VA Diagnostic Code

How to use this chart. First, if you do not know the diagnostic code assigned to the condition use the first chart, an alphabetical index, and locate the condition next to which will be assigned the diagnostic code. Then, scroll down to the second chart to find the guidance on how to rate for that diagnostic code. If you already know the diagnostic code, skip the first step and go directly to the diagnostic code in the second chart.

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Stomach, stenosis of	7309
Supraventricular tachycardia	7010
Symblepharon	6091
Syndromes:	
Chronic Fatigue Syndrome (CFS)	6354
Cushing's	7907
Meniere's	6205

Raynaud's	7117
Sleep Apnea	6847
Syphilis	6310
Syphilis:	
Cerebrospinal	8013
Meningovascular	8014
Syphilitic heart disease	7004
Syringomyelia	8024
Tabes dorsalis	8015
Tarsal or metatarsal bones	5283
Tenosynovitis, tendinitis, tendinosis or tendinopathy	5024
Testis:	
Atrophy, complete	7523
Removal	7524
Thrombocytopenia	7705
Thrombosis, brain	8008
Thyroid gland:	
Nontoxic thyroid enlargement	7902
Toxic thyroid enlargement	7901
Thyroiditis	7906
Tic, convulsive	8103
Tinnitus, recurrent	6260
Toxic nephropathy	7535
Traumatic brain injury residuals	8045
Traumatic chest wall defect	6843
Tuberculosis:	
Adenitis	7710
Bones and joints	5001
Eye	6010
Kidney	7505
Luposa (lupus vulgaris)	7811
Miliary	6311
Pleurisy, active or inactive	6732
Pulmonary:	
Active, far advanced	6701
Active, moderately advanced	6702
Active, minimal	6703
Active, advancement unspecified	6704
Active, chronic	6730
Inactive, chronic	6731
Inactive, far advanced	6721
Inactive, moderately advanced	6722
Inactive, minimal	6723
Inactive, advancement unspecified	6724
Tuberculosis luposa (lupus vulgaris)	7811
Tympanic membrane	6211
Ulcer:	
Duodenal	7305
Gastric	7304

Marginal	7306
Ureter, stricture of	7511
Urethra	
Fistula	7519
Stricture	7518
Urticaria, chronic.	7825
Uterus:	
And both ovaries, removal	7617
Disease or injury	7613
Prolapse	7621
Removal	7618
Uveitis	6000
Vagina, disease or injury	7611
Vagotomy	7348
Valvular heart disease	7000
Varicocele/Hydrocele	7543
Varicose veins	7120
Vasculitis, primary cutaneous	7826
Ventricular arrhythmia	7011
Vertebral fracture or dislocation	5235
Vibriosis (Cholera, Non-cholera)	6300
Visceral Leishmaniasis	6301
Visceroptosis	7342
Vision: see also Blindness and Loss of:	
One eye 5/200 (1.5/60), with visual acuity of other eye:	
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6075
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6076
20/40 (6/12)	6077
One eye 15/200 (4.5/60), with visual acuity of other eye:	
15/200 (4.5/60) or 20/200 (6/60)	6075
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6076
20/40 (6/12)	6077
One eye 20/200 (6/60), with visual acuity of other eye:	
20/200 (6/60)	6075
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6076
20/40 (6/12)	6077
One eye 20/100 (6/30), with visual acuity of other eye: and other eye:	
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6078
20/40 (6/12)	6079
One eye 20/70 (6/21), with visual acuity of other eye:	
20/70 (6/21) or 20/50 (6/15)	6078
20/40 (6/12)	6079
One eye 20/50 (6/15), with visual acuity of other eye:	
20/50 (6/15)	6078
20/40 (6/12)	6079
Each eye 20/40 (6/12)	6079
Vitiligo	7823
Vulva or clitoris, disease or injury of	7610
Weak foot	5277

West Nile virus infection	6335

38 CFR 4.71a

§ 4.71a Schedule of ratings - musculoskeletal system

Acute, Subacute, or Chronic Diseases

	Rating
5000 Osteomyelitis, acute, subacute, or chronic:	
Of the pelvis, vertebrae, or extending into major joints, or with multiple localization or with long history of intractability and debility, anemia, amyloid liver changes, or other continuous constitutional symptoms	100
Frequent episodes, with constitutional symptoms	60
With definite involucrum or sequestrum, with or without discharging sinus	30
With discharging sinus or other evidence of active infection within the past 5 years	20
Inactive, following repeated episodes, without evidence of active infection in past 5 years	10
Note (1): A rating of 10 percent, as an exception to the amputation rule, is to be assigned in any case of active osteomyelitis where the amputation rating for the affected part is no percent. This 10 percent rating and the other partial ratings of 30 percent or less are to be combined with ratings for ankylosis, limited motion, nonunion or malunion, shortening, etc., subject, of course, to the amputation rule. The 60 percent rating, as it is based on constitutional symptoms, is not subject to the amputation rule. A rating for osteomyelitis will not be applied following cure by removal or radical resection of the affected bone.	
Note (2): The 20 percent rating on the basis of activity within the past 5 years is not assignable following the initial infection of active osteomyelitis with no subsequent reactivation. The prerequisite for this historical rating is an established recurrent osteomyelitis. To qualify for the 10 percent rating, 2 or more episodes following the initial infection are required. This 20 percent rating or the 10 percent rating, when applicable, will be assigned once only to cover disability at all sites of previously active infection with a future ending date in the case of the 20 percent rating.	
5001 Bones and joints, tuberculosis of, active or inactive:	
Active	100
Inactive: See §§ 4.88c and 4.89	
5002 Multi-joint arthritis (except post-traumatic and gout), 2 or more joints, as an active process:	
With constitutional manifestations associated with active joint involvement, totally incapacitating	100
Less than criteria for 100% but with weight loss and anemia productive of severe impairment of health or severely incapacitating exacerbations	60

occurring 4 or more times a year or a lesser number over prolonged periods	
Symptom combinations productive of definite impairment of health objectively supported by examination findings or incapacitating exacerbations occurring 3 or more times a year	40
One or two exacerbations a year in a well-established diagnosis	20
Note (1): Examples of conditions rated using this diagnostic code include, but are not limited to, rheumatoid arthritis, psoriatic arthritis, and spondyloarthropathies.	
Note (2): For chronic residuals, rate under diagnostic code 5003.	
Note (3): The ratings for the active process will not be combined with the residual ratings for limitation of motion, ankylosis, or diagnostic code 5003. Instead, assign the higher evaluation.	
5003 Degenerative arthritis, other than post-traumatic:	
Degenerative arthritis established by X-ray findings will be rated on the basis of limitation of motion under the appropriate diagnostic codes for the specific joint or joints involved (DC 5200 etc.). When however, the limitation of motion of the specific joint or joints involved is non-compensable under the appropriate diagnostic codes, a rating of 10 pct is for application for each such major joint or group of minor joints affected by limitation of motion, to be combined, not added under diagnostic code 5003. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion. In the absence of limitation of motion, rate as below:	
With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups, with occasional incapacitating exacerbations	20
With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups	10
Note (1): The 20 pct and 10 pct ratings based on X-ray findings, above, will not be combined with ratings based on limitation of motion.	
Note (2): The 20 pct and 10 pct ratings based on X-ray findings, above, will not be utilized in rating conditions listed under diagnostic codes 5013 to 5024, inclusive.	
5004 Arthritis, gonorrheal.	
5005 Arthritis, pneumococcic.	
5006 Arthritis, typhoid.	
5007 Arthritis, syphilitic.	
5008 Arthritis, streptococcic.	
5009 Other specified forms of arthropathy (excluding gout).	
Note (1): Other specified forms of arthropathy include, but are not limited to, Charcot neuropathic, hypertrophic, crystalline, and other autoimmune arthropathies**.**	
Note (2): With the types of arthritis, diagnostic codes 5004 through 5009, rate the acute phase under diagnostic code 5002; rate any chronic residuals under diagnostic code 5003.	
5010 Post-traumatic arthritis: Rate as limitation of motion, dislocation, or other specified instability under the affected joint. If there are 2 or more joints affected, each rating shall be combined in accordance with § 4.25.	
5011 Decompression illness: Rate manifestations under the appropriate diagnostic code within the affected body system, such as arthritis for	

musculoskeletal residuals; auditory system for vestibular residuals; respiratory system for pulmonary barotrauma residuals; and neurologic system for cerebrovascular accident residuals.	
5012 Bones, neoplasm, malignant, primary or secondary	100
Note: The 100 percent rating will be continued for 1 year following the cessation of surgical, X-ray, antineoplastic chemotherapy or other prescribed therapeutic procedure. If there has been no local recurrence or metastases, rate based on residuals.	
5013 Osteoporosis, residuals of.	
5014 Osteomalacia, residuals of.	
5015 Bones, neoplasm, benign.	
5016 Osteitis deformans.	
5017 Gout.	
5019 Bursitis.	
5021 Myositis.	
5023 Heterotopic ossification.	
5024 Tenosynovitis, tendinitis, tendinosis or tendinopathy.	
Note to DCs 5013 through 5024: Evaluate the diseases under diagnostic codes 5013 through5024 as degenerative arthritis, based on limitation of motion of affected parts.	
5025 Fibromyalgia (fibrositis, primary fibromyalgia syndrome)	
With widespread musculoskeletal pain and tender points, with or without associated fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud's-like symptoms:	
That are constant, or nearly so, and refractory to therapy	40
That are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but that are present more than one-third of the time	20
That require continuous medication for control	10
Note: Widespread pain means pain in both the left and right sides of the body, that is both above and below the waist, and that affects both the axial skeleton (i.e., cervical spine, anterior chest, thoracic spine, or low back) and the extremities.	

Prosthetic Implants and Resurfacing

	Rating	
	Major	**Minor**
Note (1): When an evaluation is assigned for joint resurfacing or the prosthetic replacement of a joint under diagnostic codes 5051-5056, an additional rating under § 4.71a may not also be assigned for that joint, unless otherwise directed.		
Note (2): Only evaluate a revision procedure in the same manner as the original procedure under diagnostic codes 5051-5056 if all the original components are replaced.		
Note (3): The term “prosthetic replacement” in diagnostic codes 5051-5053 and 5055-5056 means a total replacement of the named		

joint. However, in DC 5054, "prosthetic replacement" means a total replacement of the head of the femur or of the acetabulum.		
Note (4): The 100 percent rating for 1 year following implantation of prosthesis will commence after initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.		
Note (5): The 100 percent rating for 4 months following implantation of prosthesis or resurfacing under DCs 5054 and 5055 will commence after initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.		
Note (6): Special monthly compensation is assignable during the 100 percent rating period the earliest date permanent use of crutches is established.		
5051 Shoulder replacement (prosthesis).		
Prosthetic replacement of the shoulder joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe, painful motion or weakness in the affected extremity	60	50
With intermediate degrees of residual weakness, pain or limitation of motion, rate by analogy to diagnostic codes 5200 and 5203.		
Minimum rating	30	20
5052 Elbow replacement (prosthesis).		
Prosthetic replacement of the elbow joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe painful motion or weakness in the affected extremity	50	40
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5205 through 5208.		
Minimum evaluation	30	20
5053 Wrist replacement (prosthesis).		
Prosthetic replacement of wrist joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe, painful motion or weakness in the affected extremity	40	30
With intermediate degrees of residual weakness, pain or limitation of motion, rate by analogy to diagnostic code 5214.		
Minimum rating	20	20
5054 Hip, resurfacing or replacement (prosthesis):		
For 4 months following implantation of prosthesis or resurfacing		100
Prosthetic replacement of the head of the femur or of the acetabulum:		
Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches		[1]90
Markedly severe residual weakness, pain or limitation of motion following implantation of prosthesis		70
Moderately severe residuals of weakness, pain or limitation of motion		50
Minimum evaluation, total replacement only		30
Note: At the conclusion of the 100 percent evaluation period, evaluate resurfacing under diagnostic codes 5250 through 5255; there is no minimum evaluation for resurfacing.		

5055 Knee, resurfacing or replacement (prosthesis):		
For 4 months following implantation of prosthesis or resurfacing		100
Prosthetic replacement of knee joint:		
With chronic residuals consisting of severe painful motion or weakness in the affected extremity		60
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5256, 5261, or 5262.		
Minimum evaluation, total replacement only		30
Note: At the conclusion of the 100 percent evaluation period, evaluate resurfacing under diagnostic codes 5256 through 5262; there is no minimum evaluation for resurfacing.		
5056 Ankle replacement (prosthesis).		
Prosthetic replacement of ankle joint:		
For 1 year following implantation of prosthesis		100
With chronic residuals consisting of severe painful motion or weakness		40
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to 5270 or 5271.		
Minimum rating		20

Combination of Disabilities

5104 Anatomical loss of one hand and loss of use of one foot		[1]100
5105 Anatomical loss of one foot and loss of use of one hand		[1]100
5106 Anatomical loss of both hands		[1]100
5107 Anatomical loss of both feet		[1]100
5108 Anatomical loss of one hand and one foot		[1]100
5109 Loss of use of both hands		[1]100
5110 Loss of use of both feet		[1]100
5111 Loss of use of one hand and one foot		[1]100

[1]**Also entitled to special monthly compensation.**

Table II - Ratings for Multiple Losses of Extremities with Dictator's Rating Code and 38 CFR Citation

Impairment of one extremity	**Impairment of other extremity**					
	Anatomical loss or loss of use below elbow	**Anatomical loss or loss of use below knee**	**Anatomical loss or loss of use above elbow (preventing use of prosthesis)**	**Anatomical loss or loss of use above knee (preventing use of prosthesis)**	**Anatomical loss near shoulder (preventing use of prosthesis)**	**Anatomical loss near hip (preventing use of prosthesis)**

