationary arm - Along mid-axillary line of trunk.
c Moving arm - Along lateral midline of humerus.



ADDUCTION AND ABDUCTION

a Position - Standing or sitting
b Stationary arm - Parallel to spine but at lateral aspect of body
c Moving arm - Parallel to midline of humerus toward olecranon process.

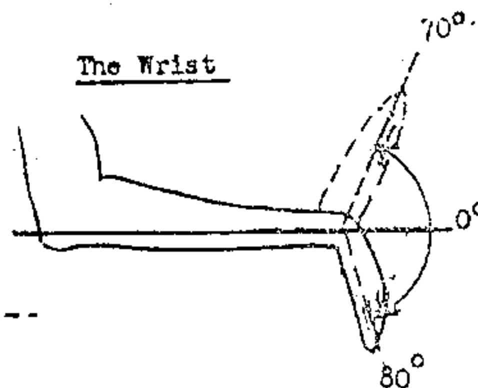
The Elbow



EXTENTION AND FLEXION

a Position - Standing, sitting, or supine. Forearm in mid-position between supination and pronation.
b Stationary arm - Along mid-line of humerus.
c Moving arm - Along midline of forsal aspect of forearm.

The Wrist



EXTENTION AND FLEXION

a Position - sitting or standing with elbow flexed and forearm in pronation.
b Stationary arm - along lateral midline of forearm.
c Moving arm - Parallel to 5th metacarpal.

2. LOWER EXTREMITIES

a. Feet:

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

(2) Pes planus: Symptomatic, severe with pronation on weight bearing which prevents the wearing of a military shoe, or when associated with vascular changes.

(3) Talipes cavus: Moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, and which prevents the wearing of a military shoe.

b. Internal derangement of the knee: Residual instability following remedial measures, if more than moderate in degree.

c. Joint ranges of motion:

Joint ranges of motion which do not equal or exceed the measurements listed below except when the limitation is temporary because of a disease, injury or remediable condition:.

(1) Hip:

(a) Flexion to 90°.
(b) Extension to 0°.

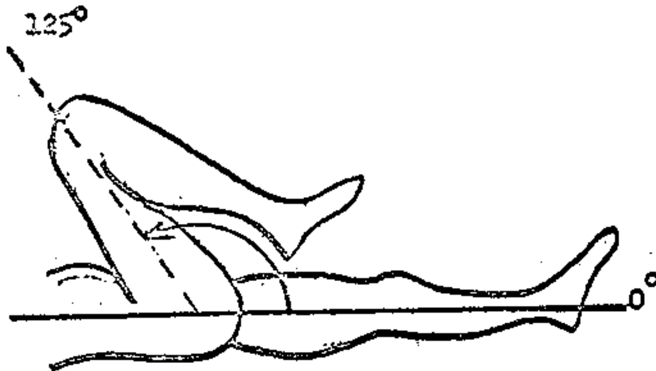
(2) Knee:

(a) Extension to 15°.
(b) Flexion to 90°.

d. Shortening of an extremity which exceeds two (2) inches.

JOINT MOTION MEASUREMENT

The Hip



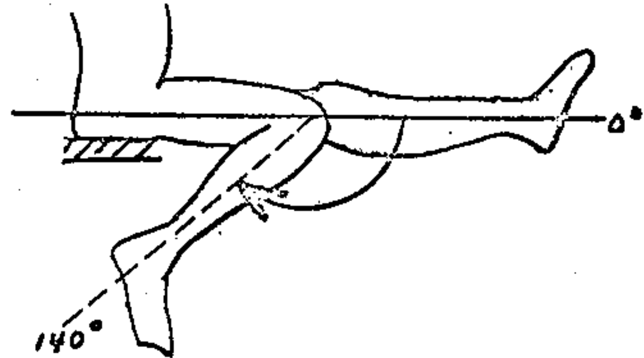
FLEXION

a Position - Supine, knee flexed; opposite knee and hip straight
b Stationary arm - Parallel to long axis of trunk.
c Moving arm - In line with lateral midline of femur.

EXTENTION

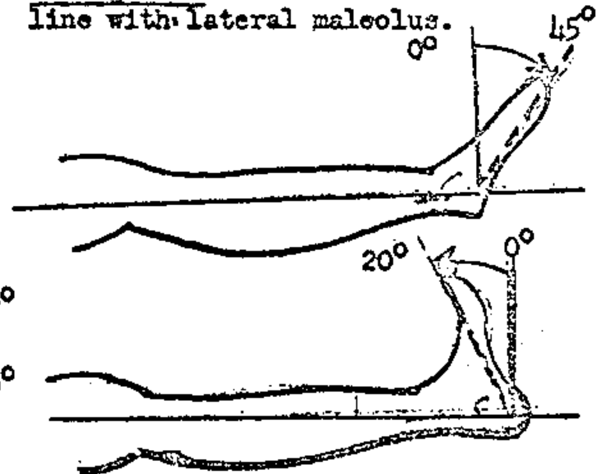
a Position - Prone
b Stationary arm - Parallel to long axis of trunk.
c Moving arm - In line with lateral midline of femur.

The Knee



EXTENTION AND FLEXION

a Position - Sitting with knee flexed.
b Stationary arm - Parallel to femur on a line from the lateral condyle to greater trochanter.
c Moving arm - Parallel to fibula on line with lateral maleolus.



