Cancelled 25 FEB 1986

# DEPARTMENT OF DEFENSE
# DIRECTIVES SYSTEM TRANSMITTAL

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ATTACHMENTS

Pages 7 and 8 of DoD Directive 1332.18, Sept 9, 68.

INSTRUCTIONS FOR RECIPIENTS

The following page changes to DoD Directive 1332.18, "Uniform Interpretation of Laws Relating to Separation from the Military Service by Reason of Physical Disability," dated September 9, 1968, have been authorized:

PAGE CHANGES

Remove: Pages 7 and 8
Insert: Attached replacement pages.

Change appears on page 8 and is indicated by marginal asterisks.

EFFECTIVE DATE AND IMPLEMENTATION

This change is effective immediately. Two (2) copies of revised implementing documents shall be forwarded to the Assistant Secretary of Defense (Manpower and Reserve Affairs) within thirty (30) days.

Maurice W. Roche

MAURICE W. ROCHE
Director, Correspondence and Directives Division
OASD(Administration)



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

SD FORM 1 MAR 62 106-1 PREVIOUS EDITIONS ARE OBSOLETE

September 9, 1968
NUMBER 1332.18

ASD(M&RA)

# Department of Defense Directive

SUBJECT Uniform Interpretation of Laws Relating to Separation from the Military Service by Reason of Physical Disability

References: (a) 10 United States Code, Chapter 61, and related laws
(b) DoD Directive 1332.18, subject as above, December 6, 1962 (hereby cancelled)

## I. REISSUANCE AND PURPOSE

This Directive reissues reference (b) to update policies, and procedures designed to insure that separations of military personnel from the Armed Forces by reason of disability under the provisions of reference (a) are accomplished uniformly throughout the Department of Defense. Reference (b) is hereby superseded and cancelled.

## II. APPLICABILITY

The provisions of this Directive apply to the Military Departments.

## III. DEFINITIONS

Definitions of terms set forth in enclosure 1 apply.

## IV. BASIC CONCEPTS

Implementation of disability separation and retirement laws by the Military Departments must not deviate from the following basic concepts:

A. 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. These laws also provide benefits for eligible members whose military service is terminated due to a service-connected disability. With the enactment of Title IV of the Career Compensation Act of 1949 (now codified in Title 10 United States Code, principally in Chapter 61) a single law was made applicable to officers and enlisted personnel of all the military services.

1. The primary requisite for eligibility for retirement or separation under reference (a) is that the member must be unfit, because of physical disability, to perform the duties of his office, grade, rank or rating.

2. Such factors as a member's, (a) inability to meet the physical standards for initial entry into the service; (b) pending voluntary or involuntary separation or retirement or release to an inactive status; (c) lack of a special skill in demand to meet the needs of his military service; (d) inability to physically qualify for specialized duties requiring a high degree of physical fitness; or (e) inability to qualify for transfer to another service or another component within the same military service are not to be used as a base for determining unfitness because of physical disability.

B. Medical conditions or physical defects which are ratable under the Veterans Administration "Schedule for Rating Disabilities", will be used as a basis for separation or retirement only if they render a member "unfit because of physical disability", as defined in enclosure 1.

## V. POLICIES

### A. Standards of Unfitness by Reason of Physical Disability

1. The mere presence of an impairment does not, of itself, justify a finding of unfitness because of physical disability. In each case considered, it is necessary to correlate the nature and degree of physical disability which is present with the requirements of the duties which the member reasonably may be expected to perform by virtue of his office, grade, rank, or rating.

   a. The overall effect of all disabilities present in an individual whose physical fitness is under evaluation must be considered both from the standpoint of how the disabilities affect the individual's performance, and requirements which may be imposed on the service concerned to maintain and protect him during future duty assignments. An individual may be unfit because of physical disability caused by a single impairment, or physical disability resulting from the overall effect of two or more impairments even though no one of them, alone, would cause unfitness.

   b. While there are many ways in which physical disability may affect an individual's capacity to perform duty, any listing of these factors should not be interpreted as limiting a Military Department Secretary in applying the many principles of "unfitness by reason of disability". Application of these principles is a prerogative of the Secretary of the Military Department concerned.

2. Certain medical conditions which normally will be considered as rendering an individual unfit because of physical disability are listed in

enclosure 2. However, this is not an all-inclusive list. The major objective in the use of such a list is to achieve uniform disposition of cases arising under the law. The guidelines in enclosure 2 are not to be taken as a mandate that possession of one or more of the listed conditions or physical defects means automatic retirement or separation from the military service. Each case must be decided upon the relevant facts and a determination of fitness or unfitness must depend upon the individual's ability to perform the duties of his office, grade, rank or rating in such a manner as to fulfill reasonably the purpose of his employment on active duty.

3. Initial enlistment, induction, or commissioning physical standards are not relevant to determining unfitness for continued military service. Once a member has been enlisted, inducted, or commissioned, the fact that he may later fall below initial entry physical standards does not in itself authorize separation or retirement unless it is also established that he is unfit because of physical disability as described above. Similarly, inability to meet physical standards established for specialized duty such as flying, or duty aboard submarines, or for transfer between components within a Military Department does not, in itself, establish eligibility for disability separation or retirement.

4. Members who are eligible for nondisability retirement are entitled to the same consideration under disability laws that is accorded to members with lesser amounts of service. Such members may therefore be retired for disability if it is clearly established that they are unfit in accordance with the criteria set forth above.

5. Notwithstanding any other provision of this Directive, after a member has been enlisted, inducted, appointed, or commissioned, he will not be declared unfit for military service

because of disabilities which existed at the 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. Presumptions

A presumption (an inference of the truth of any proposition or fact) is reached through a process of reasoning wherein one looks to probabilities rather than certainties. Matters which are "presumed" need no proof to support them, but a preponderance of evidence to the contrary will rebut a presumption.

1. In the absence of a preponderance of evidence to the contrary, and as provided in V. B. 2, and C., below, the following presumptions will apply to physical disability evaluation:

   a. A member is presumed to have been in sound physical and mental condition upon entering active service except as to physical disabilities noted and recorded at the time of entrance. Any disease or injury discovered after a member enters active service is presumed to have been incurred in line of duty while entitled to receive basic pay and not due to the member's intentional misconduct or willful neglect.

   b. It is further presumed that, even if the foregoing provision is overcome by such evidence, any additional disability or death resulting from the pre-existing injury or disease was caused by military service aggravation. Only specific findings of "natural progress" of the pre-existing injury or disease based upon well established medical principles, as distinguished from medical opinion alone, are sufficient

to overcome the presumption of military service aggravation.