Anatomical loss or loss of use below elbow	M Codes M-1 a, b, or c, 38 CFR 3.350 (c)(1)(i)	L Codes L-1 d, e, f, or g, 38 CFR 3.350(b)	M 1/2 Code M-5, 38 CFR 3.350 (f)(1)(x)	L 1/2 Code L-2 c, 38 CFR 3.350 (f)(1)(vi)	N Code N-3, 38 CFR 3.350 (f)(1)(x)	M Code M-3 c, 38 CFR 3.350 (f)(1)(viii)
Anatomical loss or loss of use below knee		L Codes L-1 a, b, or c, 38 CFR 3.350(b)	L 1/2 Code L-2 b, 38 CFR 3.350 (f)(1)(iii)	L 1/2 Code L-2 a, 38 CFR 3.350 (f)(1)(i)	M Code M-3 b, 38 CFR 3.350 (f)(1)(iv)	M Code M-3 a, 38 CFR 3.350 (f)(1)(ii)
Anatomical loss or loss of use above elbow (preventing use of prosthesis)			N Code N-1, 38 CFR 3.350 (d)(1)	M Code M-2 a, 38 CFR 3.350 (c)(1)(iii)	N 1/2 Code N-4, 38 CFR 3.350 (f)(1)(ix)	M 1/2 Code M-4 c, 38 CFR 3.350 (f)(1)(xi)
Anatomical loss or loss of use above knee (preventing use of prosthesis)				M Code M-2 a, 38 CFR 3.350 (c)(1)(ii)	M 1/2 Code M-4 b, 38 CFR 3.350 (f)(1)(vii)	M 1/2 Code M-4 a, 38 CFR 3.350 (f)(1)(v)
Anatomical loss near shoulder (preventing use of prosthesis)					O Code O-1, 38 CFR 3.350 (e)(1)(i)	N Code N-2 b, 38 CFR 3.350 (d)(3)

Amputations: Upper Extremity

	Rating	
	Major	**Minor**
Arm, amputation of:		
5120 Complete amputation, upper extremity:		
Forequarter amputation (involving complete removal of the humerus along with any portion of the scapula, clavicle, and/or ribs)	[1]100	[1]100
Disarticulation (involving complete removal of the humerus only)	[1]90	[1]90
5121 Above insertion of deltoid	[1]90	80
5122 Below insertion of deltoid	[1]80	[1]70
Forearm, amputation of:		
5123 Above insertion of pronator teres	[1]80	[1]70
5124 Below insertion of pronator teres	[1]70	[1]60
5125 Hand, loss of use of	[1]70	[1]60

Multiple Finger Amputations

	Rating	
	Major	**Minor**
5126 Five digits of one hand, amputation of	[1]70	[1]60
Four digits of one hand, amputation of:		
5127 Thumb, index, long and ring	[1]70	[1]60
5128 Thumb, index, long and little	[1]70	[1]60
5129 Thumb, index, ring and little	[1]70	[1]60
5130 Thumb, long, ring and little	[1]70	[1]60
5131 Index, long, ring and little	60	50
Three digits of one hand, amputation of:		
5132 Thumb, index and long	60	50
5133 Thumb, index and ring	60	50
5134 Thumb, index and little	60	50
5135 Thumb, long and ring	60	50
5136 Thumb, long and little	60	50
5137 Thumb, ring and little	60	50
5138 Index, long and ring	50	40
5139 Index, long and little	50	40
5140 Index, ring and little	50	40
5141 Long, ring and little	40	30
Two digits of one hand, amputation of:		
5142 Thumb and index	50	40
5143 Thumb and long	50	40
5144 Thumb and ring	50	40
5145 Thumb and little	50	40
5146 Index and long	40	30
5147 Index and ring	40	30
5148 Index and little	40	30
5149 Long and ring	30	20
5150 Long and little	30	20
5151 Ring and little	30	20
(a) The ratings for multiple finger amputations apply to amputations at the proximal interphalangeal joints or through proximal phalanges.		
(b) Amputation through middle phalanges will be rated as prescribed for unfavorable ankylosis of the fingers.		
(c) Amputations at distal joints, or through distal phalanges, other than negligible losses, will be rated as prescribed for favorable ankylosis of the fingers.		
(d) Amputation or resection of metacarpal bones (more than one-half the bone lost) in multiple fingers injuries will require a rating of 10 percent added to (not combined with) the ratings, multiple finger amputations, subject to the amputation rule applied to the forearm.		
(e) Combinations of finger amputations at various levels, or finger amputations with ankylosis or limitation of motion of the fingers will be rated on the basis of the grade of disability; *i.e.*, amputation, unfavorable ankylosis, most		

representative of the levels or combinations. With an even number of fingers involved, and adjacent grades of disability, select the higher of the two grades.		
(f) Loss of use of the hand will be held to exist when no effective function remains other than that which would be equally well served by an amputation stump with a suitable prosthetic appliance.		

Single Finger Amputations

	Rating	
	Major	**Minor**
5152 Thumb, amputation of:		
With metacarpal resection	40	30
At metacarpophalangeal joint or through proximal phalanx	30	20
At distal joint or through distal phalanx	20	20
5153 Index finger, amputation of		
With metacarpal resection (more than one-half the bone lost)	30	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	20	20
Through middle phalanx or at distal joint	10	10
5154 Long finger, amputation of:		
With metacarpal resection (more than one-half the bone lost)	20	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	10	10
5155 Ring finger, amputation of:		
With metacarpal resection (more than one-half the bone lost)	20	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	10	10
5156 Little finger, amputation of:		
With metacarpal resection (more than one-half the bone lost)	20	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	10	10
Note: The single finger amputation ratings are the only applicable ratings for amputations of whole or part of single fingers.		

[1]Entitled to special monthly compensation.

Amputations: Lower Extremity

	Rating
Thigh, amputation of:	
5160 Complete amputation, lower extremity:	
Trans-pelvic amputation (involving complete removal of the femur and intrinsic pelvic musculature along with any portion of the pelvic bones)	[2]100
Disarticulation (involving complete removal of the femur and intrinsic pelvic musculature only)	[2]90
Note: Separately evaluate residuals involving other body systems (e.g., bowel impairment, bladder impairment) under the appropriate diagnostic code.	

5161 Upper third, one-third of the distance from perineum to knee joint measured from perineum	[2]80
5162 Middle or lower thirds	[2]60
Leg, amputation of:	
5163 With defective stump, thigh amputation recommended	[2]60
5164 Amputation not improvable by prosthesis controlled by natural knee action	[2]60
5165 At a lower level, permitting prosthesis	[2]40
5166 Forefoot, amputation proximal to metatarsal bones (more than one-half of metatarsal loss)	[2]40
5167 Foot, loss of use of	[2]40
5170 Toes, all, amputation of, without metatarsal loss or transmetatarsal, amputation of, with up to half of metatarsal loss	30
5171 Toe, great, amputation of:	
With removal of metatarsal head	30
Without metatarsal involvement	10
5172 Toes, other than great, amputation of, with removal of metatarsal head:	
One or two	20
Without metatarsal involvement	0
5173 Toes, three or four, amputation of, without metatarsal involvement:	
Including great toe	20
Not including great toe	10

[2]Also entitled to special monthly compensation.

The Shoulder and Arm

	Rating	
	Major	**Minor**
5200 Scapulohumeral articulation, ankylosis of:		
Note: The scapula and humerus move as one piece.		
Unfavorable, abduction limited to 25° from side	50	40
Intermediate between favorable and unfavorable	40	30
Favorable, abduction to 60°, can reach mouth and head	30	20
5201 Arm, limitation of motion of:		
Flexion and/or abduction limited to 25° from side	40	30
Midway between side and shoulder level (flexion and/or abduction limited to 45°)	30	20
At shoulder level (flexion and/or abduction limited to 90°)	20	20
5202 Humerus, other impairment of:		
Loss of head of (flail shoulder)	80	70
Nonunion of (false flail joint)	60	50
Fibrous union of	50	40
Recurrent dislocation of at scapulohumeral joint:		
With frequent episodes and guarding of all arm movements	30	20
With infrequent episodes and guarding of movement only at shoulder level (flexion and/or abduction at 90 °)	20	20

Malunion of:		
Marked deformity	30	20
Moderate deformity	20	20
5203 Clavicle or scapula, impairment of:		
Dislocation of	20	20
Nonunion of:		
With loose movement	20	20
Without loose movement	10	10
Malunion of	10	10
Or rate on impairment of function of contiguous joint.		

The Elbow and Forearm

	Rating	
	Major	**Minor**
5205 Elbow, ankylosis of:		
Unfavorable, at an angle of less than 50° or with complete loss of supination or pronation	60	50
Intermediate, at an angle of more than 90°, or between 70° and 50°	50	40
Favorable, at an angle between 90° and 70°	40	30
5206 Forearm, limitation of flexion of:		
Flexion limited to 45°	50	40
Flexion limited to 55°	40	30
Flexion limited to 70°	30	20
Flexion limited to 90°	20	20
Flexion limited to 100°	10	10
Flexion limited to 110°	0	0
5207 Forearm, limitation of extension of:		
Extension limited to 110°	50	40
Extension limited to 100°	40	30
Extension limited to 90°	30	20
Extension limited to 75°	20	20
Extension limited to 60°	10	10
Extension limited to 45°	10	10
5208 Forearm, flexion limited to 100° and extension to 45°	20	20
5209 Elbow, other impairment of Flail joint	60	50
Joint fracture, with marked cubitus varus or cubitus valgus deformity or with ununited fracture of head of radius	20	20
5210 Radius and ulna, nonunion of, with flail false joint	50	40
5211 Ulna, impairment of:		
Nonunion in upper half, with false movement:		
With loss of bone substance (1 inch (2.5 cms.) or more) and marked deformity	40	30
Without loss of bone substance or deformity	30	20
Nonunion in lower half	20	20
Malunion of, with bad alignment	10	10
5212 Radius, impairment of:		

Nonunion in lower half, with false movement:		
With loss of bone substance (1 inch (2.5 cms.) or more) and marked deformity	40	30
Without loss of bone substance or deformity	30	20
Nonunion in upper half	20	20
Malunion of, with bad alignment	10	10
5213 Supination and pronation, impairment of:		
Loss of (bone fusion):		
The hand fixed in supination or hyperpronation	40	30
The hand fixed in full pronation	30	20
The hand fixed near the middle of the arc or moderate pronation	20	20
Limitation of pronation:		
Motion lost beyond middle of arc	30	20
Motion lost beyond last quarter of arc, the hand does not approach full pronation	20	20
Limitation of supination:		
To 30° or less	10	10
Note: In all the forearm and wrist injuries, codes 5205 through 5213, multiple impaired finger movements due to tendon tie-up, muscle or nerve injury, are to be separately rated and combined not to exceed rating for loss of use of hand.		

The Wrist

	Rating	
	Major	**Minor**
5214 Wrist, ankylosis of:		
Unfavorable, in any degree of palmar flexion, or with ulnar or radial deviation	50	40
Any other position, except favorable	40	30
Favorable in 20° to 30° dorsiflexion	30	20
Note: Extremely unfavorable ankylosis will be rated as loss of use of hands under diagnostic code **5125**.		
5215 Wrist, limitation of motion of:		
Dorsiflexion less than 15°	10	10
Palmar flexion limited in line with forearm	10	10

Evaluation of Ankylosis or Limitation of Motion of Single or Multiple Digits of the Hand

	Rating	
	Major	**Minor**
(1) For the index, long, ring, and little fingers (digits II, III, IV, and V), zero degrees of flexion represents the fingers fully extended, making a straight line with the rest of the hand. The position of function of the hand is with the wrist dorsiflexed 20 to 30 degrees, the metacarpophalangeal and		

proximal interphalangeal joints flexed to 30 degrees, and the thumb (digit I) abducted and rotated so that the thumb pad faces the finger pads. Only joints in these positions are considered to be in favorable position. For digits II through V, the metacarpophalangeal joint has a range of zero to 90 degrees of flexion, the proximal interphalangeal joint has a range of zero to 100 degrees of flexion, and the distal (terminal) interphalangeal joint has a range of zero to 70 or 80 degrees of flexion		
(2) When two or more digits of the same hand are affected by any combination of amputation, ankylosis, or limitation of motion that is not otherwise specified in the rating schedule, the evaluation level assigned will be that which best represents the overall disability (i.e., amputation, unfavorable or favorable ankylosis, or limitation of motion), assigning the higher level of evaluation when the level of disability is equally balanced between one level and the next higher level		
(3) Evaluation of ankylosis of the index, long, ring, and little fingers:		
(i) If both the metacarpophalangeal and proximal interphalangeal joints of a digit are ankylosed, and either is in extension or full flexion, or there is rotation or angulation of a bone, evaluate as amputation without metacarpal resection, at proximal interphalangeal joint or proximal thereto		
(ii) If both the metacarpophalangeal and proximal interphalangeal joints of a digit are ankylosed, evaluate as unfavorable ankylosis, even if each joint is individually fixed in a favorable position		
(iii) If only the metacarpophalangeal or proximal interphalangeal joint is ankylosed, and there is a gap of more than two inches (5.1 cm.) between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible, evaluate as unfavorable ankylosis		
(iv) If only the metacarpophalangeal or proximal interphalangeal joint is ankylosed, and there is a gap of two inches (5.1 cm.) or less between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible, evaluate as favorable ankylosis		
(4) Evaluation of ankylosis of the thumb:		
(i) If both the carpometacarpal and interphalangeal joints are ankylosed, and either is in extension or full flexion, or there is rotation or angulation of a bone, evaluate as amputation at metacarpophalangeal joint or through proximal phalanx		
(ii) If both the carpometacarpal and interphalangeal joints are ankylosed, evaluate as unfavorable ankylosis, even if each joint is individually fixed in a favorable position		
(iii) If only the carpometacarpal or interphalangeal joint is ankylosed, and there is a gap of more than two inches (5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers, evaluate as unfavorable ankylosis		
(iv) If only the carpometacarpal or interphalangeal joint is ankylosed, and there is a gap of two inches (5.1 cm.) or less between the thumb pad and the fingers, with the thumb attempting to oppose the fingers, evaluate as favorable ankylosis		