PLANTAR FLEXION AND DORSI FLEXION

a Position - Supine with heel over edge of table and knee extended.
b Stationary arm - Parallel to fibula.
c Moving arm - In line with the lateral edge of the heel and the head of the 5th metatarsal.

3. MISCELLANEOUS

a. Arthritis:

(1) Arthritis, infectious or traumatic (not including arthritis due to gonococcic infection or tuberculous arthritis) associated with persistent pain and marked loss of function with objective x-ray evidence, and documented history of recurrent incapacity for prolonged periods.

(2) Osteoarthritis: Severe symptoms associated with impairment of function, supported by x-ray evidence and documented history of recurrent incapacity for prolonged periods.

(3) Rheumatoid arthritis or rheumatoid myositis: Substantiated history of frequent incapacitating episodes and currently supported by objective and subjective findings.

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

c. Fractures:

(1) Malunion of fractures: With marked deformity and severe loss of function.

(2) Nonunion of fractures: When permanent with severe loss of function.

d. Joints:

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

(2) Contracture of joint: Marked loss of function and not remediable by surgery.

(3) Loose bodies within a joint: Marked functional impairment and complicated by arthritis to such a degree as to preclude favorable results of treatment or not remediable by surgery.

e. Myotonia congenita: Confirmed.

f. Osteitis deformans (Paget's disease): With resultant deformities or symptoms severely interfering with function.

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

Section VI. EYES AND VISION

1. EYES

a. Aphakia, bilateral.

b. Chronic congestive glaucoma: Not amenable to treatment.

c. Diseases and infections of the eye: When chronic, moderately symptomatic, progressive, and resistant to treatment.

d. Retina, detachment of:

(1) Unilateral:

(a) When the detachment is the result of documented organic progressive disease or new growth, regardless of the condition of the better eye, or with diplopia.

(2) Bilateral: 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: Not correctible by surgery, and which is severe, constant, and in zone less than 20° from the primary position.

c. Night blindness: Of such a degree that the individual requires assistance in any travel at night.

d. Visual field: Bilateral concentric constriction to less than 20°.

Section VII. GENITOURINARY SYSTEM

1. GENITOURINARY SYSTEM AND GYN

a. Endometriosis: Symptomatic and incapacitating to a degree which necessitates frequent hospitalization.

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

c. Kidney:

(1) Calculus in kidney: Bilateral, with recurrent renal colic and not responsive to treatment.

(2) Congenital anomaly including polycystic kidney, not responsive to treatment and resulting in frequent or recurrent infections, or when there is evidence of obstructive uropathy.

(3) Hydronephrosis: Moderate, bilateral, and causing continuous or frequent symptoms.

(4) Perirenal abscess, residual(s) of a severe degree.

(5) Pyelonephritis or pyelitis: Glomerulonephritis, nephritis and nephrosis chronic, which has not responded to treatment, with moderate impairment to renal function or with evidence of hypertension, eye ground changes, or cardiac abnormalities.

(6) Pyonephrosis: Not responding to treatment.

d. Stricture of the urethra or ureter: With recurrent episodes of acute urinary retention.

e. Cystectomy.

f. Cystoplasty: Reconstruction is unsatisfactory or infection persists.

g. Nephrectomy: When after treatment there is infection or pathology in remaining kidney.

h. Nephrostomy, pyelostomy, or ureterotomy: Permanent.

i. Ureterocolostomy.

j. Ureterocystostomy, ureterosigmoidostomy: When both ureters were noted to be markedly dilated with irreversible changes.

k. Urethrostomy: Complete amputation of the penis when a satisfactory urethra cannot be restored.

Section VIII. HEAD AND NECK

1. HEAD

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

2. NECK

a. Torticollis (wryneck): Severe fixed deformity with servical scoliosis, flattening of the head and face, and loss of cervical mobility.

Section IX. HEART AND VASCULAR SYSTEM

1. HEART

a. Arteriosclerotic heart disease: Associated with myocardial insufficiency (congestive heart failure), repeated anginal attacks, or objective evidence of myocardial infarction.

b. Auricular fibrillation and auricular flutter: When associated with organic heart disease.

c. Endocarditis: Bacterial endocarditis resulting in myocardial insufficiency.

d. Heart block: Associated with syncope (Adams-Stokes).

e. Paroxysmal tachycardia, ventricular or atrial: Associated with organic heart disease or if not adequately controlled by therapy.

f. Pericarditis:

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

g. Rheumatic heart disease: With exertional dyspnea, cardiac enlargement or myocardial failure.

2. VASCULAR SYSTEM

a. Arteriosclerosis obliterans or thromboangiitis obliterans: Intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of two hundred (200) yards or less on level ground at one hundred twelve (112) steps a minute without a rest or with other complications.

b. Aneurysm of aorta:

c. Periarteritis nodosa: With definite evidence of functional impairment.

d. Chronic venous insufficiency (postphlebitic syndrome): When moderate in degree and symptomatic despite elastic support.

e. Raynaud's phenomena: Manifested by trophic changes of the involved parts characterized by scarring of the skin, or ulceration.

f. Varicose veins: Severe in degree and symptomatic despite therapy.

3. MISCELLANEOUS

a. Aneurysms: Arteriovenous or other aneurysms when moderate symptoms

remain following remedial treatment or if associated with cardiac involvement.

b. Erythromelalgia: Persistent burning pain in the soles or the palms not relieved by treatment.

c. Hypertensive cardiovascular disease and hypertensive vascular disease: Variable systolic blood pressure with diastolic pressure consistently over 110 mm mercury in spite of adequate therapy, and with Grade II (Keith-Wagner-Barker) changes in the fundi, or moderate changes in the brain, heart, or kidneys.