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

2. The foregoing presumptions may be overcome only by a preponderance of evidence as distinguished from personal opinion, speculation, or conjecture. When there is reasonable doubt concerning a member's condition, an attempt should be made to resolve the doubt on the basis of further clinical investigation and observation, and such other evidence as may be adduced. In the absence of such proof by a preponderance of evidence, reasonable doubt will be resolved in favor of the member. However, in the case of members with more than three years of service, any increase in the severity of a pre-exisiting disease or injury will be considered as evidence of service aggravation, provided that such increase in severity was not due to the member's intentional misconduct or willful neglect.

C. Conditions Originating Prior to Active Military Service

1. There are certain abnormalities and residual conditions which, when discovered impel the conclusion that they must have existed or have originated before the individual entered the military service.

a. Examples of these conditions are 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 similar conditions in which medical authorities are in such consistent and universal agreement as to their cause and time of origin that no additional confirmation is needed to support the conclusion of their existence prior to military service.

b. Similarly, manifestation of lesions or symptoms of chronic disease from date of entry, or so close to that date that the disease could not have originated in so short a period, will be accepted as proof that the disease existed prior to entrance into active military service.

c. Conditions of infectious origin are to be considered with regard to the circumstances of infection and the incubation period.

d. Manifestations of disease within less than the minimum incubation period after enlistment will be accepted as proof of inception prior to military service.

2. Standard in-service medical and surgical treatment having the effect of ameliorating disease or other conditions incurred before entry into military service, (including postoperative scars and absent or poorly functioning parts or organs) do not constitute aggravation unless the treatment was required to relieve disability which had been aggravated by military service.

D. 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 A of enclosure 1. However, after a member's unfitness for military service has been established the VA schedule, as modified in enclosure 3, will be followed in rating his disabilities.

2. Enclosure 3 is prescribed for uniform use by the Military Departments. Proposed changes may be forwarded at any time to the ASD(M&RA) for consideration. Such action is particularly appropriate wherever it is considered that the ratings provided under one or more of the diagnostic codes are inadequate, excessive, or cannot be applied to members of the Military Departments generally.

E. Length of Hospitalization

1. 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 shall be determined on an individual basis, taking into consideration the interest of both the Government and the member. Normally, 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 "optimum hospital improvement".

* 2. As an exception to the foregoing, when it has been determined that a member will not return to duty and when it would be advantageous to the member to draw Veterans Administration compensation vice active duty pay from the Armed Forces, he may be immediately processed for transfer to the Temporary Disability Retired List or permanently retired for physical disability prior to attaining optimum service hospital benefits and transferral to a Veterans Administration Hospital, if clinically transportable. *



#First amendment (Ch 1, 1/7/70)

F. Counseling

1. During disability evaluation processing, each member (or, in appropriate cases the next-of-kin or legal guardian) will be carefully counseled, in clearly understandable language, concerning the significance of actions being taken in his case, their probable effect on his future, and his rights with respect to options available to him. Counseling shall also be provided before, during and after physical evaluation board consideration, at each subsequent stage of processing, and as questions are raised by the member.

2. Counselors will cover such matters as legal rights, effect of findings and recommendations, retired or severance pay, grade upon retirement, potential veteran's benefits, and recourse to and preparation of rebuttals, and assist him in their preparation when indicated.

G. Temporary Disability Retired List (TDRL)

1. Use of the Temporary Disability Retired List.

a. 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 stablized to a degree where permanent disposition is warranted will be placed on the TDRL if otherwise qualified for retirement under the provisions of 10 USC, Chapter 61.

b. The TDRL shall be used in the nature of a "pending list" for members who are unfit

because of physical disability with conditions which may be permanently disabling and who meet the other requirements of 10 USC, Chapter 61 (reference (a)) for disability retirement.

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 Secretary of the appropriate Military Department, 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, or an inadequate report is received, disposition of the case shall be made in accordance with V.G.5., below.

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 may 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 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 USC, Chapter 61 (reference (a)), unless evidence shows just cause for failure to be examined.

H. Continuance on Active Duty by Members Unfit Because of Physical Disability for Military Duty

1. With the consent of the member, particularly one with over 18 years' active military service, the Secretary of the appropriate Military Department 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 V. must be unfit because of physical disability which is basically stabilized or where accepted medical principles indicate slow progression. They must be able to maintain themselves in a normal military or naval environment, without jeopardizing their health or the health of others, 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 interest 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.

## VI. RESPONSIBILITIES

A. The Assistant Secretary of Defense (Manpower and Reserve Affairs) will (1) review Military Department implementing procedures periodically to insure their uniformity; (2) establish procedures for revising enclosure 2 to provide a complete and up-to-date listing of disabilities which may be considered as rendering members unfit for military service; and (3) review subsequent changes to Military Department standards submitted by the Secretary of a Military Department in accordance with VI. B., below.

B. The Secretaries of the Military Departments will:

1. Insure that policies and procedures established by this Directive are interpreted uniformly so that a member of one military service will be granted benefits substantially the same as a member of another military service under similar conditions. Recognizing that there are basic organizational and procedural differences among the Military Departments, it is not the intent of this Directive to establish uniform procedures where procedures in effect do not result in decidedly different case dispositions among the Military Departments.

2. Review existing procedural practices (in particular, those contributing to delays in disposition of cases, discontinuing those which duplicate effort in any case in which such discontinuance would not jeopardize the rights of the party or the interest of the Government) to insure expeditious processing of all cases arising under 10 USC, Chapter 61 (reference (a)).

3. Submit to ASD(M&RA) all substantive changes, and reasons therefor, proposed to the standards used by a Military Department for determining whether a member is fit for further service or rates a disability. The ASD(M&RA) will determine their

effect upon this Directive and the standards of other Military Departments before approving or disapproving the proposal.

## VII. AD HOC WORKING GROUPS

Temporary ad hoc working groups may be appointed by the ASD(M&RA), either on his own initiative or upon the recommendation of the Secretary of a Military Department, to perform specific tasks in the periodic review of Military Department procedures implementing reference (a). 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 one hundred and twenty (120) days.