(5) If there is limitation of motion of two or more digits, evaluate each digit separately and combine the evaluations		
I. Multiple Digits: Unfavorable Ankylosis		
5216 Five digits of one hand, unfavorable ankylosis of	60	50
Note: Also consider whether evaluation as amputation is warranted.		
5217 Four digits of one hand, unfavorable ankylosis of:		
Thumb and any three fingers	60	50
Index, long, ring, and little fingers	50	40
Note: Also consider whether evaluation as amputation is warranted.		
5218 Three digits of one hand, unfavorable ankylosis of:		
Thumb and any two fingers	50	40
Index, long, and ring; index, long, and little; or index, ring, and little fingers	40	30
Long, ring, and little fingers		
Note: Also consider whether evaluation as amputation is warranted.		
5219 Two digits of one hand, unfavorable ankylosis of:		
Thumb and any finger	40	30
Index and long; index and ring; or index and little fingers	30	20
Long and ring; long and little; or ring and little fingers	20	20
Note: Also consider whether evaluation as amputation is warranted.		
II. Multiple Digits: Favorable Ankylosis		
5220 Five digits of one hand, favorable ankylosis of	50	40
5221 Four digits of one hand, favorable ankylosis of:		
Thumb and any three fingers	50	40
Index, long, ring, and little fingers	40	30
5222 Three digits of one hand, favorable ankylosis of:		
Thumb and any two fingers	40	30
Index, long, and ring; index, long, and little; or index, ring, and little fingers	30	20
Long, ring and little fingers	20	20
5223 Two digits of one hand, favorable ankylosis of:		
Thumb and any finger	30	20
Index and long; index and ring; or index and little fingers	20	20
Long and ring; long and little; or ring and little fingers	10	10
III. Ankylosis of Individual Digits		
5224 Thumb, ankylosis of:		
Unfavorable		
Favorable		
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
5225 Index finger, ankylosis of:		
Unfavorable or favorable	10	10
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
5226 Long finger, ankylosis of:		

Unfavorable or favorable	10	10
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
5227 Ring or little finger, ankylosis of:		
Unfavorable or favorable	0	0
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
IV. Limitation of Motion of Individual Digits		
5228 Thumb, limitation of motion:		
With a gap of more than two inches (5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers	20	20
With a gap of one to two inches (2.5 to 5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers	10	10
With a gap of less than one inch (2.5 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers	0	0
5229 Index or long finger, limitation of motion:		
With a gap of one inch (2.5 cm.) or more between the fingertip and the proximal transverse crease of the palm, with the finger flexed to the extent possible, or; with extension limited by more than 30 degrees	10	10
With a gap of less than one inch (2.5 cm.) between the fingertip and the proximal transverse crease of the palm, with the finger flexed to the extent possible, and; extension is limited by no more than 30 degrees	0	0
5230 Ring or little finger, limitation of motion:		
Any limitation of motion	0	0

The Spine

	Rating
General Rating Formula for Diseases and Injuries of the Spine	
(For diagnostic codes 5235 to 5243 unless 5243 is evaluated under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes):	
With or without symptoms such as pain (whether or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease	
Unfavorable ankylosis of the entire spine	100
Unfavorable ankylosis of the entire thoracolumbar spine	50
Unfavorable ankylosis of the entire cervical spine; or, forward flexion of the thoracolumbar spine 30 degrees or less; or, favorable ankylosis of the entire thoracolumbar spine	40
Forward flexion of the cervical spine 15 degrees or less; or, favorable ankylosis of the entire cervical spine	30
Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees; or, forward flexion of the cervical spine greater than 15 degrees but not greater than 30 degrees; or, the combined range of motion of	20

	the thoracolumbar spine not greater than 120 degrees; or, the combined range of motion of the cervical spine not greater than 170 degrees; or, muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis	
	Forward flexion of the thoracolumbar spine greater than 60 degrees but not greater than 85 degrees; or, forward flexion of the cervical spine greater than 30 degrees but not greater than 40 degrees; or, combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees; or, combined range of motion of the cervical spine greater than 170 degrees but not greater than 335 degrees; or, muscle spasm, guarding, or localized tenderness not resulting in abnormal gait or abnormal spinal contour; or, vertebral body fracture with loss of 50 percent or more of the height	10
	Note (1): Evaluate any associated objective neurologic abnormalities, including, but not limited to, bowel or bladder impairment, separately, under an appropriate diagnostic code.	
	Note (2): (See also Plate V.) For VA compensation purposes, normal forward flexion of the cervical spine is zero to 45 degrees, extension is zero to 45 degrees, left and right lateral flexion are zero to 45 degrees, and left and right lateral rotation are zero to 80 degrees. Normal forward flexion of the thoracolumbar spine is zero to 90 degrees, extension is zero to 30 degrees, left and right lateral flexion are zero to 30 degrees, and left and right lateral rotation are zero to 30 degrees. The combined range of motion refers to the sum of the range of forward flexion, extension, left and right lateral flexion, and left and right rotation. The normal combined range of motion of the cervical spine is 340 degrees and of the thoracolumbar spine is 240 degrees. The normal ranges of motion for each component of spinal motion provided in this note are the maximum that can be used for calculation of the combined range of motion.	
	Note (3): In exceptional cases, an examiner may state that because of age, body habitus, neurologic disease, or other factors not the result of disease or injury of the spine, the range of motion of the spine in a particular individual should be considered normal for that individual, even though it does not conform to the normal range of motion stated in Note (2). Provided that the examiner supplies an explanation, the examiner's assessment that the range of motion is normal for that individual will be accepted.	
	Note (4): Round each range of motion measurement to the nearest five degrees.	
	Note (5): For VA compensation purposes, unfavorable ankylosis is a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the costal margin on the abdomen; dyspnea or dysphagia; atlantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. Fixation of a spinal segment in neutral position (zero degrees) always represents favorable ankylosis.	
	Note (6): Separately evaluate disability of the thoracolumbar and cervical spine segments, except when there is unfavorable ankylosis of both segments, which will be rated as a single disability.	
5235 Vertebral fracture or dislocation		
5236 Sacroiliac injury and weakness		

5237 Lumbosacral or cervical strain	
5238 Spinal stenosis	
5239 Spondylolisthesis or segmental instability	
5240 Ankylosing spondylitis	
5241 Spinal fusion	
5242 Degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome (also, see either DC 5003 or 5010)	
5243 Intervertebral disc syndrome: Assign this diagnostic code only when there is disc herniation with compression and/or irritation of the adjacent nerve root; assign diagnostic code 5242 for all other disc diagnoses.	
Evaluate intervertebral disc syndrome (preoperatively or postoperatively) either under the General Rating Formula for Diseases and Injuries of the Spine or under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes, whichever method results in the higher evaluation when all disabilities are combined under § 4.25.	
5244 Traumatic paralysis, complete:	
Paraplegia: Rate under diagnostic code 5110.	
Quadriplegia: Rate separately under diagnostic codes 5109 and 5110 and combine evaluations in accordance with § 4.25.	
Note: If traumatic paralysis does not cause loss of use of both hands or both feet, it is incomplete paralysis. Evaluate residuals of incomplete traumatic paralysis under the appropriate diagnostic code (e.g., § 4.124a, Diseases of the Peripheral Nerves).	
Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes	
With incapacitating episodes having a total duration of at least 6 weeks during the past 12 months	60
With incapacitating episodes having a total duration of at least 4 weeks but less than 6 weeks during the past 12 months	40
With incapacitating episodes having a total duration of at least 2 weeks but less than 4 weeks during the past 12 months	20
With incapacitating episodes having a total duration of at least one week but less than 2 weeks during the past 12 months	10
Note (1): For purposes of evaluations under diagnostic code 5243, an incapacitating episode is a period of acute signs and symptoms due to intervertebral disc syndrome that requires bed rest prescribed by a physician and treatment by a physician.	
Note (2): If intervertebral disc syndrome is present in more than one spinal segment, provided that the effects in each spinal segment are clearly distinct, evaluate each segment on the basis of incapacitating episodes or under the General Rating Formula for Diseases and Injuries of the Spine, whichever method results in a higher evaluation for that segment.	

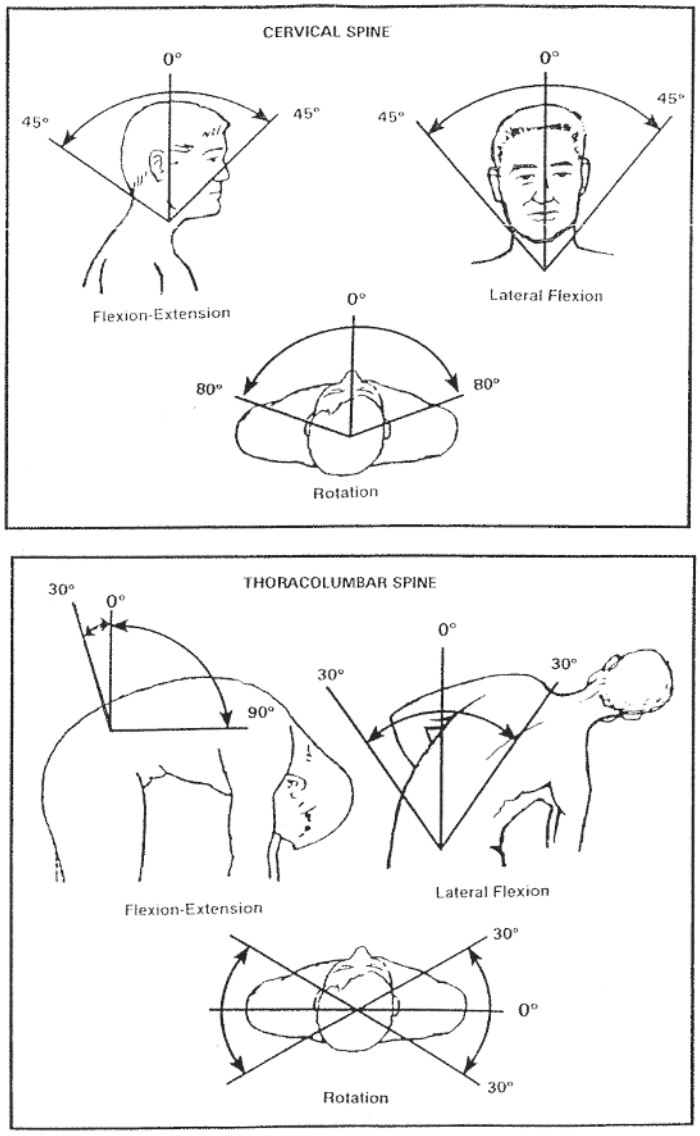

PLATE V
RANGE OF MOTION OF CERVICAL AND THORACOLUMBAR SPINE

The Hip and Thigh

	Rating
5250 Hip, ankylosis of:	
Unfavorable, extremely unfavorable ankylosis, the foot not reaching ground, crutches necessitated	[3]90
Intermediate	70
Favorable, in flexion at an angle between 20° and 40°, and slight adduction or abduction	60
5251 Thigh, limitation of extension of:	
Extension limited to 5°	10
5252 Thigh, limitation of flexion of:	
Flexion limited to 10°	40
Flexion limited to 20°	30

Flexion limited to 30°	20
Flexion limited to 45°	10
5253 Thigh, impairment of:	
Limitation of abduction of, motion lost beyond 10°	20
Limitation of adduction of, cannot cross legs	10
Limitation of rotation of, cannot toe-out more than 15°, affected leg	10
5254 Hip, flail joint	80
5255 Femur, impairment of:	
Fracture of shaft or anatomical neck of:	
With nonunion, with loose motion (spiral or oblique fracture)	80
With nonunion, without loose motion, weight bearing preserved with aid of brace	60
Fracture of surgical neck of, with false joint	60
Malunion of:	
Evaluate under diagnostic codes 5256, 5257, 5260, or 5261 for the knee, or 5250-5254 for the hip, whichever results in the highest evaluation.	

[3]Entitled to special monthly compensation.

The Knee and Leg

	Rating
5256 Knee, ankylosis of:	
Extremely unfavorable, in flexion at an angle of 45° or more	60
In flexion between 20° and 45°	50
In flexion between 10° and 20°	40
Favorable angle in full extension, or in slight flexion between 0° and 10°	30
5257 Knee, other impairment of:	
Recurrent subluxation or instability:	
Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes both an assistive device (*e.g.,* cane(s), crutch(es), walker) and bracing for ambulation	30
One of the following:	
(a) Sprain, incomplete ligament tear, or repaired complete ligament tear causing persistent instability, and a medical provider prescribes a brace and/or assistive device (*e.g.,* cane(s), crutch(es), walker) for ambulation.	
(b) Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes either an assistive device (*e.g.,* cane(s), crutch(es), walker) or bracing for ambulation	20
Sprain, incomplete ligament tear, or complete ligament tear (repaired, unrepaired, or failed repair) causing persistent instability, without a prescription from a medical provider for an assistive device (*e.g.,* cane(s), crutch(es), walker) or bracing for ambulation	10
Patellar instability:	
A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription by a medical provider for a brace and either a cane or a walker	30

A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription by a medical provider for one of the following: A brace, cane, or walker	20
A diagnosed condition involving the patellofemoral complex with recurrent instability (with or without history of surgical repair) that does not require a prescription from a medical provider for a brace, cane, or walker	10
Note (1): For patellar instability, the patellofemoral complex consists of the quadriceps tendon, the patella, and the patellar tendon.	
Note (2): A surgical procedure that does not involve repair of one or more patellofemoral components that contribute to the underlying instability shall not qualify as surgical repair for patellar instability (including, but not limited to, arthroscopy to remove loose bodies and joint aspiration).	
5258 Cartilage, semilunar, dislocated, with frequent episodes of "locking," pain, and effusion into the joint	20
5259 Cartilage, semilunar, removal of, symptomatic	10
5260 Leg, limitation of flexion of:	
Flexion limited to 15°	30
Flexion limited to 30°	20
Flexion limited to 45°	10
Flexion limited to 60°	0
5261 Leg, limitation of extension of:	
Extension limited to 45°	50
Extension limited to 30°	40
Extension limited to 20°	30
Extension limited to 15°	20
Extension limited to 10°	10
Extension limited to 5°	0
5262 Tibia and fibula, impairment of:	
Nonunion of, with loose motion, requiring brace	40
Malunion of:	
Evaluate under diagnostic codes 5256, 5257, 5260, or 5261 for the knee, or 5270 or 5271 for the ankle, whichever results in the highest evaluation.	
Medial tibial stress syndrome (MTSS), or shin splints:	
Requiring treatment for no less than 12 consecutive months, and unresponsive to surgery and either shoe orthotics or other conservative treatment, both lower extremities	30
Requiring treatment for no less than 12 consecutive months, and unresponsive to surgery and either shoe orthotics or other conservative treatment, one lower extremity	20
Requiring treatment for no less than 12 consecutive months, and unresponsive to either shoe orthotics or other conservative treatment, one or both lower extremities	10
Treatment less than 12 consecutive months, one or both lower extremities	0
5263 Genu recurvatum (acquired, traumatic, with weakness and insecurity in weight-bearing objectively demonstrated)	10

The Ankle

	Rating
5270 Ankle, ankylosis of:	
In plantar flexion at more than 40°, or in dorsiflexion at more than 10° or with abduction, adduction, inversion or eversion deformity	40
In plantar flexion, between 30° and 40°, or in dorsiflexion, between 0° and 10°	30
In plantar flexion, less than 30°	20
5271 Ankle, limited motion of:	
Marked (less than 5 degrees dorsiflexion or less than 10 degrees plantar flexion)	20
Moderate (less than 15 degrees dorsiflexion or less than 30 degrees plantar flexion)	10
5272 Subastragalar or tarsal joint, ankylosis of:	
In poor weight-bearing position	20
In good weight-bearing position	10
5273 Os calcis or astragalus, malunion of:	
Marked deformity	20
Moderate deformity	10
5274 Astragalectomy	20

The Ankle

	Rating
5275 Bones, of the lower extremity, shortening of:	
Over 4 inches (10.2 cms.)	[3]60
3 ½ to 4 inches (8.9 cms. to 10.2 cms.)	[3]50
3 to 3 ½ inches (7.6 cms. to 8.9 cms.)	40
2 ½ to 3 inches (6.4 cms. to 7.6 cms.)	30
2 to 2 ½ inches (5.1 cms. to 6.4 cms.)	20
1 ¼ to 2 inches (3.2 cms. to 5.1 cms.)	10
Note: Measure both lower extremities from anterior superior spine of the ilium to the internal malleolus of the tibia. Not to be combined with other ratings for fracture or faulty union in the same extremity.	