Section X. LUNGS AND CHEST WALL

1. NON-TUBERCULOUS LESIONS

a. Asthma: Associated with emphysema and frequent attacks not controlled by medication.

b. Atelectasis or massive collapse of the lung: Moderately symptomatic with paroxysmal cough at frequent intervals throughout the day, moderate to severe emphysema, or residuals or complications which require repeated hospitalization.

c. Bronchiectasis and bronchiolectasis: Cylindrical or saccular type which is moderately symptomatic, with paroxysmal cough at frequent intervals throughout the day, moderate to severe emphysema with moderate to large amount of bronchiectatic sputum, recurrent pneumonia, or residuals or complications which require repeated hospitalization.

d. Bronchitis: Chronic, severe, persistent cough, considerable expectoration, moderate to severe emphysema, dyspnea at rest or on slight exertion, residuals or complications which require repeat hospitalization.

e. Cystic disease of the lung, congenital: Involving more than one lobe.

f. Hemopneumothorax, hemothorax and pyopneumothorax: Severe pleuritis residuals with persistent underweight, marked restriction of respiratory excursions and chest deformity, or marked weakness and fatigability on slight exertion.

g. Histoplasmosis: Chronic active disease not responding to treatment and demonstrable moderate to severe reduction of pulmonary function.

h. Pleurisy, chronic, or pleural adhesions: Severe dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions and demonstrable moderate to severe reduction of pulmonary function.

i. Pneumothorax, spontaneous: Repeated episodes of pneumothorax not correctible by surgery.

j. Emphysema: Marked emphysema with dyspnea on mild exertion and demonstrable moderate to severe reduction in pulmonary function.

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

l. Pneumoconiosis: Severe, with dyspnea on mild exertion.

m. Pulmonary sarcoidosis: If not responding to therapy and complicated by demonstrable moderate to severe reduction in pulmonary function.

Section XI. MOUTH, NOSE, PHARYNX, TRACHEA, ESOPHAGUS, AND LARYNX

1. MOUTH, NOSE, PHARYNX, TRACHEA, ESOPHAGUS, AND LARYNX

a. Esophagus:

(1) Esophagitis: Persistent and severe.

(2) Diverticulum of the esophagus of such a degree as to cause frequent regurgitation, obstruction, and weight loss.

(3) Stricture of the esophagus of such a degree as to restrict diet to liquids, require frequent dilatation and hospitalization, and cause the individual to have difficulty in maintaining weight and nutrition.

b. Larynx:

(1) Paralysis of the larynx characterized by bilateral vocal cord paralysis seriously interfering with speech and adequate airway.

(2) Stenosis of the larynx of a degree causing respiratory embarrassment upon moderate exertion.

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

Section XI. SKIN AND CELLULAR TISSUES

1. SKIN AND CELLULAR TISSUES

a. Atopic dermatitis: Severe, requiring frequent hospitalization.

b. Amyloidosis: Generalized.

c. Dermatitis herpetiformis: Which fails to respond to therapy.

d. Dermatomyositis.

e. Epidermolysis bullosa.

f. Erythema multiforme: Recurrent.

g. Exfoliative dermatitis: Chronic.

h. Elephantiasis or chronic lymphedema: Not responsive to treatment.

i. Hidradenitis suppurativa and folliculitis decalvans.

j. Hyperhidrosis: Of the hands or feet when severe and complicated by a dermatitis or infection, either fungal or bacterial, not responsive to therapy.

k. Leukemia cutis and mycosis fungoides:

l. Lichen planus: Generalized and not responsive to treatment.

m. Lupus erythematosus: Chronic discoid variety with extensive involvement of the skin and mucous membranes and when the condition does not respond to treatment.

n. Panniculitis: Relapsing, febrile, nodular.

o. Parapsoriasis and psoriasis: Extensive and not controlled by treatment.

p. Pemphigus vulgaris, pemphigus foliaceus, pemphigus vegetans and pemphigus erythematosus.

q. Scars and keloids: So extensive or adherent that they seriously interfere with function.

r. Scleroderma: Generalized or of the linear type which seriously interfere with the function of an extremity.

Section XII. SPINE, SCAPULAE, RIBS, AND SACRO-ILIAC JOINTS

1. SPINE, SCAPULAE, RIBS, AND SACRO-ILIAC JOINTS

a. Congenital dislocation of hip.

b. Spina bifida: Demonstrable signs and moderate symptoms of cord or root involvement.

c. Spondylolisthesis or spondylolysis: Moderate displacement and symptoms requiring repeated hospitalization.

d. Coxa vara: Severe, with pain, deformity, and arthritic changes.

e. Herniation of nucleus pulposus: Severe with objective findings moderate to severe objective or requires repeated hospitalization despite an appropriate interval of therapy.

Section XIII. SYSTEMIC DISEASES, AND MISCELLANEOUS CONDITIONS AND DEFECTS

1. SYSTEMIC DISEASES

a. Blastomycosis.

b. Brucellosis: Chronic with substantiated recurring febrile episodes, severe fatigability, lassitude, depression or general malaise.

c. Leprosy of any type.

d. Lupus erythematosus disseminated, chronic.

e. Myasthenia gravis.

f. Porphyria cutanea tarda.

g. Sarcoidosis: Progressive with severe or multiple organ involvement and not responsible to therapy.