## VIII. EFFECTIVE DATE AND IMPLEMENTATION

This Directive is effective immediately. Two (2) copies of each implementing document of the Military Departments shall be forwarded to the Assistant Secretary of Defense (Manpower and Reserve Affairs) within sixty (60) days.

Paul H. Nitze
Deputy Secretary of Defense

Enclosures - 3
1. Definitions
2. Medical Conditions and Physical Defects which Normally Render a Member Physically Unfit for Further Military Duty
3. Application of V. A. Schedule for Rating Disabilities

# 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 impairment which results in a lessening or weakening of the capacity of the body or any of its parts, to perform that which, according to accepted medical principles, is considered to be normal.

• 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 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 behavior disorders, personality disorders, and primary mental deficiency.

• F. Accepted Medical Principles. Accepted medical principles are fundamental deductions consistent with medical facts which are 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 the patient's medical fitness for further active service can be determined, and it is considered probable that further treatment for a reasonable period in a military hospital will not result in material change in the patient's condition which would alter his ultimate type of disposition or amount of separation benefits.

• H. Reasonable Doubt. A reasonable doubt is one which exists when the evidence does not satisfactorily prove or disprove the claim. It is a substantial doubt (not specious) and within the range of probabilities as distinguished from pure speculation or remote possibility. It

is not a means of reconciling actual conflict or contradictions in the evidence.

I. Disability of a Permanent Nature. A disability will be considered as permanent if, based upon accepted medical principles, the defect has stabilized to the extent that the compensable percentage rating will, with reasonable expectation, remain unchanged during the 5-year statutory period; or if the compensable percentage rating is 80 percent or more and there is reasonable expectation that it will not reduce below 80 percent during the 5-year statutory period.

J. Disability Which May be of a Permanent Nature. A disability will be considered as "may be permanent" if, based upon accepted medical principles, the defect is of such a nature that accurate assessment cannot be made of its permanent degree of severity or percentage rating.

# MEDICAL CONDITIONS AND PHYSICAL DEFECTS WHICH NORMALLY RENDER A MEMBER PHYSICALLY UNFIT FOR FURTHER DUTY

## TABLE OF CONTENTS

# TABLE OF CONTENTS

## SECTION I

## 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, to require 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. 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.

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. Per se, except when responding well to ordinary 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. 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 gastrojejeunostomy or pyloroplasty with or without vagotomy, when, in spite of good medical management, the individual:

(a) Develops incapacitating dumping syndrome, or

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

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

(d) Not to be confused with dumping syndrome, and not ordinarily considered as representative of unfitness are: Postoperative symptoms such as moderate feeling of fullness after eating; the need to avoid or restrict the ingestion of high carbohydrate foods; the need for daily schedule of a number of small meals with or without additional "snacks".

e. Gastrostomy. When permanent.

f. Ileostomy. When permanent.

g. Pancreatoctomy. Except for partial pancreatoctomy for a benign condition which does not result in moderate residual symptoms.

h. Pancreaticoduodenostomy, pancreaticogastrostomy, pancreaticojejeunostomy. Followed by more than mild symptoms of digestive disturbance, or requiring insulin.

i. Proctectomy.

j. Proctopexy, proctoplasty, proctorrhaphy, or proctotomy. If fecal incontinence remains after appropriate treatment.

## SECTION II

## BLOOD AND BLOOD-FORMING TISSUE DISEASES

1. When response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.

a. Anemia.

b. Hemolytic disease, chronic. Symptomatic, or with recurrent crises.

c. Leukopenia, chronic.

d. Polycythemia.

e. Purpura and other bleeding diseases.

f. Thromboembolic disease.

g. Splenomegaly, chronic.

## SECTION III

## DENTAL

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

## SECTION IV

## 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, suppurative, resistant to treatment, and necessitating frequent or prolonged medical care.

2. Hearing.

a. Ordinarily, a hearing defect is not sufficient reason for considering an individual unfit because of physical disability. Many individuals having a hearing defect are benefited by a hearing aid and can continue to perform effective duty.

b. When the unaided average hearing loss in the better ear is 30 decibels or more in the normal speech range (pure tone audiometric values at the 500, 1000, 2000 cycles per second), the individual will be evaluated at an audiology and speech center. Audiology specialists at this center will recommend referral to a PEB when appropriate. This recommendation may be based on either the results of pure tone audiometry or speech reception threshold and discrimination, whichever in the judgment of these specialists most accurately reflects the degree of the hearing loss.

## SECTION V

## ENDOCRINE AND METABOLIC CONDITIONS

1. Endocrine and Metabolic Diseases.

a. Acromegaly. With functional impairment, or requiring major replacement therapy.

b. Adrenal hyperfunction. Not responding to therapy.

c. Adrenal hypofunction. Requiring medication for control.

d. Diabetes insipidus. Unless mild, with good response to treatment.

e. Diabetes mellitus. When proven to require insulin or combinations of oral hypoglycemic drugs in addition to restrictive diet for control.

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

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

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

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

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

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

## SECTION VI

## EXTREMITIES

1. Upper.

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:

(1) Shoulder:

(a) Forward elevation to 90°.

(b) Abduction to 90°.

(2) Elbow:

(a) Flexion to 100°.

(b) Extension to 60°.