[3] Also entitled to special monthly compensation

The Foot

	Rating
5269 Plantar fasciitis:	
No relief from both non-surgical and surgical treatment, bilateral	30
No relief from both non-surgical and surgical treatment, unilateral	20
Otherwise, unilateral or bilateral	10
Note (1): With actual loss of use of the foot, rate 40 percent	

Note (2): If a veteran has been recommended for surgical intervention, but is not a surgical candidate, evaluate under the 20 percent or 30 percent criteria, whichever is applicable	
5276 Flatfoot, acquired:	
Pronounced; marked pronation, extreme tenderness of plantar surfaces of the feet, marked inward displacement and severe spasm of the tendo achillis on manipulation, not improved by orthopedic shoes or appliances	
Bilateral	50
Unilateral	30
Severe; objective evidence of marked deformity (pronation, abduction, etc.), pain on manipulation and use accentuated, indication of swelling on use, characteristic callosities:	
Bilateral	30
Unilateral	20
Moderate; weight-bearing line over or medial to great toe, inward bowing of the tendo achillis, pain on manipulation and use of the feet, bilateral or unilateral	10
Mild; symptoms relieved by built-up shoe or arch support	0
5277 Weak foot, bilateral:	
A symptomatic condition secondary to many constitutional conditions, characterized by atrophy of the musculature, disturbed circulation, and weakness:	
Rate the underlying condition, minimum rating	10
5278 Claw foot (pes cavus), acquired:	
Marked contraction of plantar fascia with dropped forefoot, all toes hammer toes, very painful callosities, marked varus deformity:	
Bilateral	50
Unilateral	30
All toes tending to dorsiflexion, limitation of dorsiflexion at ankle to right angle, shortened plantar fascia, and marked tenderness under metatarsal heads:	
Bilateral	30
Unilateral	20
Great toe dorsiflexed, some limitation of dorsiflexion at ankle, definite tenderness under metatarsal heads:	
Bilateral	10
Unilateral	10
Slight	0
5279 Metatarsalgia, anterior (Morton's disease), unilateral, or bilateral	10
5280 Hallux valgus, unilateral:	
Operated with resection of metatarsal head	10
Severe, if equivalent to amputation of great toe	10
5281 Hallux rigidus, unilateral, severe:	
Rate as hallux valgus, severe.	
Note: Not to be combined with claw foot ratings.	
5282 Hammer toe:	
All toes, unilateral without claw foot	10
Single toes	0
5283 Tarsal, or metatarsal bones, malunion of, or nonunion of:	
Severe	30
Moderately severe	20
Moderate	10

Note: With actual loss of use of the foot, rate 40 percent.	
5284 Foot injuries, other:	
Severe	30
Moderately severe	20
Moderate	10
Note: With actual loss of use of the foot, rate 40 percent.	

The Skull

	Rating
5296 Skull, loss of part of, both inner and outer tables:	
With brain hernia	80
Without brain hernia:	
Area larger than size of a 50-cent piece or 1.140 in² (7.355 cm²)	50
Area intermediate	30
Area smaller than the size of a 25-cent piece or 0.716 in² (4.619 cm²)	10
Note: Rate separately for intracranial complications.	

The Ribs

	Rating
5297 Ribs, removal of:	
More than six	50
Five or six	40
Three or four	30
Two	20
One or resection of two or more ribs without regeneration	10
Note (1): The rating for rib resection or removal is not to be applied with ratings for purulent pleurisy, lobectomy, pneumonectomy or injuries of pleural cavity.	
Note (2): However, rib resection will be considered as rib removal in thoracoplasty performed for collapse therapy or to accomplish obliteration of space and will be combined with the rating for lung collapse, or with the rating for lobectomy, pneumonectomy or the graduated ratings for pulmonary tuberculosis.	

The Coccyx

	Rating
5298 Coccyx, removal of:	
Partial or complete, with painful residuals	10
Without painful residuals	0

38 CFR 4.73

§ 4.72 [Reserved]

§ 4.73 Schedule of ratings - muscle injuries.

Note (1):
When evaluating any claim involving muscle injuries resulting in loss of use of any extremity or loss of use of both buttocks (diagnostic code 5317, Muscle Group XVII), refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation.

Note (2):
Ratings of slight, moderate, moderately severe, or severe for diagnostic codes 5301 through 5323 will be determined based upon the criteria contained in § 4.56.

The Shoulder Girdle and Arm

	Rating	
	Dominant	**Nondominant**
5301 Group I. *Function:* Upward rotation of scapula; elevation of arm above shoulder level. *Extrinsic muscles of shoulder girdle:* (1) Trapezius; (2) levator scapulae; (3) serratus magnus		
Severe	40	30
Moderately severe	30	20
Moderate	10	10
Slight	0	0
5302 Group II. *Function*: Depression of arm from vertical overhead to hanging at side (1, 2); downward rotation of scapula (3, 4); 1 and 2 act with Group III in forward and backward swing of arm. *Extrinsic muscles of shoulder girdle: (1) Pectoralis major II (costosternal); (2) latissimus dorsi and teres major (teres major, although technically an intrinsic muscle, is included with latissimus dorsi); (3) pectoralis minor; (4) rhomboid*		
Severe	40	30
Moderately severe	30	20
Moderate	20	20
Slight	0	0
5303 Group III. *Function:* Elevation and abduction of arm to level of shoulder; act with 1 and 2 of Group II in forward and backward swing of arm. *Intrinsic muscles of shoulder girdle: (1) Pectoralis major I (clavicular); (2) deltoid*		
Severe	40	30

Moderately severe	30	20
Moderate	20	20
Slight	0	0
5304 Group IV. *Function:* Stabilization of shoulder against injury in strong movements, holding head of humerus in socket; abduction; outward rotation and inward rotation of arm. *Intrinsic muscles of shoulder girdle: (1) Supraspinatus; (2) infraspinatus and teres minor; (3) subscapularis; (4) coracobrachialis*		
Severe	30	20
Moderately severe	20	20
Moderate	10	10
Slight	0	0
5305 Group V. *Function:* Elbow supination (1) (long head of biceps is stabilizer of shoulder joint); flexion of elbow (1, 2, 3). *Flexor muscles of elbow: (1) Biceps; (2) brachialis; (3) brachioradialis*		
Severe	40	30
Moderately severe	30	20
Moderate	10	10
Slight	0	0
5306 Group VI. *Function:* Extension of elbow (long head of triceps is stabilizer of shoulder joint). *Extensor muscles of the elbow:* (1) Triceps; (2) anconeus.		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0

The Forearm and Hand

	Rating	
	Dominant	**Nondominant**
5307 Group VII. Function: Flexion of wrist and fingers. Muscles arising from internal condyle of humerus: Flexors of the carpus and long flexors of fingers and thumb; pronator		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0
5308 Group VIII. Function: Extension of wrist, fingers, and thumb; abduction of thumb. Muscles arising mainly from		

external condyle of humerus: Extensors of carpus, fingers, and thumb; supinator		
Severe	30	20
Moderately Severe	20	20
Moderate	10	10
Slight	0	0
5309 Group IX. *Function:* The forearm muscles act in strong grasping movements and are supplemented by the intrinsic muscles in delicate manipulative movements. *Intrinsic muscles of hand:* Thenar eminence; short flexor, opponens, abductor and adductor of thumb; hypothenar eminence; short flexor, opponens and abductor of little finger; 4 lumbricales; 4 dorsal and 3 palmar interossei		
Note: The hand is so compact a structure that isolated muscle injuries are rare, being nearly always complicated with injuries of bones, joints, tendons, etc. Rate on limitation of motion, minimum 10 percent.		

The Foot and Leg

	Rating
5310 Group X. *Function:* Movements of forefoot and toes; propulsion thrust in walking. *Intrinsic muscles of the foot: Plantar:* (1) Flexor digitorum brevis; (2) abductor hallucis; (3) abductor digiti minimi; (4) quadratus plantae; (5) lumbricales; (6) flexor hallucis brevis; (7) adductor hallucis; (8) flexor digiti minimi brevis; (9) dorsal and plantar interossei. Other important plantar structures: Plantar aponeurosis, long plantar and calcaneonavicular ligament, tendons of posterior tibial, peroneus longus, and long flexors of great and little toes	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
Dorsal: (1) Extensor hallucis brevis; (2) extensor digitorum brevis. Other important dorsal structures: cruciate, crural, deltoid, and other ligaments; tendons of long extensors of toes and peronei muscles	
Severe	20
Moderately Severe	10
Moderate	10
Slight	0
Note: Minimum rating for through-and-through wounds of the foot - 10.	

5311 Group XI. *Function:* Propulsion, plantar flexion of foot (1); stabilization of arch (2, 3); flexion of toes (4, 5); Flexion of knee (6). *Posterior and lateral crural muscles, and muscles of the calf:* (1) Triceps surae (gastrocnemius and soleus); (2) tibialis posterior; (3) peroneus longus; (4) peroneus brevis; (5) flexor hallucis longus; (6) flexor digitorum longus; (7) popliteus; (8) plantaris	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
5312 Group XII. *Function:* Dorsiflexion (1); extension of toes (2); stabilization of arch (3). *Anterior muscles of the leg:* (1) Tibialis anterior; (2) extensor digitorum longus; (3) extensor hallucis longus; (4) peroneus tertius	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

The Pelvic Girdle and Thigh

	Rating
5313 Group XIII. *Function:* Extension of hip and flexion of knee; outward and inward rotation of flexed knee; acting with rectus femoris and sartorius (see XIV, 1, 2) synchronizing simultaneous flexion of hip and knee and extension of hip and knee by belt-over-pulley action at knee joint. *Posterior thigh group, Hamstring complex of 2-joint muscles:* (1) Biceps femoris; (2) semimembranosus; (3) semitendinosus	
Severe	40
Moderately Severe	30
Moderate	10
Slight	0
5314 Group XIV. *Function:* Extension of knee (2, 3, 4, 5); simultaneous flexion of hip and flexion of knee (1); tension of fascia lata and iliotibial (Maissiat's) band, acting with XVII (1) in postural support of body (6); acting with hamstrings in synchronizing hip and knee (1, 2). *Anterior thigh group:* (1) Sartorius; (2) rectus femoris; (3) vastus externus; (4) vastus intermedius; (5) vastus internus; (6) tensor vaginae femoris	
Severe	40
Moderately Severe	30
Moderate	10
Slight	0

5315 Group XV. *Function:* Adduction of hip (1, 2, 3, 4); flexion of hip (1, 2); flexion of knee (4). *Mesial thigh group:* (1) Adductor longus; (2) adductor brevis; (3) adductor magnus; (4) gracilis	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
5316 Group XVI. *Function:* Flexion of hip (1, 2, 3). *Pelvic girdle group 1:* (1) Psoas; (2) iliacus; (3) pectineus	
Severe	40
Moderately Severe	30
Moderate	10
Slight	0
5317 Group XVII. *Function:* Extension of hip (1); abduction of thigh; elevation of opposite side of pelvis (2, 3); tension of fascia lata and iliotibial (Maissiat's) band, acting with XIV (6) in postural support of body steadying pelvis upon head of femur and condyles of femur on tibia (1). *Pelvic girdle group 2:* (1) Gluteus maximus; (2) gluteus medius; (3) gluteus minimus	
Severe	*50
Moderately Severe	40
Moderate	20
Slight	0
5318 Group XVIII. *Function:* Outward rotation of thigh and stabilization of hip joint. *Pelvic girdle group 3:* (1) Pyriformis; (2) gemellus (superior or inferior); (3) obturator (external or internal); (4) quadratus femoris	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

* If bilateral, see § 3.350(a)(3) of this chapter to determine whether the veteran may be entitled to special monthly compensation.