Section XIV. TUMORS AND MALIGNANT DISEASES

1. MALIGNANT NEOPLASMS

Malignant growths when inoperable or metastasized beyond regional nodes.

Section XV. NEUROLOGICAL AND ASSOCIATED DISEASES

1. MULTIPLE SCLEROSIS

2. PARALYSIS AGITANS

3. CHOREA, CHRONIC PROGRESSIVE

4. HEPATOLENTICULAR DEGENERATION

5. ATROPHY MUSCULAR MYELOPATHIC (including poliomyelitis, severe residuals)

6. AMYOTROPHIC SCLEROSIS LATERAL

7. ATROPHY, MUSCULAR PROGRESSIVE

8. MYELOPATHY, TRANSVERSE
9. SYRINGOMYELIA
10. DYSTROPHY, PROGRESSIVE MUSCULAR
11. MYOTONIA CONGENITAL
12. CHRONIC MENINGITIS
13. FRIEDREICH'S ATAXIA

SECTION I

GENERAL

1. The Veterans Administration Schedule for Rating Disabilities. Title 10 USC Chapter 61 requires that disabilities of members who have been found physically unfit be rated "under the standard schedule of rating disabilities in use by the Veterans Administration at the time of the determination." This has been interpreted to pertain to that portion of the Veterans Administration publications, Schedule for Rating Disabilities, which lists medical conditions and the corresponding rating percentages which reflect permanent evaluation of disabilities, as distinguished from temporary convalescent ratings. The latter are not applicable to cases of servicemen arising under chapter 61 of Title 10 U.S.C. but are intended to provide guidance under laws and policies peculiar to the Veterans Administration only.

2. Zero Percent Ratings and Minimum Ratings:

a. Occasionally a medical condition which causes unfitness for military service is of such mild degree that it does not meet the criteria even for the lowest rating provided in the schedule under the applicable code number. A zero percent rating may be applied in such cases, even though the lowest rating listed is 10 or more, except when "minimum ratings" are specified. See paragraph b. below. It should be noted that the zero percent rating does not preclude the award of compensation as prescribed by law for ratings less than 30%.

b. In some instances the 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 Schedule provides for a minimum rating for "residuals" in certain medical conditions. The instructions may be "rate residuals, minimum - - - ," or it may specify what impairment to rate, and give a minimum rating for that impairment. Examples are 8011, anterior poliomyelitis, and 6015, benign new growths 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% rating is appropriate.

3. Amputation Rule. This rule provides that the combined permanent rating for disabilities of an extremity will not exceed the rating for the amputation level next higher than the site of injury. This means that a disability of an extremity will not be given a higher rating than would be given if the limb were amputated at the most distal of the customary amputation sites which would include the damaged tissue in the part removed.

4. Conversion of Combined Ratings. Paragraphs 25 and 26, pages 9 and 10 of the VA Schedule, which explain conversion of combined ratings to the nearest number divisible by 10, are supplemented as follows. Should ratings for disabilities in paired extremities be combined to equal 59 percent, 5.9 percent (10 percent bilateral factor) may be added to total 64.9 percent which may be converted to 65 percent and, according to the same rule, be further converted to 70 percent. This is proper even though the combined rating was less than 65 percent and underwent two upward conversions.

SECTION II

PRINCIPLES IN APPLYING THE VETERANS ADMINISTRATION SCHEDULE

1. Disabilities by Code Numbers. The instructions and explanatory notes which follow are listed according to the VA code numbers of the conditions to which they apply. Only those conditions which require comment or have caused misunderstanding in the past are included:

5000. OSTEOMYELITIS

a. Note (1) on page 30 of the VA Schedule may appear to be ambiguous in its instructions concerning application of the amputation rule. It means that in rating active osteomyelitis of any part whose amputation would be ratable at less than 20% (ordinarily the minimum rating for active osteomyelitis), a rating of 10% may be assigned. This constitutes disregard of the amputation rule in those instances where the rating for amputation would be 0%. Example: A case of active osteomyelitis of the little finger distal to the proximal interphalangeal joint may be rated at 10 per cent even though amputation at that level is ratable at 0% (note (b), page 33R - Code 5227). However, a ratable disability exists only so long as the distal phalanx with its active osteomyelitis remains.

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

5002. RHEUMATOID ARTHRITIS

a. In its early stages this disease, although often symmetrical, is usually migratory, and for this reason affected parts are not credited with the bilateral factor until permanent contracture deformities and muscle atrophy develop in paired extremities. For the "minimum 50%" rating, actual beginning contracture with atrophy of muscles is a requirement, whether the rating is for either "multiple major joint involvement" or "multiple group involvement of minor joints".

b. Some conditions, originally diagnosed as rheumatoid arthritis, undergo clinical courses which in retrospect generate doubt of the accuracy of the original diagnosis. In these cases, rating as hypertrophic arthritis is appropriate, in accordance with the note under code 5002, unless a new diagnosis ratable under its own code number has been established.

c. There are occasional instances in which the manifestations of rheumatoid arthritis, even though widespread, become stabilized at a relatively mild, benign level. Here the rating of "not less than 10% for each major joint or group of minor joints" may be patently excessive for the over-all impairment of function. In such circumstances the rating for hypertrophic arthritis may be applied.