# Measurement of Ankylosis and Joint Motion

## Upper Extremities

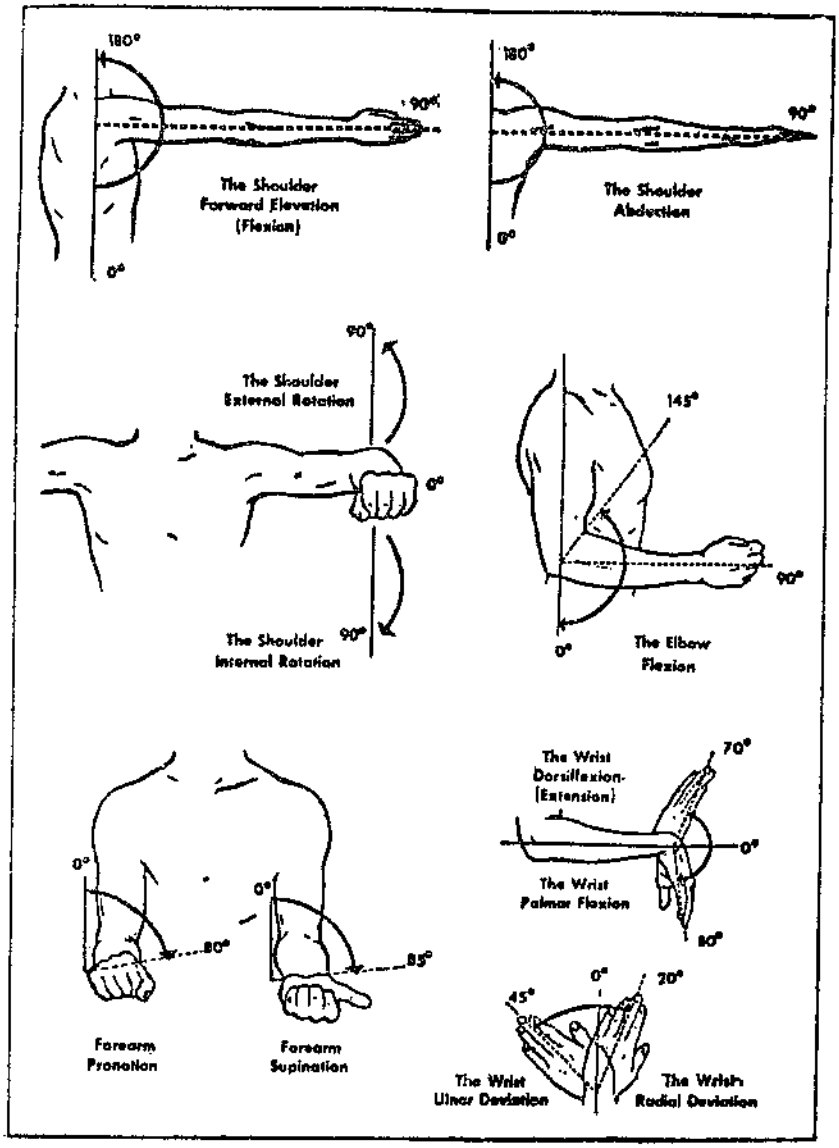



**PLATE I**

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

c. Dislocated Shoulder. When not repairable or surgery is contraindicted.

2. Lower.

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, more than moderate, with pronation on weight bearing which 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, or which prevents the wearing of a military shoe.

c. Internal derangement of the knee.

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

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

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:

(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 which exceeds two inches.

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. Severe symptoms 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. Substantiated history of frequent incapacitating episodes supported by objective and subjective findings.

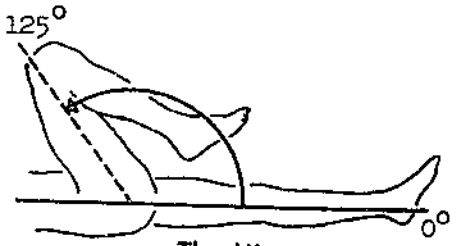
b. Chondromalacia or Osteochrondritis dessicans. Severe, manifested by frequent joint effusion, more than moderate interference with function or with severe residuals from surgery.

c. Fractures.

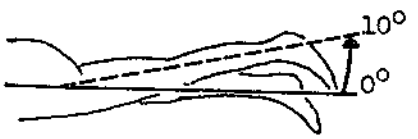
(1) Malunion. When after appropriate treatment, there is more than moderate malunion with marked deformity or more than moderate loss of function.

Measurement of Ankylosis and Joint Motion

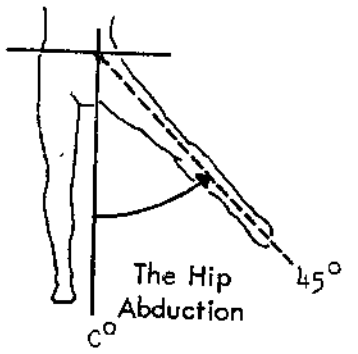
Lower Extremities

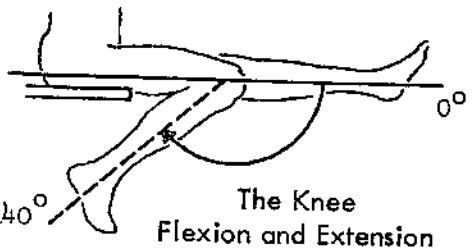



The Hip
Flexion

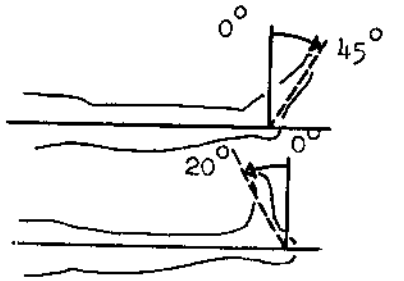



The Hip
EXTENSION




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°.

(2) Nonunion. When after an appropriate healing period, the nonunion persists 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.

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

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

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

e. Muscles.

(1) Flaccid paralysis of one or more muscles, producing loss of function which precludes satisfactory performance of duty.

(2) Spastic paralysis of one or more muscles producing loss of function which precludes the satisfactory performance of military duty.

f. Myotonia congenita.

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.

## SECTION VII

## 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 2e below, or

(2) The diameter of the field of vision in the better eye is less than $20^{\circ}$.

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 unfitting, per se; however, residuals or complications, or the underlying disease may be unfitting.

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

g. Retina, detachment of.

(1) Unilateral.

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

(b) When the visual field in the better eye is constricted to less than $20^{\circ}$.

(c) When uncorrectible diplopia exists.

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

(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. Which is severe, constant, and in zone less than $20^{\circ}$ 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) Visual acuity which cannot be corrected to at least 20/70 in the better eye, and the corrected vision is 20/400 or worse in the poorer eye or

(2) An eye has been enucleated, or

(3) When vision is correctible only by the use of contact lenses or other specified corrective device (telescope lenses, etc.).

f. Visual fields. When the visual field in the better eye is constricted to less than $20^{\circ}$.

## SECTION VIII

## 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. Bilateral and symptomatic.

(2) Congenital anomaly. Bilateral, 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). When renal function is impaired, or if the focus of frequent infection.

(4) Hydronephrosis. More than mild, bilateral, and causing continuous or frequent symptoms.

(5) Hypoplasia of the kidney. Associated with elevated blood pressure or frequent infections.

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

(7) Nephrosis, other than mild.