The Torso and Neck

	Rating
5319 Group XIX. *Function:* Support and compression of abdominal wall and lower thorax; flexion and lateral motions of spine; synergists in strong downward movements of arm (1). *Muscles of the abdominal wall:* (1) Rectus abdominis; (2) external oblique; (3) internal oblique; (4) transversalis; (5) quadratus lumborum	
Severe	50
Moderately Severe	30
Moderate	10
Slight	0

5320 Group XX. *Function:* Postural support of body; extension and lateral movements of spine. *Spinal muscles:* Sacrospinalis (erector spinae and its prolongations in thoracic and cervical regions)	
Cervical and thoracic region:	
Severe	40
Moderately Severe	20
Moderate	10
Slight	0
Lumbar region:	
Severe	60
Moderately Severe	40
Moderate	20
Slight	0
5321 Group XXI. *Function:* Respiration. *Muscles of respiration:* Thoracic muscle group	
Severe or Moderately Severe	20
Moderate	10
Slight	0
5322 Group XXII. *Function:* Rotary and forward movements of the head; respiration; deglutition. *Muscles of the front of the neck:* (Lateral, supra-, and infrahyoid group.) (1) Trapezius I (clavicular insertion); (2) sternocleidomastoid; (3) the "hyoid" muscles; (4) sternothyroid; (5) digastric	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
5323 Group XXIII. *Function:* Movements of the head; fixation of shoulder movements. *Muscles of the side and back of the neck:* Suboccipital; lateral vertebral and anterior vertebral muscles	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

Miscellaneous

	Rating
5324 Diaphragm, rupture of, with herniation. Rate under diagnostic code 7346	
5325 Muscle injury, facial muscles. Evaluate functional impairment as seventh (facial) cranial nerve neuropathy (diagnostic code 8207), disfiguring scar (diagnostic code 7800), etc. Minimum, if interfering to any extent with mastication - 10	
5326 Muscle hernia, extensive. Without other injury to the muscle - 10	
5327 Muscle, neoplasm of, malignant (excluding soft tissue sarcoma) - 100	

Note: A rating of 100 percent shall continue beyond the cessation of any surgery, radiation treatment, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residual impairment of function.	
5328 Muscle, neoplasm of, benign, postoperative. Rate on impairment of function, *i.e.*, limitation of motion, or scars, diagnostic code 7805, etc	
5329 Sarcoma, soft tissue (of muscle, fat, or fibrous connective tissue) - 100	
Note: A rating of 100 percent shall continue beyond the cessation of any surgery, radiation treatment, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residual impairment of function.	
5330 Rhabdomyolysis, residuals of:	
Rate each affected muscle group separately and combine in accordance with § 4.25	
Note: Separately evaluate any chronic renal complications within the appropriate body system.	
5331 Compartment syndrome:	
Rate each affected muscle group separately and combine in accordance with § 4.25	

(Authority: 38 U.S.C. 1155)
[62 FR 30239, June 3, 1997, as amemded 85 FR 76464, Nov. 30, 2020]

38 CFR 4.75(b)

The Organs of Special Sense.

§ 4.75 General considerations for evaluating visual impairment.

(a) ***Visual impairment.*** The evaluation of visual impairment is based on impairment of visual acuity (excluding developmental errors of refraction), visual field, and muscle function.

(b) ***Examination for visual impairment.*** The examination must be conducted by a licensed optometrist or by a licensed ophthalmologist. The examiner must identify the disease, injury, or other pathologic process responsible for any visual impairment found. Examinations of visual fields or muscle function will be conducted only when there is a medical indication of disease or injury that may be associated with visual field defect or

impaired muscle function. Unless medically contraindicated, the fundus must be examined with the claimant's pupils dilated.

(c) ***Service-connected visual impairment of only one eye.*** Subject to the provisions of 38 CFR 3.383(a), if visual impairment of only one eye is service-connected, the visual acuity of the other eye will be considered to be 20/40 for purposes of evaluating the service-connected visual impairment.

(d) ***Maximum evaluation for visual impairment of one eye.*** The evaluation for visual impairment of one eye must not exceed 30 percent unless there is anatomical loss of the eye. Combine the evaluation for visual impairment of one eye with evaluations for other disabilities of the same eye that are not based on visual impairment (e.g., disfigurement under diagnostic code 7800).

(e) ***Anatomical loss of one eye with inability to wear a prosthesis***. When the claimant has anatomical loss of one eye and is unable to wear a prosthesis, increase the evaluation for visual acuity under diagnostic code 6063 by 10 percent, but the maximum evaluation for visual impairment of both eyes must not exceed 100 percent. A 10-percent increase under this paragraph precludes an evaluation under diagnostic code 7800 based on gross distortion or asymmetry of the eye but not an evaluation under diagnostic code 7800 based on other characteristics of disfigurement.

(f) ***Special monthly compensation***. When evaluating visual impairment, refer to 38 CFR 3.350 to determine whether the claimant may be entitled to special monthly compensation. Footnotes in the schedule indicate levels of visual impairment that potentially establish entitlement to special monthly compensation; however, other levels of visual impairment combined with disabilities of other body systems may also establish entitlement.

(Authority: 38 U.S.C. 1114 and 1155)
[73 FR 66549, Nov. 10, 2008]

§ 4.75 Visual acuity.

(a) ***Examination of visual acuity***. Examination of visual acuity must include the central uncorrected and corrected visual acuity for distance and near vision using Snellen's test type or its equivalent.

(b) ***Evaluation of visual acuity.***

1) Evaluate central visual acuity on the basis of corrected distance vision with central fixation, even if a central scotoma is present. However, when the lens required to correct distance vision in the poorer eye differs by more than three diopters from the lens required to correct distance vision in the better eye (and the difference is not due to congenital or developmental refractive error), and either the poorer eye or both eyes are service connected, evaluate the visual acuity of the poorer eye using either its uncorrected or corrected visual acuity, whichever results in better combined visual acuity.

2) Provided that he or she customarily wears contact lenses, evaluate the visual acuity of any individual affected by a corneal disorder that results in severe irregular astigmatism that can be improved more by contact lenses than by eyeglass lenses, as corrected by contact lenses.

3) In any case where the examiner reports that there is a difference equal to two or more scheduled steps between near and distance corrected vision, with the near vision being

worse, the examination report must include at least two recordings of near and distance corrected vision and an explanation of the reason for the difference. In these cases, evaluate based on corrected distance vision adjusted to one step poorer than measured.

4) To evaluate the impairment of visual acuity where a claimant has a reported visual acuity that is between two sequentially listed visual acuities, use the visual acuity which permits the higher evaluation.

(Authority: 38 U.S.C. 1155)

[73 FR 66549, Nov. 10, 2008]

§ 4.76a Computation of average concentric contraction of visual fields.

Table III – Normal Visual Field Extent at 8 Principal Meridians

Meridian	Normal Degrees
Temporally	85
Down temporally	85
Down	65
Down nasally	50
Nasally	60
Up nasally	55
Up	45
Up temporally	55
Total	500

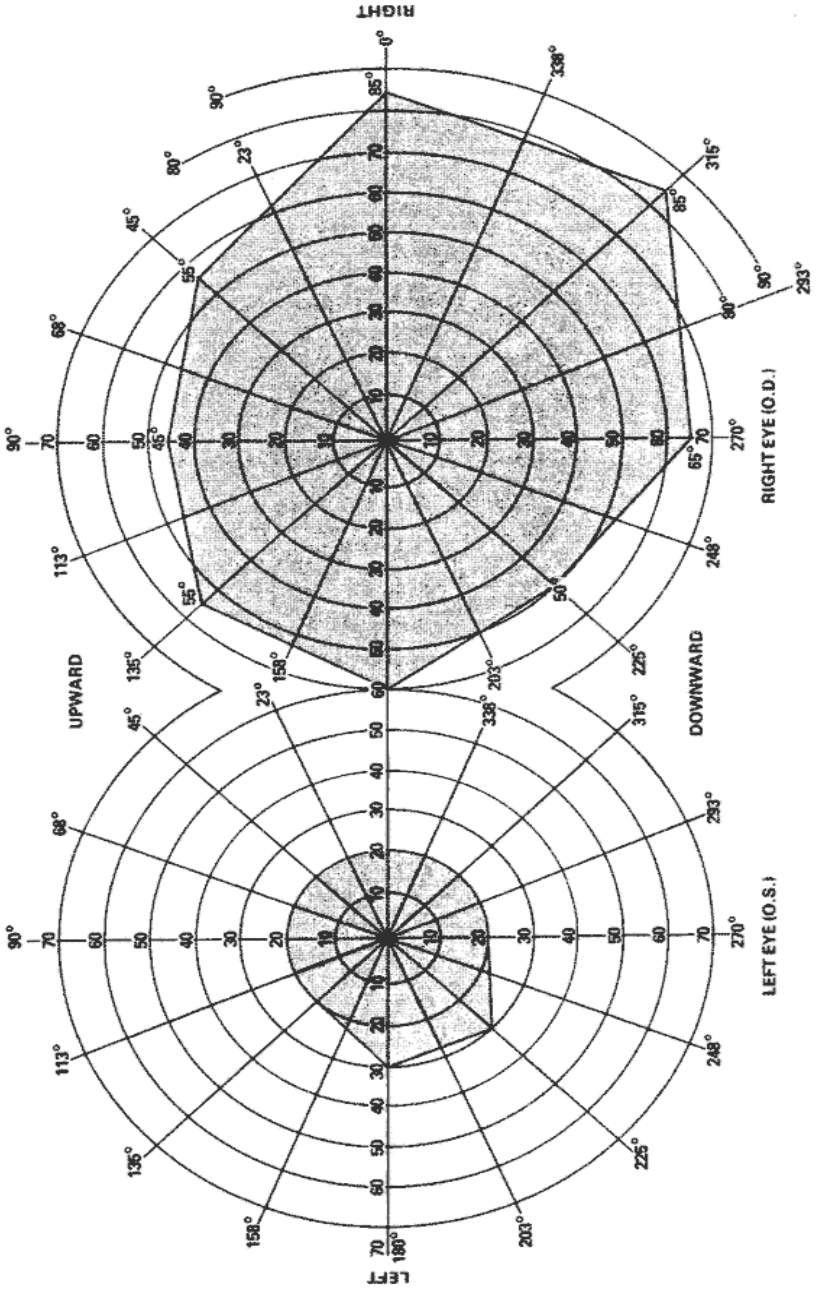

Figure 1. Chart of visual field showing normal field right eye and abnormal contraction visual field left eye.

TS-19 52a

Example of computation of concentric contraction under the schedule with abnormal findings taken from Figure 1.

Loss	Degrees
Temporally	55
Down temporally	55

Down	45
Down nasally	30
Nasally	40
Up nasally	35
Up	25
Up temporally	35
Total loss	320

Remaining field 500° minus 320° = 180°. 180° ÷ 8 = 22½° average concentric contraction.

(Authority: 38 U.S.C. 1155)
[43 FR 45352, Oct. 2, 1978, as amended at 73 FR 66549, Nov. 10, 2008]

§ 4.75 Visual fields.

(a) ***Examination of visual fields.*** Examiners must use either Goldmann kinetic perimetry or automated perimetry using Humphrey Model 750, Octopus Model 101, or later versions of these perimetric devices with simulated kinetic Goldmann testing capability. For phakic (normal) individuals, as well as for pseudophakic or aphakic individuals who are well adapted to intraocular lens implant or contact lens correction, visual field examinations must be conducted using a standard target size and luminance, which is Goldmann's equivalent III/4e. For aphakic individuals not well adapted to contact lens correction or pseudophakic individuals not well adapted to intraocular lens implant, visual field examinations must be conducted using Goldmann's equivalent IV/4e. The examiner must document the results for at least 16 meridians 22 ½ degrees apart for each eye and indicate the Goldmann equivalent used. See Table III for the normal extent (in degrees) of the visual fields at the 8 principal meridians (45 degrees apart). When the examiner indicates that additional testing is necessary to evaluate visual fields, the additional testing must be conducted using either a tangent screen or a 30-degree threshold visual field with the Goldmann III stimulus size. The examination report must document the results of either the tangent screen or of the 30-degree threshold visual field with the Goldmann III stimulus size.

(b) ***Evaluation of visual fields***. Determine the average concentric contraction of the visual field of each eye by measuring the remaining visual field (in degrees) at each of eight principal meridians 45 degrees apart, adding them, and dividing the sum by eight.

(c) ***Combination of visual field defect and decreased visual acuity***. To determine the evaluation for visual impairment when both decreased visual acuity and visual field defect are present in one or both eyes and are service connected, separately evaluate the visual acuity and visual field defect (expressed as a level of visual acuity), and combine them under the provisions of § 4.25.

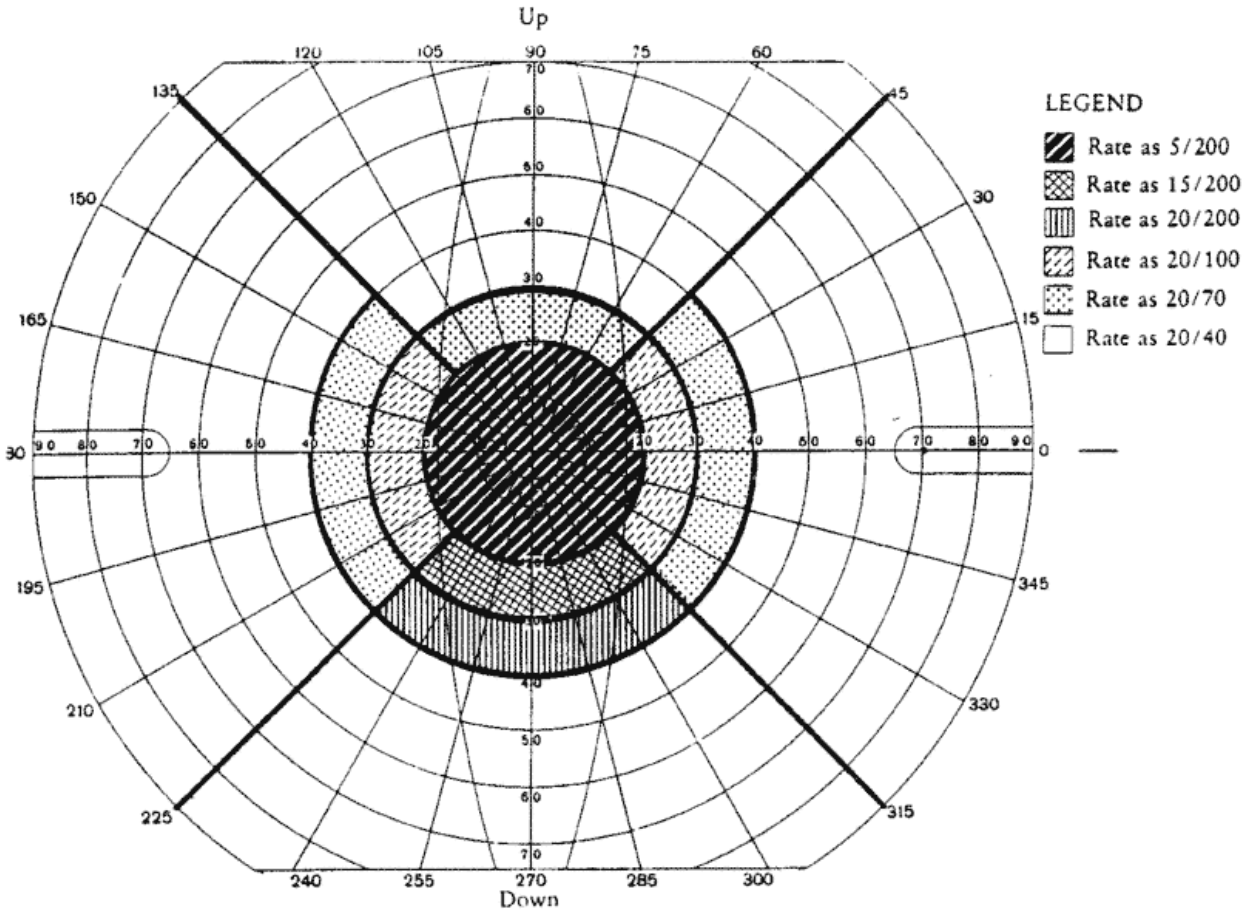

Figure 2. Goldmann Perimeter Chart

52c

(Authority: 38 U.S.C. 1155)
[53 FR 30262, Aug. 11, 1988, as amended at 73 FR 66549, Nov. 10, 2008; 74 FR 7648, Feb. 19, 2009; 83 FR 15320, Apr. 10, 2018]

38 CFR 4.78(b)(1)

§ 4.78 Muscle function.