5003. ARTHRITIS, HYPERTROPHIC

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

b. The note on page 31 of the Schedule under code 5003, pertaining to utilization of the 10% and 20% ratings listed above the note is not intended for application to DC 5013 through 5024.

c. The "Other Ratings" referred to in the second sentence of the note under code 5003 means "ratings for osteoarthritis other than the 10% and 20% ratings listed." Such "other ratings" should be applied by analogy to limitation of motion or ankylosis, whichever is appropriate. They should not be applied unless there is, in addition to x-ray confirmation of the disease within the joints being separately rated, a degree of swelling, muscle spasm, or other positive evidence of painful motion sufficient to produce a ratable limitation of motion. The instruction is intended to provide for more equitable ratings for localized, severe, constant functional impairment than can be represented by the 10% and 20% ratings for the more generalized manifestations. Such separate ratings are not to be combined with the basic 10% and 20% ratings. It should be emphasized that separate rating of specific joints or joint groups are to be applied only when there are continuous manifestations that impose a substantial, constant handicap to the individual. It is not intended for application to the fluctuating types of impairment such as morning "aches and pains" which tend to improve or disappear as the day progresses.

d. The Schedule provides that two or more major joints, or two or more minor joint groups must be involved in order to merit a rating under code 5003. Osteoarthritis affecting only a single major joint (one knee, for instance) or a single group of minor joints (such as the lumbar spine) is not ratable unless there is a ratable limitation of motion as described in paragraph c. above.

5010. ARTHRITIS DUE TO DIRECT TRAUMA

When an affected joint merits a rating higher than 10%, the analogy appropriate to the impairment must be used. Diagnosis alone is insufficient for the 10% rating. See note under VA code 5010.

5099. BONES, JOINTS, AND MUSCLES, OTHER DISEASE OF

See Code 7904 for rating osteitis fibrosa cystica (Recklinghausen's disease).

5100 - 5151. The difficulty frequently encountered in rating multiple finger disabilities 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. The disability may then be rated in accordance with the notes of instruction at the bottom of page 33-R of the Schedule. The method is as follows:

Step One: Determine the grade value for each affected finger as shown in the chart below:

Defect of individual Finger	Ratable As:	Grade Value
Amputation through distal phalanx or distal joint. (Other than negligible tip losses)	Favorable ankylosis (Note c., p. 33-R, VA Schedule)	Grade 1
Amputation through middle phalanx	Unfavorable ankylosis (Note b., p. 33-R)	Grade 2
Amputation through proximal phalanx or proximal I-P Joint	Amputation (Note a., p. 33-R)	Grade 3
Amputation of entire digit, with amputation or resection of more than one half of the metacarpal	Single finger amputation with metacarpal resection (Code Nos. 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 defects (favorable ankylosis, unfavorable ankylosis, etc.) for the average grade value of the disabled hand. The proper code number and rating can then be determined within that category according to the number of fingers involved.

Example:

An evaluee has had his thumb amputated through the distal phalanx, the index and little fingers through the middle phalanges, and the entire ring finger including more than one half of the metacarpal.

Grade value for thumb - - - - - - - - - - - 1
Grade value for index finger - - - - - - - 2
Grade value for little finger - - - - - - - 2
Grade value for ring and metacarpal - - - 4
Total value - - - - - - - - - - - - - - - - 9

Total Value = average grade value
No. of fingers involved

$\frac{9}{4} = 2\frac{1}{4} = 2$

Referring to the chart above, Grade 2 is ratable as Unfavorable ankylosis.

Unfavorable ankylosis of four fingers - thumb, index, ring, and little - is ratable under Code No. 5217 at 60 (major), or 50 (minor).

5171. AMPUTATION OF GREAT TOE

Must be through the proximal phalanx to warrant a 10% rating.

5200 - 5295. RATINGS INVOLVING JOINT MOTION

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

b. 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 (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 of extension of the part distal to the joint.

c. 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. The distinction must be carefully made for appropriate rating. See paragraph 16, page 20 of the VA Schedule 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 DC 5213 subject to the amputation rule. If there is less than complete loss of supination or pronation, DC 5205 may be combined with 5213 but not to exceed the rating for unfavorable ankylosis under DC 5205.

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

5209 - 5212. OTHER IMPAIRMENTS OF ELBOW, RADIUS, AND ULNA

These codes are not to be combined with 5213.

5213. IMPAIRMENT OF PRONATION AND SUPINATION

a. Limitation of either pronation or supination may be rated, but never both in the same arm.

b. See paragraph 40, page 27-R, VA Schedule.

5251 - 5252. LIMITATION OF EXTENSION AND FLEXION OF THE THIGH

The ratings allowable under these codes may not adequately reflect the degree of disability when the motion is only mildly limited, but is due to damage to the sacro-iliac region, pelvis, acetabulum, or head of femur. More appropriate ratings may be selected from codes 5255 (femur, impairment of, with hip disability) or 5294 (sacro-iliac injury). Paragraph 34, page 26 of the VA Schedule contains 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 fracture lines.

5299 - 5255. HIP ARTHROPLASTY AND PROSTHESES

The disability resulting from defects requiring hip prostheses such as vitallium cup or artificial devices should be rated in accordance with the entire disability picture under the appropriate diagnostic code and not necessarily 60% under DC 5255.