(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 more than mild mental and constitutional symptoms.

h. Strictures of the urethra or ureter. Severe and not amenable to treatment.

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 50 cc or if refractory symptomatic infection persists.

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.

f. Penis, amputation of.

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 hypronephrosis 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.

## SECTION IX

## HEAD

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

## SECTION X

## 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 comprise 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 correctible by surgery and producing limiting symptomatic conditions precluding 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 similiar 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 (post-phlebitic syndrome). When more than mild and symptomatic despite elastic support.

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 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.

3. Miscellaneous.

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-Wagener-Barker) changes in the fundi.

b. Residual of surgery of the heart, pericardium or vascular system. When surgery results in inability of the individual to perform duties without discomfort or dyspnea.

## SECTION XI

## LUNGS AND CHEST WALL

1. Tuberculous Lesions. See pertinent service publications.

a. Pulmonary Tuberculosis (to include tuberculous pleurisy). When treatment and return to useful duty will probably require more than 15 months.

2. Nontuberculous Conditions. Pulmonary diseases, other than acute infections, must be evaluated in terms of respiratory function, manifested clinically by exertional tolerance, and in the laboratory by measurements which must be interpreted as exertional or altitudinal tolerance. Symptoms of cough, pain, and recurrent infections may limit a member's activity. Many of the conditions listed below may co-exist, and in combination may produce unfitness.

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 exeration, 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, pynopneumothorax or chronic fibrotic pleurisy. More than moderate restriction of respiratory excursions and chest deformity, or weakness and fatigability on slight exertion.

g. Histoplasmosis. With significant residuals or failure to respond to treatment.

h. Pneumothorax, spontaneous. Repeated episodes of pneumothorax not correctible 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 the Lungs and Chest.

Lobectomy. If pulmonary function (ventilatory tests) is impaired to a moderate degree or more.

## SECTION XII

## MOUTH, NOSE, PHARYNX, LARYNX AND TRACHEA

1. Larynx.

a. Paralysis of the larynx. Characterized by bilateral 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, and does not respond to treatment.

c. Trachea. Stenosis of.

## SECTION XIII

## NEUROLOGICAL DISORDERS

1. Neurological Disorders.

a. Amyotrophic sclerosis, lateral.

b. Atrophy, muscular, myelopathic. Includes severe residuals of poliomyelitis.

c. Atrophy, muscular. Progressive.

d. Chorea. Chronic and progressive.

e. Friedreich's ataxia.

f. Hepatolenticular degeneration.

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

h. Multiple sclerosis.

i. Myelopathy, transversa.

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

k. Paralysis agitans.

l. Peripheral nerve conditions.

(1) Neuralgia. When symptoms are severe, persistent, and not responsive to treatment.

(2) Neuritis. When manifested by more than moderate, permanent functional impairment.

(3) Paralysis due to peripheral nerve injury. When manifested by more than moderate, permanent functional impairment.

m. Syringomyelia.

n. General. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, 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 of such a degree as to definitely interfere with the performance of duty.

## SECTION XIV

## PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

1. Psychoses. Recurrent psychotic episodes, or a single well-established psychotic episode with existing symptoms or residuals thereof sufficient to interfere with performance of duty or normal pursuits.

2. Psychoneuroses. Severe symptoms, persistent or recurrent, 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. Character and behavior disorders. Character and behavior disorders may render an individual unsuitable 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 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 of such degree as to interfere with the satisfactory performance of duty are unsuitable and should be recommended for administrative separation.

## SECTION XV

## SKIN AND CELLULAR TISSUES

1. Skin and Cellular Tissues.

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

b. Atopic dermatitis. More than moderate or requiring frequent hospitalization.

c. Cysts and tumors. See Section XVIII below.

d. Dermatitis herpetiformis. Which fails to respond to therapy.

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

f. Elephantiasis or chronic lymphedema. Not responsive to treatment.

g. Epidermolysis bullosa.

h. Erythema multiforme. More than moderate and chronic or recurrent.

i. Exfoliative dermatitis. Chronic.

j. Fungus infections, superficial. If not responsive to therapy and resulting in frequent absences from duty.

k. Hidradenitis, suppurative and folliculitis decalvans.

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

m. Leukemia cutis and mycosis fungoides.

n. Lichen planus. Generalized and not responsive to treatment.

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

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

q. Parapsoriasis. Extensive and not controlled by treatment.

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

s. Psoriasis. Extensive and not controllable by treatment.

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

u. 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.

v. Tuberculosis of the skin. See Section XVII, paragraph 1-k, below.

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

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

y. Other skin disorders. If chronic, or of a nature which requires frequent medical care or interferes with the satisfactory performance of military duty.

## SECTION XVI

## SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS

1. Spine, Scapulae, Ribs, and Sacroiliac Joints. (See also Section VI, paragraph 3, above).

a. Congenital anomalies.

(1) Dislocation, congenital, of hip.

(2) Spina bifida. Demonstrable signs and moderate symptoms of root or cord involvement.

(3) Spondylolysis or spondylolisthesis. With more than mild symptoms resulting in repeated outpatient visits, or repeated hospitalization.

b. Coxa vara. More than moderate with pain, deformity, and arthritic changes.

c. 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.

d. Kyphosis. More than moderate, or interfering with function, or causing unmilitary appearance.

e. Scoliosis. Severe deformity with over two inches deviation of tips of spinous processes from the midline.

## SECTION XVII

## SYSTEMIC DISEASES, AND MISCELLANEOUS CONDITIONS AND DEFECTS

1. Systemic Diseases.

a. Amyloidosis. Generalized.

b. Dermatomyositis.

c. Leprosy. Any type.

d. Lupus erythematosus, disseminated, chronic.

e. Myasthenia gravis.

f. Mycoses. Active, not responsive to therapy or requiring prolonged treatment, or when complicated by residuals which in themselves are unfitting.

g. Panniculitis. Relapsing, febrile, nodular.

h. Porphyria.

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

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

k. Tuberculosis, active.

2. General and Miscellaneous Conditions and Defects. Conditions and defects, individually or in combination, not elsewhere provided for in this annex, if:

a. The individual is precluded from a reasonable fulfillment of the purpose of his employment in the military service, or

b. The individual's health or well-being would be compromised if he were to remain in the military service, or

c. The individual's retention in the military service would prejudice the best interests of the Government.