(a) ***Examination of muscle function.*** The examiner must use a Goldmann perimeter chart or the Tangent Screen method that identifies the four major quadrants (upward, downward, left, and right lateral) and the central field (20 degrees or less) (see Figure 2). The examiner must document the results of muscle function testing by identifying the quadrant(s) and range(s) of degrees in which diplopia exists.

(b) ***Evaluation of muscle function***

1. An evaluation for diplopia will be assigned to only one eye. When a claimant has both diplopia and decreased visual acuity or visual field defect, assign a level of corrected visual acuity for the poorer eye (or the affected eye, if disability of only one eye is service-connected) that is: one step poorer than it would otherwise warrant if the evaluation for diplopia under diagnostic code 6090 is 20/70 or 20/100; two steps poorer if the evaluation under diagnostic code 6090 is 20/200 or 15/200; or three steps poorer if the evaluation under diagnostic code 6090 is 5/200. This adjusted level of corrected visual acuity, however, must not exceed a level of 5/200. Use the adjusted visual acuity for the poorer eye (or the affected eye, if disability of only one eye is service-connected), and the corrected visual acuity for the better eye (or visual acuity of 20/40 for the other eye, if only one eye is service connected) to determine the percentage evaluation for visual impairment under diagnostic codes 6065 through 6066.

2. When diplopia extends beyond more than one quadrant or range of degrees, evaluate diplopia based on the quadrant and degree range that provides the highest evaluation.

3. When diplopia exists in two separate areas of the same eye, increase the equivalent visual acuity under diagnostic code 6090 to the next poorer level of visual acuity, not to exceed 5/200.

(Authority: 38 U.S.C. 1155)

[73 FR 66550, Nov. 10, 2008, as amended at 83 FR 15321, Apr. 10, 2018]

38 CFR 4.79

§ 4.79 Schedule of ratings – eye

Diseases of the Eye

	Rating
General Rating Formula for Diseases of the Eye:	
Evaluate on the basis of either visual impairment due to the particular condition or on incapacitating episodes, whichever results in a higher evaluation	
With documented incapacitating episodes requiring 7 or more treatment visits for an eye condition during the past 12 months	60
With documented incapacitating episodes requiring at least 5 but less than 7 treatment visits for an eye condition during the past 12 months	40
With documented incapacitating episodes requiring at least 3 but less than 5 treatment visits for an eye condition during the past 12 months	20
With documented incapacitating episodes requiring at least 1 but less than 3 treatment visits for an eye condition during the past 12 months	10

Note (1): For the purposes of evaluation under 38 CFR 4.79, an incapacitating episode is an eye condition severe enough to require a clinic visit to a provider specifically for treatment purposes	
Note (2): Examples of treatment may include but are not limited to: Systemic immunosuppressants or biologic agents; intravitreal or periocular injections; laser treatments; or other surgical interventions	
Note (3): For the purposes of evaluating visual impairment due to the particular condition, refer to 38 CFR 4.75-4.78 and to § 4.79, diagnostic codes 6061-6091	
6000 Choroidopathy, including uveitis, iritis, cyclitis, or choroiditis.	
6001 Keratopathy.	
6002 Scleritis.	
6006 Retinopathy or maculopathy not otherwise specified	
6007 Intraocular hemorrhage.	
6008 Detachment of retina.	
6009 Unhealed eye injury.	
Note: This code includes orbital trauma, as well as penetrating or non-penetrating eye injury	
6010 Tuberculosis of eye:	
Active	100
Inactive: Evaluate under § 4.88c or § 4.89 of this part, whichever is appropriate	
6011 Retinal scars, atrophy, or irregularities:	
Localized scars, atrophy, or irregularities of the retina, unilateral or bilateral, that are centrally located and that result in an irregular, duplicated, enlarged, or diminished image	10
Alternatively, evaluate based on the General Rating Formula for Diseases of the Eye, if this would result in a higher evaluation	
6012 Angle-closure glaucoma	
Evaluate under the General Rating Formula for Diseases of the Eye. Minimum evaluation if continuous medication is required	10
6013 Open-angle glaucoma	
Evaluate under the General Rating Formula for Diseases of the Eye. Minimum evaluation if continuous medication is required	10
6014 Malignant neoplasms of the eye, orbit, and adnexa (excluding skin):	
Malignant neoplasms of the eye, orbit, and adnexa (excluding skin) that require therapy that is comparable to those used for systemic malignancies, i.e., systemic chemotherapy, X-ray therapy more extensive than to the area of the eye, or surgery more extensive than enucleation	100
Note: Continue the 100 percent rating beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy, or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating will be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination will be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, evaluate based on residuals	

Malignant neoplasms of the eye, orbit, and adnexa (excluding skin) that do not require therapy comparable to that for systemic malignancies:	
Separately evaluate visual and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations	
6015 Benign neoplasms of the eye, orbit, and adnexa (excluding skin):	
Separately evaluate visual and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations	
6016 Nystagmus, central	10
6017 Trachomatous conjunctivitis:	
Active: Evaluate under the General Rating Formula for Diseases of the Eye, minimum rating	30
Inactive: Evaluate based on residuals, such as visual impairment and disfigurement (diagnostic code 7800)	
6018 Chronic conjunctivitis (nontrachomatous):	
Active: Evaluate under the General Rating Formula for Diseases of the Eye, minimum rating	10
Inactive: Evaluate based on residuals, such as visual impairment and disfigurement (diagnostic code 7800)	
6019 Ptosis, unilateral or bilateral:	
Evaluate based on visual impairment or, in the absence of visual impairment, on disfigurement (diagnostic code 7800).	
6020 Ectropion:	
Bilateral	20
Unilateral	10
6021 Entropion:	
Bilateral	20
Unilateral	10
6022 Lagophthalmos:	
Bilateral	20
Unilateral	10
6023 Loss of eyebrows, complete, unilateral or bilateral	
6024 Loss of eyelashes, complete, unilateral or bilateral	
6025 Disorders of the lacrimal apparatus (epiphora, dacryocystitis, etc.):	
Bilateral	20
Unilateral	10
6026 Optic neuropathy	
6027 Cataract:	
Preoperative: Evaluate under the General Rating Formula for Diseases of the Eye	
Postoperative: If a replacement lens is present (pseudophakia), evaluate under the General Rating Formula for Diseases of the Eye. If there is no replacement lens, evaluate based on aphakia (diagnostic code 6029)	
6029 Aphakia or dislocation of crystalline lens:	
Evaluate based on visual impairment, and elevate the resulting level of visual impairment one step.	

Minimum (unilateral or bilateral)	30
6030 Paralysis of accommodation (due to neuropathy of the Oculomotor Nerve (cranial nerve III)).	20
6032 Loss of eyelids, partial or complete:	
Separately evaluate both visual impairment due to eyelid loss and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations.	
6034 Pterygium:	
Evaluate under the General Rating Formula for Diseases of the Eye, disfigurement (diagnostic code 7800), conjunctivitis (diagnostic code 6018), etc., depending on the particular findings, and combine in accordance with § 4.25	
6035 Keratoconus	
6036 Status post corneal transplant:	
Evaluate under the General Rating Formula for Diseases of the Eye. Minimum, if there is pain, photophobia, and glare sensitivity	10
6037 Pinguecula:	
Evaluate based on disfigurement (diagnostic code 7800).	
6040 Diabetic retinopathy	
6042 Retinal dystrophy (including retinitis pigmentosa, wet or dry macular degeneration, early onset macular degeneration, rod and/or cone dystrophy)	
6046 Post-chiasmal disorders	
Impairment of Central Visual Acuity	
6061 Anatomical loss of both eyes [1]	100
6062 No more than light perception in both eyes [1]	100
6063 Anatomical loss of one eye: [1]	
In the other eye 5/200 (1.5/60)	100
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	60
In the other eye 20/50 (6/15)	50
In the other eye 20/40 (6/12)	40
6064 No more than light perception in one eye:[1]	
In the other eye 5/200 (1.5/60)	100
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
6065 Vision in one eye 5/200 (1.5/60):	
In the other eye 5/200 (1.5/60)	[1]100

In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
6066 Visual acuity in one eye 10/200 (3/60) or better:	
Vision in one eye 10/200 (3/60):	
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
Vision in one eye 15/200 (4.5/60):	
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	40
In the other eye 20/50 (6/15)	30
In the other eye 20/40 (6/12)	20
Vision in one eye 20/200 (6/60):	
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	40
In the other eye 20/50 (6/15)	30
In the other eye 20/40 (6/12)	20
Vision in one eye 20/100 (6/30):	
In the other eye 20/100 (6/30)	50
In the other eye 20/70 (6/21)	30
In the other eye 20/50 (6/15)	20
In the other eye 20/40 (6/12)	10
Vision in one eye 20/70 (6/21):	
In the other eye 20/70 (6/21)	30
In the other eye 20/50 (6/15)	20
In the other eye 20/40 (6/12)	10
Vision in one eye 20/50 (6/15):	
In the other eye 20/50 (6/15)	10
In the other eye 20/40 (6/12)	10
Vision in one eye 20/40 (6/12):	
In the other eye 20/40 (6/12)	0

[1]Review for entitlement to special monthly compensation under 38 CFR 3.350.

Ratings for Impairment of Visual Fields

	Rating
6080 Visual field defects:	
Homonymous hemianopsia	30
Loss of temporal half of visual field:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21)	
Loss of nasal half of visual field:	
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15)	
Loss of inferior half of visual field:	
Bilateral	30
Unilateral	10
Loss of superior half of visual field:	
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15)	
Concentric contraction of visual field:	
With remaining field of 5 degrees:[1]	
Bilateral	100
Unilateral	30
Or evaluate each affected eye as 5/200 (1.5/60)	
With remaining field of 6 to 15 degrees:	
Bilateral	70
Unilateral	20
Or evaluate each affected eye as 20/200 (6/60)	
With remaining field of 16 to 30 degrees:	
Bilateral	50
Unilateral	10
Or evaluate each affected eye as 20/100 (6/30)	
With remaining field of 31 to 45 degrees:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21)	
With remaining field of 46 to 60 degrees:	
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15)	
6081 Scotoma, unilateral:	
Minimum, with scotoma affecting at least one-quarter of the visual field (quadrantanopsia) or with centrally located scotoma of any size	10

Alternatively, evaluate based on visual impairment due to scotoma, if that would result in a higher evaluation	

[1]Review for entitlement to special monthly compensation under 38 CFR 3.350.

Ratings for Impairment of Muscle Function

Degree of diplopia	Equivalent visual acuity
6090 Diplopia (double vision):	
(a) Central 20 degrees	5/200 (1.5/60)
(b) 21 degrees to 30 degrees	
(1) Down	15/200 (4.5/60)
(2) Lateral	20/100 (6/30)
(3) Up	20/70 (6/21)
(c) 31 degrees to 40 degrees	
(1) Down	20/200 (6/60)
(2) Lateral	20/70 (6/21)
(3) Up	20/40 (6/12)
Note: In accordance with 38 CFR 4.31, diplopia that is occasional or that is correctable with spectacles is evaluated at 0 percent.	
6091 Symblepharon:	
Evaluate under the General Rating Formula for Diseases of the Eye, lagophthalmos (diagnostic code 6022), disfigurement (diagnostic code 7800), etc., depending on the particular findings, and combine in accordance with § 4.25	

(Authority: 38 U.S.C. 1155)

[73 FR 66550, Nov. 10, 2008, as amended at 83 FR 15321, Apr. 10, 2018]

§§ 4.80-4.84 [Reserved]

38 CFR 4.85(a)

IMPAIRMENT OF AUDITORY ACUITY

§ 4.85 Evaluation of hearing impairment.

(a) An examination for hearing impairment for VA purposes must be conducted by a state-licensed audiologist and must include a controlled speech discrimination test (Maryland CNC) and a puretone audiometry test. Examinations will be conducted without the use of hearing aids.

(b) Table VI, "Numeric Designation of Hearing Impairment Based on Puretone Threshold Average and Speech Discrimination," is used to determine a Roman numeral designation (I through XI) for hearing impairment based on a combination of the percent of speech discrimination (horizontal rows) and the puretone threshold average (vertical columns). The Roman numeral designation is located at the point where the percentage of speech discrimination and puretone threshold average intersect.

(c) Table VIa, "Numeric Designation of Hearing Impairment Based Only on Puretone Threshold Average," is used to determine a Roman numeral designation (I through XI) for hearing impairment based only on the puretone threshold average. Table VIa will be used when the examiner certifies that use of the speech discrimination test is not appropriate because of language difficulties, inconsistent speech discrimination scores, etc., or when indicated under the provisions of § 4.86.

(d) "Puretone threshold average," as used in Tables VI and VIa, is the sum of the puretone thresholds at 1000, 2000, 3000 and 4000 Hertz, divided by four. This average is used in all cases (including those in § 4.86) to determine the Roman numeral designation for hearing impairment from Table VI or VIa.

(e) Table VII, "Percentage Evaluations for Hearing Impairment," is used to determine the percentage evaluation by combining the Roman numeral designations for hearing impairment of each ear. The horizontal rows represent the ear having the better hearing and the vertical columns the ear having the poorer hearing. The percentage evaluation is located at the point where the row and column intersect.

(f) If impaired hearing is service-connected in only one ear, in order to determine the percentage evaluation from Table VII, the non-service-connected ear will be assigned a Roman Numeral designation for hearing impairment of I, subject to the provisions of § 3.383 of this chapter.

(g) When evaluating any claim for impaired hearing, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation due either to deafness, or to deafness in combination with other specified disabilities.