5285 - 5295. THE SPINE

a. The joints of the cervical, dorsal and lumbar segments of the spine and the combination of sacro-iliac 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 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 dorso-lumbar movement is not analogous to the requirement 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 deformity (see c. below) of one or more vertebral bodies, 10% is to be added to, not combined with, the rating for each spinal segment in which such deformity appears. The instruction in the italicized note under code 5285 pertaining to ratings for ankylosis and limited motion applies also to the addition of 10% for demonstrable deformity of a vertebral body. The 10% is to be added to the rating for the segment before that rating is combined with 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 as follows:

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

c. The addition to the rating of 10% 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 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% 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% when combined, if the combined effect of such separate disabilities is complete ankylosis of the spine at a favorable angle.

5296. THE SKULL

a. Diagnostic burr holes are ratable. Where there are more than one, the areas of each should be added, and the total rated. The following may be helpful as a reference in determining appropriate ratings:

1 centimeter = 0.3937 inches
1 inch = 2.54 centimeters
1 square centimeter = 0.1550 square inches
2 square centimeters = 0.3100 square inches
3 square centimeters = 0.4650 square inches

Area of a circle = πr^2, where r = radius of the circle. To calculate area of a circle in square inches from the diameter in centimeters:

Square inch = $\pi (\frac{d}{2})^2 K$, where d = diameter of the circle in centimeters, and k is the conversion factor 0.155.

DIAMETER OF CIRCLE	AREA	
	Sq cm	Sq inches
1 cm	0.7854	0.1216
2 cm	3.1416	0.4869
3 cm	7.0686	1.0956
4 cm	12.5664	1.9478
½ in		0.19635
1 in		0.7854
1½ in		1.76715
2 in		3.1416

b. Loss of part of the skull is ratable whether or not the defect had been repaired with a prosthetic plate.

c. 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.

d. It should be noted that there must be loss of both inner and outer tables of the skull for a defect to be ratable under this code.

e. The rating problem created by the disparity in the criteria for area measurement (50¢ piece = 1.1075 square inches; 25¢ piece = 0.6903 square inches) should be resolved in favor of the member.

5297. REMOVAL OF RIBS

a. The Schedule for removal of ribs contemplates the complete removal from the vertebral angle to the costo-cartilage junction. Lesser extents are rated as resection.

b. Pneumonectomy is to be included with those conditions (purulent pleurisy, lobectomy, injuries of pleural cavity) for which an additional rating for rib resection or removal is not to be applied. Exceptions to this rule may be warranted in those instances where subsequent surgery is required for the resection or removal of additional ribs for the purpose of revision of the shape of the chest wall. See the comment for code 6815, pneumonectomy, in this guide.

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 paragraph 16, page 20 of the VA Schedule.

b. Damaged muscles whose only action is on an impaired, ratable joint are not additionally ratable. The rating should be made on whichever defect warrants the higher percentage.

6000 - 6090. DISEASES OF THE EYE

The VA Schedule makes several references to the limitation of combined ratings for disabilities of the same eye 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. As stated in paragraph 11, page 53-R of the Schedule, the restriction is subject to the following exceptions - enucleation or serious cosmetic defect. Accordingly, where there is a cosmetic defect even though limited to the eye per se associated with the visual loss, representing a separate and distinct entity, namely, facial disfigurement, a separate of 10, 30, or 50% - depending on the facts in the case - is permitted under DC 7800 to be combined with the rating for the visual loss or rating for enucleation.

6013. GLAUCOMA, SIMPLE, PRIMARY, NONCONGESTIVE

The minimum rating is applicable if the diagnosis is satisfactorily established, whether or not acuity or field vision has been affected. The rating is for the disease rather than for functional impairment of an individual organ.

6081. SCOTOMA, PATHOLOGICAL

The rating is 10% whether unilateral or bilateral. It is, of course, to be combined with other ratings, with the reservation that the rating for one eye may not exceed 30% unless there is an enucleation or a serious cosmetic defect (paragraph 11, page 53, VA Schedule). It should be noted that central scotoma cannot be combined with central visual loss.

DISEASES OF THE EAR

6200 - Otitis Media, suppurative, chronic.

The 10% 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%, 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. The rule against pyramiding should be applied.

6277 - 6297. IMPAIRMENT OF AUDITORY ACUITY

Controlled speech reception and discrimination tests, when available, are desirable adjuncts to the evaluation of auditory acuity. They should be used as aids in estimating degree of impairment, but not necessarily as the controlling factor. Pure tone audiometry remains the most reliable single means of making the determination. Tests by conversational voice expressed in feet are not to be used for rating purposes.

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 the highest applicable rating is awarded. This instruction does not apply to speech impairment due to loss of whole or part of the tongue, which is to be rated under code 7202.

6721 - 6724. INACTIVE TUBERCULOSIS

a. The date of beginning of inactivity is of primary importance in the evaluation of disabilities due to tuberculosis. Tuberculosis may be considered inactive:

(1) When these criteria are met: No symptoms of tuberculosis origin. Serial roentgenograms must be stable or show very slow shrinkage of the tuberculous lesion. No evidence of cavity. Sputum or gastric washings negative on culture or guinea pig inoculation. These conditions shall have existed not less than six months.

(2) On a date of inactivity established by a Veterans Administration 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 hospital discharge which ever is later.

b. Treatment by medication is frequently continued beyond the date when the disease becomes "inactive" according to the criteria listed above. Care should be exercised to avoid confusion of the date of the end of such treatment schedule with that of the beginning of the "inactive" status.

6815. PNEUMONECTOMY

The 60% 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.

6816. LOBECTOMY

An entire lobe must be removed for the defect to be ratable. Excision of the right middle lobe, a lingula, or a segment of a lobe is not ratable. When a major lobe has been removed from each lung, the defects are rated separately at 30 per cent, and the ratings are combined in the usual manner.