Questionable cases will be referred to physical evaluation boards for a determination of unfitness.

## SECTION XVIII

## TUMORS AND MALIGNANT DISEASES

1. Malignant Neoplasms.

Malignant neoplasms when they are of such a nature as to preclude satisfactory performance of duty.

2. Neoplastic Conditions of Lymphoid and Blood-Forming Tissues.

Neoplastic conditions of the lymphoid and blood-forming tissues normally render an individual unfit for further military service.

3. Benign Neoplasms.

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

## SECTION XIX

## VENEREAL DISEASES

1. Veneral Diseases.

a. Symptomatic neurosyphilis in any form.

b. Complications or residuals of veneral diseases of such chronicity or degree of severity that the individual is incapable of performing useful duty.

# APPLICATION OF THE VETERANS ADMINISTRATION SCHEDULE FOR RATING DISABILITIES

## TABLE OF CONTENTS

## Section I --- 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 Chapter 61 of Title 10, USC, (reference (a)). However, not all the General Policy provisions 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 I of this enclosure replaces paragraphs 1 through 31 of the VA Schedule. The remainder of the VA Schedule (paragraph 40 et seq.) is applicable to the Military Departments 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 Section II of this enclosure as being inapplicable.

2. Essentials of Evaluative Rating. 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.

3. Higher of Two Evaluations. In view of the number of atypical instances, it is not expected especially with the more fully described grades, that all cases will show all the findings specified in the VA Schedule. However, findings sufficiently

characteristic to identify the disease and the disability therefrom and, above all, coordination of rating with impairment of function is required in all instances. It is not the intent of the VASRD that there be a rigid requirement for the presence of all enumerated manifestations of a given disability. Those manifestations sufficiently and significantly representative of the entity and the severity of limitations imposed on the member are the only requirements. Where there is a question as to which of two percentage evaluations shall be applied, the higher evaluation will be assigned if the disability picture 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 Section II 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 overrating. For example, disability from fracture of a tibia with malunion, limitation 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 ratings 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 even for the lowest rating provided in the VA Schedule under the applicable code number. A zero 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 (see paragraph 8.b., below). It should be noted that the zero percent rating does not preclude the award of compensation as prescribed by law for ratings of less than 30 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 poliomelitis, 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 zero percent is appropriate.

9. Extra Schedular Ratings in Exceptional Cases. The requirement to use the VA Schedule in rating disabilities vests in the Secretary of each 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 schedular evaluations are found to be inadequate extraschedular 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 schedular 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 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 service is not ascertainable in terms of the schedule, no deduction will be made.

11. Combined Ratings Table. When a member has more than one compensable disability, the percentages are combined rather than added. 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 accordance 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 .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.)

12. 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 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 use of the terms "arms" and "legs" is not intended to distinguish between the arm, forearm, and hand, or the thigh, leg, and foot, but relates 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.

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.

13. 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 diagnoses

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 will generally be represeneted 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 should be that of the medical examiner, with no requirement to translate his terms into schedule nomenclature. 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 (7006 - 7005) 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 (8024 - 8513).

c. When an unlisted condition is rated by analogy, e.g., sypondylolisthesis rated as sacro - iliac injury and weakness (5299 - 5295). 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 be "99" for all unlisted conditions. This procedure will facilitate a close check of new and unlisted conditions, rated by analogy.

## Section II - RATING PRINCIPLES

Disabilities are listed in VA Code number sequence. Instructions and explanatory notes which follow are listed according to the code numbers in the VA Schedule for Rating Disabilities. Only those conditions which require special comment or those which have been the cause of misunderstanding in the past are included.

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-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 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.

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 minor 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 joint 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 series of codes).

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 should be emphasized that separate ratings 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.

5099, Bones, Joints, and Muscles, Other Disease of.

Malignant new growths of joints or muscles should be rated as 5299-5012 or 5399-5012, respectively. Upon expiration of the one-year period specified in the note following Code 5012, rate residuals as otherwise provided for joint or muscle injuries.

5126-5151, Multiple Finger Disabilities. 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 in the VASRD. The method is as follows:

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

| Defect of Individual Finger | Rated As | Grade Value |
|---|---|---|
| Amputation through distal phalanx 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 the metacarpal | Single finger amputation with metacarpal resection (Codes 5152 thru 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 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 finger through the middle phalanges, and the entire ring finger, including more than one half of the metacarpal.

Grade value for the thumb----------1
Grade value for the index finger----------2
Grade value for the little finger----------2

Grade value for the ring and metacarpal------ 4
Total value---------- 9

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

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

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 VA Code Number 5127 at 60 percent (for major hand) or 50 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 (pages 26R and 27R) of the VASRD.

b. 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.

c. 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.

d. 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 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 a 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 should be resolved in the member's favor.

c. "Motion lost beyond last quarter of arc" means that the forearm can be pronated from $0^{\circ}$ thru $45^{\circ}$, but no further. (See paragraph 71 and the illustration of forearm pronation, Plate 1, page 26 of the VA Schedule.)

5251-5252, 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.

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, The 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 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 subparagraph c. below) 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. | | 30 |
| 4. | Code 5285-5292---------- | 20% |
| 5. | Demonstrable deformity of L1-------- | +10 |
| 6. | | 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, The 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 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 inch
2 square centimeters = 0.3100 square inch
3 square centimeters = 0.4650 square inch

| Diameter of Circle | Sq Cm | Area of Circle | Sq In |
|---|---|---|---|
| 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 Inch | | | 1.76715 |
| 2 Inch | | | 3.1416 |

* Size of the average diagnostic burr hole

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% of diagnostic burr holes heal within 5 years.

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

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 inch) should be resolved in favor of the member.

5297, Removal of Ribs.

a. The VASRD, for removal of ribs, 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.

5299-5255, 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 VA, and not necessarily 60 percent under Code 5255.

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 be additionally 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 impossible 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 apporatus, 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 evaluee'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. Copies of the records showing visual field defects should be attached to the narrative summary. Muscle function examinations will be made and reported in accordance with paragraph 77 of the VA Schedule.

6000-6009, Conditions Involving Structures of the Globe.

Disabilities resulting from these conditions should be rated 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 requirements, 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 whichever one of the codes 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.

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 applies whether the disease process involves one or both eyes.

6029, Aphakia. The expression "one step less" used in the note under this code in the VASRD refers to less vision, not to percentage evaluation.