6820. 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 coccidioidomycosis (6821) or pneumoconiosis (6802) when the predominant manifestation is in the lungs. If the disease is manifested by lymphadenopathy, transient joint pains, and occasional febrile episodes, the appropriate analogy may be to brucellosis (6316).

7000 - 7122. CARDIOVASCULAR DISEASE

a. To avoid pyramiding, only one rating should be given for all manifestations of cardiovascular-renal disease which, according to accepted medical principles, are etiologically related. For example, hypertension, arteriosclerosis, and nephritis involving vascular abnormalities are so closely associated that they may be regarded as one clinical entity. The disability should be rated 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 over-all impairment to the point that the next higher percentage under the selected code will be justified. The note under code 7507 is pertinent in this respect.

b. Valvular heart disease not of arteriosclerotic or hypertensive origin should be rated as rheumatic heart disease, code 7000.

AMERICAN HEART ASSOCIATION DIAGNOSTIC STANDARDS

Symptoms	Signs	Functional Capacity	Therapeutic Classification
1. No angina, dyspnea or severe weakness. Restriction of activity not necessary. Majority resumed former work.	A. No significant abnormalities.	Class I Ordinary physical activity does not cause discomfort, i.e., symptoms of undue fatigue or weakness, palpitation dyspnea or anginal pain.	Class A or B Ordinary physical activity need not be restricted.

2. Mild or infrequent angina. Activity only slightly restricted. Many working, but number complained of some dyspnea and weakness.	B. Mild or moderate abnormalities, i.e. in ECG or size of heart.	Class II, and possibly III.- Ordinary physical activity (or less than this for Class III) causes discomfort. No discomfort at rest.	Class C Ordinary physical activity should be moderately restricted. Avoid strenuous effort.
3. Severe or Frequent angina. Dyspnea and weakness. Activity definitely restricted. Majority unfit for any work with only few doing light work.	C. Advance ECG changes. Marked enlargement of heart.	Class III Less than ordinary physical activity causes discomfort. No discomfort at rest.	Class D Ordinary physical activity should be markedly restricted.
4. Intractable angina, symptoms of congestive faulure. Activity markedly or completely restricted.	D. Definite evidence of congestive failure.	Class IV Any physical activity produces discomfort, which is present even at rest.	Class E Complete rest with confinement to bed or chair required.

?00. RHEUMATIC HEART DISEASE

a. Assumption of the existence prior to service of a ratable degree of ıeumatic heart disease is sometimes justified even though its presence was not previously recorded. Such an assumption, of course, would 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 degree is minimal or uncertain.

c. The 100 per cent rating for rheumatic heart disease for six months is not applicable.

7005 - 7006. ARTERIOSCLEROTIC HEART DISEASE, MYOCARDIAL INFRACTION

a. A rating for arteriosclerotic heart disease is not to be combined with one for hypertensive heart or vascular disease (7007 or 7101).

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

7007 - 7101. HYPERTENSIVE HEART DISEASE AND HYPERTENSIVE VASCULAR DISEASE

Blood pressure readings to be used in determining disability rating percentages ɔuld be obtained under normal circumstances and during usual activities. It ɔuld be emphasized that hypertension brought under control through optimum condi-.ons, that is, during hospitalization under a regime of medication and enforced

rest, may not be used as a basis for evaluation unless it is established that such control continues while under ordinary activity. The level of hypertension is not to be determined by "an average of all readings rather, the predominant readings will be the basis for determination of the level of hypertension.

7007. HYPERTENSIVE HEART DISEASE

a. This code is not to be combined with 7005 or 7101.

b. 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. It should be kept in mind that to justify the 30% rating for hypertensive heart disease all of the criteria mentioned in the Schedule for that rating should be met, and that "definite enlargement of the heart" means positive evidence of enlargement beyond "doubtful" or "borderline" myocardial hypertrophy.

7100. ARTERIOSCLEROSIS, GENERAL

The 20% rating under this code is rarely appropriate. Manifestations of the disease preferably should be rated for impairment of the body system involved of the greatest degree.

7101. HYPERTENSIVE VASCULAR DISEASE

This code is not to be combined with 7005 or 7007. See the comments under 7007 - 7101, above.

7114 - 7117. PERIPHERAL VASCULAR DISEASES

a. The symptoms and signs of each of these conditions are to be considered 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, the percentage of disability is to be based upon the most severely affected extremity. The rating of that extremity is to be used as the total percentage, unless each of two or more extremities separately meets the requirements for evaluation in excess of 20%. In the latter case, 10% 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, the above procedure will be applied to the upper extremities, then to the lower extremities. These ratings will then be combined if each group has a total rating in excess of 20%.

c. The bilateral factor should be applied in all cases of an amputation of one extremity with any compensable degree of disability of the other extremity.

d. A peripheral vascular disease rating of 20% or less will not be combined with any other peripheral vascular disease rating.

e. Peripheral vascular disease rating chart for codes 7114 through 7117.

PERIPHERAL VASCULAR DISEASE RATING CHART

ONE EXTREMITY INVOLVED	COMBINED RATING
20	20
40	40
60	60

TWO EXTREMITIES NOT PAIRED (ONE ARM & ONE LEG)

20	20	20
40	20	40
40	40	40 (combined 40=64=60)
60	20	60
60	40	60 (combined 40=76=80)
60	60	60 (combined 60=84=80)

TWO PAIRED EXTREMITIES (TWO ARMS OR TWO LEGS)

20	20	20
40	20	40
40	40	40 +10=50
60	20	60
60	40	60 +10=70
60	60	60 +10=70

THREE EXTREMITIES

PAIRED		OTHER	
20	20	20	20
20	20	40	40
20	20	60	60
40	20	20	40
40	20	40	40 (combined 40=64=60)
40	20	60	60 (combined 40=76=80)
40	40	20	40 +10=50
40	40	40	(40 +10) combined 40=70
40	40	60	(40 +10) combined 60=80
60	40	20	60 +10=70
60	40	40	60 +10 combined 40=82=80
60	40	60	60 +10 combined 60=88=90
60	60	20	60 +10=70
60	60	40	60 +10 combined 40=82=80
60	60	60	60 +10 combined 60=88=90

ALL EXTREMITIES INVOLVED

PAIRED		PAIRED	COMBINED RATING
20	20	20 20	20
40	20	20 20	40
60	20	20 20	60
40	40	20 20	40 +10=50
40	20	40 20	40 combined 40=64=60
40	40	40 20	40 +10 combined 40=70
40	40	40 40	40 +10 combined 40+10=75=80
60	40	40 40	60 +10 combined 40+10=85=90
60	40	60 40	60 +10 combined 60+10=91=90
60	60	40 40	60 +10 combined 40+10=85=9
60	60	60 40	60 +10 combined 60+10=91=90
60	60	60 60	60 +10 combined 60+10=91=90

GASTRITIS, UNSPECIFIED (BOTTOM OF PAGE 89-R, VA SCHEDULE)

The absence of a code number for this condition does not preclude its use as a diagnosis when an underlying condition cannot be identified.

7307. GASTRITIS, HYPERTROPHIC

Identification by gastroscopic examination is required to establish this diagnosis.

7308. POSTGASTRECTOMY SYNDROME

a. A rating under this code is not justified unless there is symptomatology beyond the expected sequelae of a gastrectomy. Such features as a moderate feeling of fullness after eating, a need to restrict ingestion of high carbohydrate foods, and a schedule of four or five meals daily with or without additional "snacks" are among those expected following the operation and are not ratable as post gastrectomy syndrome.

b. The permanent degree of disability caused by postgastrectomy syndrome can rarely be estimated until one or two years have elapsed after the operation. Gradual changes in the degree of disability may take place over even longer periods.

28 - 7329 INTESTINAL RESECTIONS

Do not combine ratings under 7328 with 7329. Where portions of both intestines have been removed rating should be made 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 should be rated as a skin condition except, when an active process is present, it should be rated by analogy to VA Code 5000.

7399. DIAPHRAGMATIC HERNIA

This type of hernia may be rated by analogy with 7306 - ulcer, marginal. The usual precautions with regard to underlying psychiatric conditions are to be observed.

7399. PANCREATITIS

This disease is to be rated by analogy to cholecystitis - 7314, or ulcer, marginal - 7306, whichever is more appropriate according to type and severity of signs and symptoms. Diabetes mellitus, if present, is to be rated separately.

7801. SCARS, BURN, THIRD DEGREE

The following instructions will supplement the criteria under code 7801 in the VA Schedule in order to arrive at a more realistic rating of actual impairment and function than might otherwise be obtained.

a. Third degree burn scars which cause limitation of function of underlying structures should be rated by analogy to other codes which reflect the functional impairment.

b. Rate the remainder of unsuccessfully healed or grafted third degree burn areas according to code 7801 of the VA Schedule, not exceeding 40% for total areas measured.

c. Rate areas of successfully grafted third degree burns as second degree burns, at 10% for each square foot of burned area not to exceed 40% for total areas measured if function of underlying or adjacent structures is not impaired.

7809. LUPUS ERYTHEMATOSUS

Lupus erythematosus disseminatus should be evaluated on the basis of the system predominantly affected with rating increased to the next higher level where there is lesser but considerable involvement of another system.

7913. DIABETES MELLITUS

a. The severity of each case is to be individualized, taking into consideration complications, age of 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. 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 or 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 regime of normal activity.

b. Diabetes which is controlled by diet in combination with oral medication, without insulin, and is without impairment of health or vigor, or limitation of activity, is considered to be "mild", ratable at 10%.

8000 - 8026. ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM

a. Careful correlation of the note under code 8026 with the italicized introduction to codes 8000 - 8026 should enable boards to select the proper rating approach. In some of these conditions the minimum rating may be awarded on the basis of 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 not more likely attributable to other disease, the condition should be considered "ratable at 0%."

b. When ratings in excess of the minimums are awarded, the codes utilized in rating the manifestations of the disease must be cited.

c. The minimum rating cannot be combined with any separately rated residual.

8007 - 8009. BRAIN VESSELS

a. The 100 per cent rating under these codes will not be applied. Rate on residuals.

8023 - 8025. PROGRESSIVE MUSCULAR ATROPHY AND MYASTHENIA GRAVIS

Combined ratings may be assigned under these codes with the bilateral factor added.

8510 - 8713. RADICULAR GROUPS

These codes are not to be combined with codes 8514 - 8717.

8599. SCALENUS ANTICUS SYNDROME

This syndrome should be rated by analogy with the lower radicular group (8512), 'r less commonly with either erythromelalgia (7119) or Raynaud's Disease (7117), ·pending upon predominant symptoms and over-all functional impairment.