6081, Scotoma, Pathological. The rating is 10 percent 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 percent unless there is an enucleation or a serious cosmetic defect. Central scotoma cannot, however, be combined with central visual loss.

6200-6297, Diseases of the Ear.

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. The rule against pyramiding should be applied.

6277-6297, Impairment of Auditory Acuity.

a. The evaluations for deafness derived from the VASRD are intended to make proper allowance for improvement by hearing aids. Examination to determine this improvement is therefore unnecessary.

b. Evaluation of this impairment can be through the use of either of the following in VASRD: Table I, page 62-R (controlled speech reception and discrimination tests), or Table II, page 63-2R (pure tone and audiometry).

c. For adjudicative purposes, it is necessary that the concerned boards and review agencies be provided with conclusions from audiology specialists relative to which of the two methods of testing best depicts the severity of the organic hearing loss.

d. Most audiometric examinations now being performed use as reference-zero level the one recommended by the International Standards Organization (ISO). The previously used standards were those established by the American Standards Association (ASA). Table II, page 63-3R, VASRD, is based on the ASA reference standards. When pure tone audiometric tests based on the ISO Standards are noted in the clinical records, Table II of the VASRD cannot be utilized for rating until the hearing levels are converted to the ASA standards. The ISO levels are numerically greater than, and may be converted to the ASA levels, by subtracting the difference in decibels at each frequency in the normal range of hearing as follows:

| At Frequency (CPS) | 500 | 1000 | 2000 |
|---|---|---|---|
| Convert ISO to ASA | | | |
| By Subtracting | 15 | 10 | 10 |

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. Residual impairments will be rated under the appropriate code. When a member is determined to be unfit due to recurrence of disease, and there is no residual functional impairment, consideration should be given to use of the zero percent rating.

6350, Lupus Erythematosus, systemic. Collagen diseases will be rated 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, the highest applicable rating will be awarded. This instruction does not apply to specch impairment due to loss of whole or part of the tongue, which is to be rated under Code 7202.

6600-6602, Asthma. Appropriate ventilatory function studies must be included in clinical records to support the diagnosis and degree of severity in these pulmonary diseases.

Inactive Tuberculosis. After tuberculosis (pulmonary or nonpulmonary) has been inactive for at least six months as defined below, the history thereof does not present a manifest or latent impairment of function and is therefore not considered to be a physical disability as defined in VI. E. of the basic Directive. Moreover, disability laws administered by the Military Departments require generally that the final degree of disability be determined within a period of 5 years. Therefore, the graduated ratings for tuberculosis (page 68-R of the VA Schedule and VA Code 6721-6724) providing for re-evaluation by the VA and reduced percentages over a period of not less than 11 years, cannot be applied within the Military Departments. However, if a member is considered to be physically unfit because of another condition after his tuberculosis has become inactive, he is rated on any residuals of the original tuberculous condition that may be present.

Residuals of Inactive Nonpulmonary Tuberculosis. Graduated ratings for inactive nonpulmonary tuberculosis will not be applied by the Military Departments. After the condition has become inactive, residuals (e.g., ankylosis, surgical removal of a part, etc.) are rated under appropriate VA code for the specific residual preceded by the VA code for the tuberculosis of the body part affected (e.g., tuberculosis of the hip joint with residual ankylosis, coded as 5001-5250).

6721-6724, 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 roetgenograms must be stable or show very slow shrinkage of the tuberculous lession. No evidence of cavity. Slutum or gastric washings negative on culture on guinea pig inoculation. These conditions shall have existed not less than 6 months.

(2) On a date of inactivity established 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 hospital discharge, whichever is later.

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

c. Rating Residuals. Graduated ratings for inactive pulmonary tuberculosis will not be applied by the Military Departments. After the condition becomes inactive, residuals (e.g., impairment of pulmonary function, surgical removal or resection of a part, etc.) will be rated under the appropriate VA code, subject to the limitations contained in paragraph 96 of the VA Schedule.

6800, 6801, 6802, 6811, 6812, and 6818, Non-Tuberculous Diseases.

Appropriate ventilatory 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 6 months" rating. Rate the underlying condition, if known, or consider rating by analogy to asthma.

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.

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 (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.

6899, Emphysema. Rate by the closest analogy, such as Code 6802 or 6600.

7000 Series, Cardiovascular Disease.

a. To avoid pyramiding, only one rating should be given for all manifestations of cardiovascular-renal disease when, according to accepted medical principles, the conditions are etiologically related.

For example, hypertension, arteriosclerosis, and nephritis involving vasular 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 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. Valvular heart disease not of arteriosclerotic or hypertensive origin should be rated 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, 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 presence of enlargement is uncertain. Voltage abnormalities alone are not acceptable as electrocariographic 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 procedure, the rating should be assigned on the basis of the residual functional impairment.

7005-7006, Arteriosclerotic Heart Disease, Myocardial Infarction.

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

b. A rating of 100 percent under this code solely on the basis of the acute attack occuring 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 typical history of coronary occlusion or thrombosis or 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 80-percent rating. Following a typical history of coronary occlusion or thrombosis or myocardial infarction, complicated by congestive heart failure or other related significant complications, and requiring active therapy such as digitalis, diuretics and/or restricted diet.

(3) The 60-percent rating. Following a typical history of acute coronary occlusion or thrombosis or myocardial infarction with substantiated repeated attacks of angina pectoris or similar significant continuing complications. Also, substantiated repeated attacks of angina pectoris without antecedent myocardial infarction.

(4) 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 infarcion without continuing symptoms indicative of complications of arteriosclerotic heart disease. Also, a single episode of angina pectoris with temporary or permanent electrocardiographic changes consistent with myocardial ischemia.

d. When an occlusion or other acute condition 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.

e. 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.

Blood pressure reading to be used in determining disability rating percentages should be obtained under normal circumstances and during usual activities. When antihypertensive medication is required for control, the rating is based on the pressures obtained during usual activities while under medication. It should be emphasized that hypertension brought under control through optimum conditions, that is, during hospitalization under a regimem 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 five days, on treatment, and under conditions as close as possible to normal duty performance, will be necessary. Blood pressure levels should also be correlated 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 will be the basis for determination of the level of hypertension.

7007, Hypertensive Heart Disease.

a. Code 7007 is not to be combined with Codes 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. Generally, to justify the 30-percent rating for hypertensive heart disease, all of the criteria mentioned in the VASRD for that rating should be met. "Definite enlargement of the heart" means certain left ventricular 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 at least be consistent with that diagnosis.

7099, Aortic Grafts. The possible grave prognosis for a member who has an aortic graft should be kept in mind when evaluating this condition. Although relatively few symptoms may exist following the graft, this procedure usually warrants a 30-percent rating under VA Codes 7099-7005 on the basis of latent impairment. If symptomatology still exists following the grafting procedure, it should be rated according to the VA Schedule for the underlying condition.

7100, Arteriosclerosis, General. The 20-percent rating under this code is rarely appropriate. Manifestations of the disease preferably should be rated for impairment of the body system involved to the greatest degree.

7114-7117, Peripheral Vascular Disease.

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 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, the above procedure will be applied 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. 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 percent or less will not be combined 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 |

e. Peripheral vascular disease rating chart (cont'd)

| Three extremities involved<br>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<br>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, care must be taken 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 postgrastecomy 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.

7328-732°, Intestinal Resections. 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 when it should 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 contraindicating 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.

7399, Pancreatitis. This disease is to be rated by analogy to Code 7314 (cholecystitis) or Code 7306 (ulcer, marginal), whichever is more appropriate according to the type and severity of signs and symptoms. Diabetes mellitus, if present, is to be rated separately.

7500-7529, The Genito-Urinary System. Sterility and impotence are not ratable entities.

7526, Prostate Gland, Resection or Removal. Because of improved surgical techniques, the minimum 20-percent rating is excessive in many cases. Until the VA Schedule is revised, however, the 20-percent minimum rating is to be applied.

7709, Lymphogranulomatosis (Hodgkin's Disease). The unpredictable course that this disease may take, and its grave ultimate

prognosis, frequently presents difficulty in assigning an equitable percentage rating. With an established diagnosis and accurate clinical staging, and with adequate supporting evidence including negative evidence, members in Stages I and IIA should be assigned the 30-percent rating unless the symptoms present justify a higher rating. Members in Stage IIB should be rated not lower than 60-percent. Members in Stage III are normally rated at 100-percent.

7801, Scars, Burn, Third Degree. The following instructions will supplement the criteria under Code 7801 in the Veterans Administration Schedule for Rating Disabilities to permit a realistic rating of actual impairment of function:

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 unsuccessfully healed or grafted areas according to Code 7801. Footnotes in the VASRD apply.

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

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

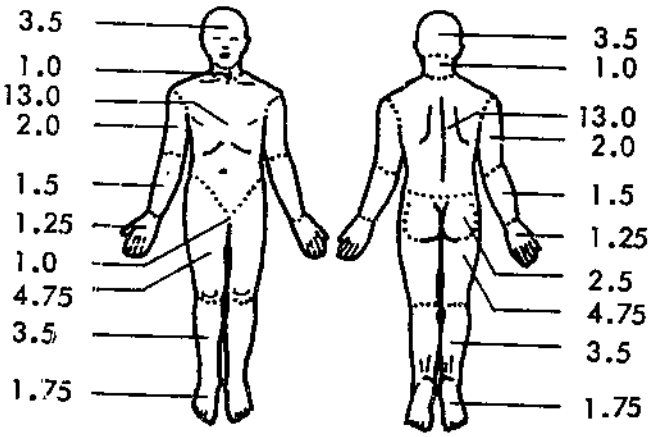
Average 70 kgm (150lb) male body surface = $1.7M^2$
2636 $in^2$ = 18.3 $ft^2$
1 meter = 39.37 inches
1 $meter^2$ = 1550.6 $inches^2$

7802, Scars, Burns, Second Degree. VA Code 7802 limits rating to 10-percent for second degree burns affecting an area or areas approximately 1 square foot. Where there are widely separated areas and each area is approximately 1 square foot or more, 10-percent may be assigned for each scar.

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

# 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 | % of body surface | Area | |
|---|---|---|---|
| | | sq. inches | sq. feet |
| Anterior or posterior head | 3.5 | 92 | 0.64 |
| Anterior or posterior neck | 1.0 | 26 | 0.18 |
| Anterior or posterior trunk | 13.0 | 343 | 2.38 |
| Anterior or posterior arm | 2.0 | 53 | 0.37 |
| Anterior or posterior forearm | 1.5 | 40 | 0.27 |
| Dorsal or palmar hand & fingers | 1.25 | 33 | 0.23 |
| Buttock | 2.5 | 66 | 0.46 |
| Genitalia | 1.0 | 26 | 0.18 |
| Anterior or posterior thigh | 4.75 | 125 | 0.87 |
| Anterior or posterior calf | 3.5 | 92 | 0.64 |
| Dorsal foot or sole, incl. toes | 1.75 | 46 | 0.32 |

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." 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 regimen 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-percent.

8000-8046, Organic Diseases of the Central Nervous System.

Careful correlation of the note 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 6 months 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 re-evaluations.

8023-8025, Progressive Muscular Atrophy and Myasthenia Gravis. 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. Cases of paralysis of the common peroneal nerve with foot drop, VA Code 8521, will be rated 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. This syndrome should be rated 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, The Epilepsies. Attacks following omission of prescribed medication or the ingestion of alcoholic beverages are not indicative of the controllability of the disease, and should not be included in the determination of the disability percentage.

9200-9210, Psychotic Disorders. Ratings should be based on actual industrial inadaptability. Social inadaptability and symptomatology (such as autism, affect-disturbance and loosening of associations) are to be evaluated only as they affect industrial adaptability. See paragraphs 125 through 130 of the VASRD.

a. Complete. Members determined to have this degree of severity will most often be declared incompetent and, if not transferred to a VA hospital, be discharged to the care of a relative or guardian. Generally, it is inconsistent to rate a member's condition as "complete" whose disposition is other than the foregoing.

b. Severe. This degree of severity will rarely be used because the member whose condition fulfills its criteria is usually more appropriately given a rating of "complete".

c. Considerable and Definite. These degrees of severity are considered appropriate when the member has some potential employability. A member's overall life-adjustment will be considered in a choice of the degree of severity.

d. Slight. The "slight" degree of severity will be appropriately applicable subsequent to psychotic episodes, with or without residuals, when none of the foregoing are applicable.