(h) *Numeric tables VI, VIA*, and VII.*

38 CFR 4.85(h)

TABLE VI

NUMERIC DESIGNATION OF HEARING IMPAIRMENT BASED ON PURETONE THRESHOLD AVERAGE AND SPEECH DISCRIMINATION

Puretone Threshold Average

% of discrim-ination	0-41	42-49	50-57	58-65	66-73	74-81	82-89	90-97	98+
92-100	I	I	I	II	II	II	III	III	IV
84-90	II	II	II	III	III	III	IV	IV	IV
76-82	III	III	IV	IV	IV	V	V	V	V
68-74	IV	IV	V	V	VI	VI	VII	VII	VII
60-66	V	V	VI	VI	VII	VII	VIII	VIII	VIII
52-58	VI	VI	VII	VII	VIII	VIII	VIII	VIII	IX
44-50	VII	VII	VIII	VIII	VIII	IX	IX	IX	X
36-42	VIII	VIII	VIII	IX	IX	IX	X	X	X
0-34	IX	X	XI	XI	XI	XI	XI	XI	XI

TABLE VIA*

NUMERIC DESIGNATION OF HEARING IMPAIRMENT BASED ONLY ON PURETONE THRESHOLD AVERAGE

Puretone Threshold Average

0-41	42-48	49-55	56-62	63-69	70-76	77-83	84-90	91-97	98-104	105+
I	II	III	IV	V	VI	VII	VIII	IX	X	XI

* This table is for use only as specified in §§ 4.85 and 4.86.

TABLE VII

PERCENTAGE EVALUATION FOR HEARING IMPAIRMENT (DIAGNOSTIC CODE 6100)

Poorer Ear

Better Ear	XI	X	IX	VIII	VII	VI	V	IV	III	II	I
XI	100*										
X	90	80									
IX	80	70	60								
VIII	70	60	50	50							
VII	60	60	50	40	40						
VI	50	50	40	40	30	30					
V	40	40	40	30	30	20	20				
IV	30	30	30	20	20	20	10	10			
III	20	20	20	20	20	10	10	10	0		
II	10	10	10	10	10	10	10	0	0	0	
I	10	10	0	0	0	0	0	0	0	0	0

* Review for entitlement to special monthly compensation under §3.350 of this chapter.

§ 4.86 Exceptional patterns of hearing impairment.

a) When the pure tone threshold at each of the four specified frequencies (1000, 2000, 3000, and 4000 Hertz) is 55 decibels or more, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. Each ear will be evaluated separately.

b) When the pure tone threshold is 30 decibels or less at 1000 Hertz, and 70 decibels or more at 2000 Hertz, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. That numeral will then be elevated to the next higher Roman numeral. Each ear will be evaluated separately.

(Authority: 38 U.S.C. 1155)

[64 FR 25209, May 11, 1999]

38 CFR 4.87

§ 4.87 Schedule of ratings - ear.

Diseases of the Ear

	Rating
6200 Chronic suppurative otitis media, mastoiditis, or cholesteatoma (or any combination):	
During suppuration, or with aural polyps	10
Note: Evaluate hearing impairment, and complications such as labyrinthitis, tinnitus, facial nerve paralysis, or bone loss of skull, separately.	
6201 Chronic nonsuppurative otitis media with effusion (serous otitis media):	
Rate hearing impairment	
6202 Otosclerosis:	
Rate hearing impairment	
6204 Peripheral vestibular disorders:	
Dizziness and occasional staggering	30
Occasional dizziness	10
Note: Objective findings supporting the diagnosis of vestibular disequilibrium are required before a compensable evaluation can be assigned under this code. Hearing impairment or suppuration shall be separately rated and combined.	
6205 Meniere's syndrome (endolymphatic hydrops):	
Hearing impairment with attacks of vertigo and cerebellar gait occurring more than once weekly, with or without tinnitus	100
Hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus	60
Hearing impairment with vertigo less than once a month, with or without tinnitus	30
Note: Evaluate Meniere's syndrome either under these criteria or by separately evaluating vertigo (as a peripheral vestibular disorder), hearing impairment, and tinnitus, whichever method results in a higher overall evaluation. But do not combine an evaluation for hearing impairment, tinnitus, or vertigo with an evaluation under diagnostic code 6205.	
6207 Loss of auricle:	
Complete loss of both	50

Complete loss of one	30
Deformity of one, with loss of one-third or more of the substance	10
6208 Malignant neoplasm of the ear (other than skin only)	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation treatment, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based on that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
6209 Benign neoplasms of the ear (other than skin only):	
Rate on impairment of function.	
6210 Chronic otitis externa:	
Swelling, dry and scaly or serous discharge, and itching requiring frequent and prolonged treatment	10
6211 Tympanic membrane, perforation of	0
6260 Tinnitus, recurrent	10
Note (1): A separate evaluation for tinnitus may be combined with an evaluation under diagnostic codes 6100, 6200, 6204, or other diagnostic code, except when tinnitus supports an evaluation under one of those diagnostic codes.	
Note (2): Assign only a single evaluation for recurrent tinnitus, whether the sound is perceived in one ear, both ears, or in the head.	
Note (3): Do not evaluate objective tinnitus (in which the sound is audible to other people and has a definable cause that may or may not be pathologic) under this diagnostic code, but evaluate it as part of any underlying condition causing it.	

(Authority: 38 U.S.C. 1155)

[64 FR 25210, May 11, 1999, as amended at 68 FR 25823, May 14, 2003]

38 CFR 4.87a

§ 4.87a Schedule of ratings – other sense organs.

	Rating
6275 Sense of smell, complete loss	10
6276 Sense of taste, complete loss	10
Note: Evaluation will be assigned under diagnostic codes 6275 or 6276 only if there is an anatomical or pathological basis for the condition.	

INFECTIOUS DISEASES, IMMUNE DISORDERS AND NUTRITIONAL DEFICIENCIES

§ 4.88 [Reserved]

§ 4.88a Chronic fatigue syndrome.

(a) For VA purposes, the diagnosis of chronic fatigue syndrome requires:
1. new onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least six months; and
2. the exclusion, by history, physical examination, and laboratory tests, of all other clinical conditions that may produce similar symptoms; and
3. six or more of the following:
   i. acute onset of the condition,
   ii. low grade fever,
   iii. nonexudative pharyngitis,
   iv. palpable or tender cervical or axillary lymph nodes,
   v. generalized muscle aches or weakness,
   vi. fatigue lasting 24 hours or longer after exercise,
   vii. headaches (of a type, severity, or pattern that is different from headaches in the pre-morbid state),
   viii. migratory joint pains,
   ix. neuropsychologic symptoms,
   x. sleep disturbance.

(b) [Reserved]

[59 FR 60902, Nov. 29, 1994]

38 CFR 4.88b

§ 4.88b Schedule of ratings – infectious diseases, immune disorders and nutritional deficiencies

Note:

Rate any residual disability of infection within the appropriate body system as indicated by the notes in the evaluation criteria. As applicable, consider the long-term health effects potentially associated with infectious diseases as listed in § 3.317(d) of this chapter, specifically Brucellosis, Campylobacter jejuni, Coxiella burnetii (Q fever), Malaria, Mycobacterium Tuberculosis, Nontyphoid Salmonella, Shigella, Visceral Leishmaniasis, and West Nile virus.

	Rating
General Rating Formula for Infectious Diseases:	
For active disease	100
After active disease has resolved, rate at 0 percent for infection. Rate any residual disability of infection within the appropriate body system.	

6300 Vibriosis (Cholera, Non-cholera):	
Evaluate under the General Rating Formula.	
Note: Rate residuals of cholera and non-cholera vibrio infections, such as renal failure, skin, and musculoskeletal conditions, within the appropriate body system.	
6301 Visceral leishmaniasis:	
As active disease	100
Note 1: Continue a 100 percent evaluation beyond the cessation of treatment for active disease. Six months after discontinuance of such treatment, determine the appropriate disability rating by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. Thereafter, rate under the appropriate body system any residual disability of infection, which includes, but is not limited to liver damage and bone marrow disease.	
Note 2: Confirm the recurrence of active infection by culture, histopathology, or other diagnostic laboratory testing.	
6302 Leprosy (Hansen's disease):	
As active disease	100
Note: Continue a 100 percent evaluation beyond the cessation of treatment for active disease. Six months after discontinuance of such treatment, determine the appropriate disability rating by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. Thereafter, rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, skin lesions, peripheral neuropathy, or amputations.	
6304 Malaria:	
Evaluate under the General Rating Formula.	
Note 1*:* The diagnosis of malaria, both initially and during relapse, depends on the identification of the malarial parasites in blood smears or other specific diagnostic laboratory tests such as antigen detection, immunologic (immunochromatographic) tests, and molecular testing such as polymerase chain reaction tests.	
Note 2: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, liver or splenic damage, and central nervous system conditions.	
6305 Lymphatic filariasis, to include elephantiasis:	
Evaluate under the General Rating Formula.	
Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, epididymitis, lymphangitis, lymphatic obstruction, or lymphedema affecting extremities, genitals, and/or breasts.	
6306 Bartonellosis:	
Evaluate under the General Rating Formula.	
Note*:* Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, endocarditis or skin lesions.	

6307 Plague:	
Evaluate under the General Rating Formula.	
Note: Rate under the appropriate body system any residual disability of infection.	
6308 Relapsing Fever:	
Evaluate under the General Rating Formula.	
Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, liver or spleen damage, iritis, uveitis, or central nervous system involvement.	
6309 Rheumatic fever:	
Evaluate under the General Rating Formula.	
Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, heart damage.	
6310 Syphilis, and other treponema infections:	
Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, diseases of the nervous system, vascular system, eyes, or ears (see DC 7004, DC 8013, DC 8014, DC 8015, and DC 9301).	
6311 Tuberculosis, miliary:	
As active disease	100
Inactive disease: See §§ 4.88c and 4.89.	
Note 1: Confirm the recurrence of active infection by culture, histopathology, or other diagnostic laboratory testing.	
Note 2: Rate under the appropriate body system any residual disability of infection which includes, but is not limited to, skin conditions and conditions of the respiratory, central nervous, musculoskeletal, ocular, gastrointestinal, and genitourinary systems and those residuals listed in § 4.88c.	
6312 Non-tuberculosis mycobacterium infection:	
As active disease	100
Note 1**:** Continue the rating of 100 percent for the duration of treatment for active disease followed by a mandatory VA exam. If there is no relapse, rate on residuals. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
Note 2: Confirm the recurrence of active infection by culture, histopathology, or other diagnostic laboratory testing.	
Note 3**:** Rate under the appropriate body system any residual disability of infection which includes, but is not limited to, skin conditions and conditions of the respiratory, central nervous, musculoskeletal, ocular, gastrointestinal, and genitourinary systems and those residuals listed in § 4.88c.	
6313 Avitaminosis:	
Marked mental changes, moist dermatitis, inability to retain adequate nourishment, exhaustion, and cachexia	100
With all of the symptoms listed below, plus mental symptoms and impaired bodily vigor	60
With stomatitis, diarrhea, and symmetrical dermatitis	40

With stomatitis, or achlorhydria, or diarrhea	20
Confirmed diagnosis with nonspecific symptoms such as: decreased appetite, weight loss, abdominal discomfort, weakness, inability to concentrate and irritability	10
6314 Beriberi:	
As active disease:	
With congestive heart failure, anasarca, or Wernicke-Korsakoff syndrome	100
With cardiomegaly, or; with peripheral neuropathy with footdrop or atrophy of thigh or calf muscles	60
With peripheral neuropathy with absent knee or ankle jerks and loss of sensation, or; with symptoms such as weakness, fatigue, anorexia, dizziness, heaviness and stiffness of legs, headache or sleep disturbance	30
Thereafter rate residuals under the appropriate body system.	
6315 Pellagra	
Marked mental changes, moist dermatitis, inability to retain adequate nourishment, exhaustion, and cachexia	100
With all of the symptoms listed below, plus mental symptoms and impaired bodily vigor	60
With stomatitis, diarrhea, and symmetrical dermatitis	40
With stomatitis, or achlorhydria, or diarrhea	20
Confirmed diagnosis with nonspecific symptoms such as: decreased appetite, weight loss, abdominal discomfort, weakness, inability to concentrate and irritability	10
6316 Brucellosis:	
Evaluate under the General Rating Formula.	
Note 1: Culture, serologic testing, or both must confirm the initial diagnosis and recurrence of active infection.	
Note 2: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, meningitis, liver, spleen and musculoskeletal conditions	
6317 Rickettsial, ehrlichia, and anaplasma infections:	
Evaluate under the General Rating Formula.	
Note 1: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, bone marrow, spleen, central nervous system, and skin conditions.	
Note 2: This diagnostic code includes, but is not limited to, scrub typhus, Rickettsial pox, African tick-borne fever, Rocky Mountain spotted fever, ehrlichiosis, or anaplasmosis.	
6318 Melioidosis:	
Evaluate under the General Rating Formula.	
Note 1: Confirm by culture or other specific diagnostic laboratory tests the initial diagnosis and any relapse or chronic activity of infection.	
Note 2: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, arthritis, lung lesions, or meningitis	

6319 Lyme disease:	
Evaluate under the General Rating Formula.	
Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, arthritis, Bell's palsy, radiculopathy, ocular, or cognitive dysfunction.	
6320 Parasitic diseases otherwise not specified:	
Evaluate under the General Rating Formula.	
Note: Rate under the appropriate body system any residual disability of infection.	
6325 Hyperinfection syndrome or disseminated strongyloidiasis:	
As active disease	100
Note: Continue the rating of 100 percent through active disease followed by a mandatory VA exam. If there is no relapse, rate on residual disability. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
6326 Schistosomiasis:	
As acute or asymptomatic chronic disease	0
Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, conditions of the liver, intestinal system, female genital tract, genitourinary tract, or central nervous system	
6329 Hemorrhagic fevers, including dengue, yellow fever, and others:	
Evaluate under the General Rating Formula.	
Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, conditions of the central nervous system, liver, or kidney	
6330 Campylobacter jejuni infection:	
Evaluate under the General Rating Formula.	
Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, Guillain-Barre syndrome, reactive arthritis, or uveitis.	
6331 Coxiella burnetii infection (Q fever):	
Evaluate under the General Rating Formula.	
Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, chronic hepatitis, endocarditis, osteomyelitis, post Q-fever chronic fatigue syndrome, or vascular infections.	
6333 Nontyphoid salmonella infections:	
Evaluate under the General Rating Formula.	
Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, reactive arthritis	
6334 Shigella infections:	
Evaluate under the General Rating Formula.	

Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, hemolytic-uremic syndrome or reactive arthritis.	
6335 West Nile virus infection:	
Evaluate under the General Rating Formula.	
Note: Rate under the appropriate body system any residual disability of infection, which includes, but is not limited to, variable physical, functional, or cognitive disabilities.	
6350 Lupus erythematosus, systemic (disseminated):	
Not to be combined with ratings under DC 7809 Acute, with frequent exacerbations, producing severe impairment of health	100
Exacerbations lasting a week or more, 2 or 3 times per year	60
Exacerbations once or twice a year or symptomatic during the past 2 years	10
Note: Evaluate this condition either by combining the evaluations for residuals under the appropriate system, or by evaluating DC 6350, whichever method results in a higher evaluation	
6351 HIV-related illness:	
AIDS with recurrent opportunistic infections (see Note 3) or with secondary diseases afflicting multiple body systems; HIV-related illness with debility and progressive weight loss	100
Refractory constitutional symptoms, diarrhea, and pathological weight loss; or minimum rating following development of AIDS-related opportunistic infection or neoplasm	60
Recurrent constitutional symptoms, intermittent diarrhea, and use of approved medication(s); or minimum rating with T4 cell count less than 200	30
Following development of HIV-related constitutional symptoms; T4 cell count between 200 and 500; use of approved medication(s); or with evidence of depression or memory loss with employment limitations	10
Asymptomatic, following initial diagnosis of HIV infection, with or without lymphadenopathy or decreased T4 cell count	0
Note 1: In addition to standard therapies and regimens, the term “approved medication(s)” includes treatment regimens and medications prescribed as part of a research protocol at an accredited medical institution	
Note 2: Diagnosed psychiatric illness, central nervous system manifestations, opportunistic infections, and neoplasms may be rated separately under the appropriate diagnostic codes if a higher overall evaluation results, provided the disability symptoms do not overlap with evaluations otherwise assignable above.	
Note 3: The following list of opportunistic infections are considered AIDS-defining conditions, that is, a diagnosis of AIDS follows if a person has HIV and one more of these infections, regardless of the CD4 count - candidiasis of the bronchi, trachea, esophagus, or lungs; invasive cervical cancer; coccidioidomycosis; cryptococcosis; cryptosporidiosis; cytomegalovirus (particularly CMV retinitis); HIV-related encephalopathy; herpes simplex-chronic ulcers for greater than one month, or bronchitis, pneumonia, or esophagitis; histoplasmosis; isosporiasis (chronic intestinal); Kaposi's	

sarcoma; lymphoma; mycobacterium avium complex; tuberculosis; pneumocystis jirovecii (carinii) pneumonia; pneumonia, recurrent; progressive multifocal leukoencephalopathy; salmonella septicemia, recurrent; toxoplasmosis of the brain; and wasting syndrome due to HIV	
6354 Chronic fatigue syndrome (CFS):	
Debilitating fatigue, cognitive impairments (such as inability to concentrate, forgetfulness, or confusion), or a combination of other signs and symptoms:	
Which are nearly constant and so severe as to restrict routine daily activities almost completely and which may occasionally preclude self-care	100
Which are nearly constant and restrict routine daily activities to less than 50 percent of the pre-illness level; or which wax and wane, resulting in periods of incapacitation of at least six weeks total duration per year	60
Which are nearly constant and restrict routine daily activities from 50 to 75 percent of the pre-illness level; or which wax and wane, resulting in periods of incapacitation of at least four but less than six weeks total duration per year	40
Which are nearly constant and restrict routine daily activities by less than 25 percent of the pre-illness level; or which wax and wane, resulting in periods of incapacitation of at least two but less than four weeks total duration per year	20
Which wax and wane but result in periods of incapacitation of at least one but less than two weeks total duration per year; or symptoms controlled by continuous medication	10
Note: For the purpose of evaluating this disability, incapacitation exists only when a licensed physician prescribes bed rest and treatment.	

38 CFR 4.88c

§ 4.88c Ratings for inactive non-pulmonary tuberculosis initially entitled after August 19, 1968.

	Rating
For 1 year after date of inactivity, following active tuberculosis	100
Thereafter: Rate residuals under the specific body system or systems affected.	
Following the total rating for the 1 year period after date of inactivity, the schedular evaluation for residuals of non-pulmonary tuberculosis, i.e., ankylosis, surgical removal of a part, etc., will be assigned under the appropriate diagnostic code for the residual preceded by the diagnostic code for tuberculosis of the body part affected. For example, tuberculosis of the hip joint with residual ankylosis would be coded 5001-5250. Where there are existing residuals of pulmonary and non-pulmonary conditions, the evaluations for residual separate functional impairment may be combined.	
Where there are existing pulmonary and non-pulmonary conditions, the total rating for the 1 year, after attainment of inactivity, may not be applied to both conditions	

during the same period. However, the total rating during the 1-year period for the pulmonary or for the non-pulmonary condition will be utilized, combined with evaluation for residuals of the condition not covered by the 1-year total evaluation, so as to allow any additional benefit provided during such period.	

[34 FR 5062, Mar. 11, 1969. Redesignated at 59 FR 60902, Nov. 29, 1994]

38 CFR 4.89

§ 4.89 Ratings for inactive non-pulmonary tuberculosis in effect on August 19, 1968.

Public Law 90-493 repealed section 356 of title 38, United States Code which provided graduated ratings for inactive tuberculosis. The repealed section, however, still applies to the case of any veteran who on August 19, 1968, was receiving or entitled to receive compensation for tuberculosis. The use of the protective provisions of Pub. L. 90-493 should be mentioned in the discussion portion of all ratings in which these provisions are applied. For use in rating cases in which the protective provisions of Pub. L. 90-493 apply, the former evaluations are retained in this section.

	Rating
For 2 years after date of inactivity, following active tuberculosis, which was clinically identified during service or subsequently	100
Thereafter, for 4 years, or in any event, to 6 years after date of inactivity	50
Thereafter, for 5 years, or to 11 years after date of inactivity	30
Thereafter, in the absence of a schedular compensable permanent residual	0
Following the total rating for the 2-year period after date of inactivity, the schedular evaluation for residuals of non-pulmonary tuberculosis, i.e., ankylosis, surgical removal of a part, etc., if in excess of 50 percent or 30 percent will be assigned under the appropriate diagnostic code for the specific residual preceded by the diagnostic code for tuberculosis of the body part affected. For example, tuberculosis of the hipjoint with residual ankylosis would be coded 5001-5250.	
The graduated ratings for non-pulmonary tuberculosis will not be combined with residuals of non-pulmonary tuberculosis unless the graduated rating and the rating for residual disability cover separate functional losses, e.g., graduated ratings for tuberculosis of the kidney and residuals of tuberculosis of the spine. Where there are existing pulmonary and non-pulmonary conditions, the graduated evaluation for the pulmonary, or for the non-pulmonary, condition will be utilized, combined with evaluations for residuals of the condition not covered by the graduated evaluation utilized, so as to provide the higher evaluation over such period.	
The ending dates of all graduated ratings of non-pulmonary tuberculosis will be controlled by the date of attainment of inactivity.	
These ratings are applicable only to veterans with non-pulmonary tuberculosis active on or after October 10, 1949.	

[29 FR 6718, May 22, 1964, as amended at 34 FR 5062, Mar. 11, 1969; 43 FR 45361, Oct. 2, 1978]

THE RESPIRATORY SYSTEM

§ 4.96 Special provisions regarding evaluation of respiratory conditions

a) ***Rating coexisting respiratory conditions.*** Ratings under diagnostic codes 6600 through 6817 and 6822 through 6847 will not be combined with each other. Where there is lung or pleural involvement, ratings under diagnostic codes 6819 and 6820 will not be combined with each other or with diagnostic codes 6600 through 6817 or 6822 through 6847. A single rating will be assigned under the diagnostic code which reflects the predominant disability with elevation to the next higher evaluation where the severity of the overall disability warrants such elevation. However, in cases protected by the provisions of Pub. L. 90-493, the graduated ratings of 50 and 30 percent for inactive tuberculosis will not be elevated.

b) ***Rating "protected" tuberculosis cases.*** Public Law 90-493 repealed section 356 of title 38, United States Code which had provided graduated ratings for inactive tuberculosis. The repealed section, however, still applies to the case of any veteran who on August 19, 1968, was receiving or entitled to receive compensation for tuberculosis. The use of the protective provisions of Pub. L. 90-493 should be mentioned in the discussion portion of all ratings in which these provisions are applied. For application in rating cases in which the protective provisions of Pub. L. 90-493 apply the former evaluations pertaining to pulmonary tuberculosis are retained in § 4.97.

c) ***Special monthly compensation***. When evaluating any claim involving complete organic aphonia, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, there are other conditions in this section which under certain circumstances also establish entitlement to special monthly compensation.

d) ***Special provisions for the application of evaluation criteria for diagnostic codes 6600, 6603, 6604, 6825-6833, and 6840-6845.***

    1) Pulmonary function tests (PFT's) are required to evaluate these conditions except:
        i. When the results of a maximum exercise capacity test are of record and are 20 ml/kg/min or less. If a maximum exercise capacity test is not of record, evaluate based on alternative criteria.
        ii. When pulmonary hypertension (documented by an echocardiogram or cardiac catheterization), cor pulmonale, or right ventricular hypertrophy has been diagnosed.
        iii. When there have been one or more episodes of acute respiratory failure.
        iv. When outpatient oxygen therapy is required.
    2) If the DLCO (SB) (Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method) test is not of record, evaluate based on alternative criteria as long as the examiner states why the test would not be useful or valid in a particular case.
    3) When the PFT's are not consistent with clinical findings, evaluate based on the PFT's unless the examiner states why they are not a valid indication of respiratory functional impairment in a particular case.

4) Post-bronchodilator studies are required when PFT's are done for disability evaluation purposes except when the results of pre-bronchodilator pulmonary function tests are normal or when the examiner determines that post-bronchodilator studies should not be done and states why.
5) When evaluating based on PFT's, use post-bronchodilator results in applying the evaluation criteria in the rating schedule unless the post-bronchodilator results were poorer than the pre-bronchodilator results. In those cases, use the pre-bronchodilator values for rating purposes.
6) When there is a disparity between the results of different PFT's (FEV-1 (Forced Expiratory Volume in one second), FVC (Forced Vital Capacity), etc.), so that the level of evaluation would differ depending on which test result is used, use the test result that the examiner states most accurately reflects the level of disability.
7) If the FEV-1 and the FVC are both greater than 100 percent, do not assign a compensable evaluation based on a decreased FEV-1/FVC ratio.

(Authority: 38 U.S.C. 1155)
[34 FR 5062, Mar. 11, 1969, as amended at 61 FR 46727, Sept. 5, 1996; 71 FR 52459, Sept. 6, 2006]

38 CFR 4.97

§ 4.97 Schedule of rating – respiratory system.

DISEASES OF THE NOSE AND THROAT	
	Rating
6502 Septum, nasal, deviation of:	
Traumatic only,	
With 50-percent obstruction of the nasal passage on both sides or complete obstruction on one side	10
6504 Nose, loss of part of, or scars:	
Exposing both nasal passages	30
Loss of part of one ala, or other obvious disfigurement	10
Note: Or evaluate as DC 7800, scars, disfiguring, head, face, or neck.	
6510 Sinusitis, pansinusitis, chronic.	
6511 Sinusitis, ethmoid, chronic.	
6512 Sinusitis, frontal, chronic.	
6513 Sinusitis, maxillary, chronic.	
6514 Sinusitis, sphenoid, chronic	
General Rating Formula for Sinusitis (DC's 6510 through 6514):	
Following radical surgery with chronic osteomyelitis, or; near constant sinusitis characterized by headaches, pain and tenderness of affected sinus, and purulent discharge or crusting after repeated surgeries	50
Three or more incapacitating episodes per year of sinusitis requiring prolonged (lasting four to six weeks) antibiotic treatment, or; more than six non-incapacitating episodes per year of sinusitis characterized by headaches, pain, and purulent discharge or crusting	30

One or two incapacitating episodes per year of sinusitis requiring prolonged (lasting four to six weeks) antibiotic treatment, or; three to six non-incapacitating episodes per year of sinusitis characterized by headaches, pain, and purulent discharge or crusting	10
Detected by X-ray only	0
Note: An incapacitating episode of sinusitis means one that requires bed rest and treatment by a physician.	
6515 Laryngitis, tuberculous, active or inactive.	
Rate under §§ 4.88c or 4.89, whichever is appropriate.	
6516 Laryngitis, chronic:	
Hoarseness, with thickening or nodules of cords, polyps, submucous infiltration, or pre-malignant changes on biopsy	30
Hoarseness, with inflammation of cords or mucous membrane	10
6518 Laryngectomy, total.	[1]100
Rate the residuals of partial laryngectomy as laryngitis (DC 6516), aphonia (DC 6519), or stenosis of larynx (DC 6520).	
6519 Aphonia, complete organic:	
Constant inability to communicate by speech	[1]100
Constant inability to speak above a whisper	60
Note: Evaluate incomplete aphonia as laryngitis, chronic (DC 6516).	
6520 Larynx, stenosis of, including residuals of laryngeal trauma (unilateral or bilateral):	
Forced expiratory volume in one second (FEV-1) less than 40 percent of predicted value, with Flow-Volume Loop compatible with upper airway obstruction, or; permanent tracheostomy	100
FEV-1 of 40- to 55-percent predicted, with Flow-Volume Loop compatible with upper airway obstruction	60
FEV-1 of 56- to 70-percent predicted, with Flow-Volume Loop compatible with upper airway obstruction	30
FEV-1 of 71- to 80-percent predicted, with Flow-Volume Loop compatible with upper airway obstruction	10
Note: Or evaluate as aphonia (DC 6519).	
6521 Pharynx, injuries to:	
Stricture or obstruction of pharynx or nasopharynx, or; absence of soft palate secondary to trauma, chemical burn, or granulomatous disease, or; paralysis of soft palate with swallowing difficulty (nasal regurgitation) and speech impairment	50
6522 Allergic or vasomotor rhinitis:	
With polyps	30
Without polyps, but with greater than 50-percent obstruction of nasal passage on both sides or complete obstruction on one side	10
6523 Bacterial rhinitis:	
Rhinoscleroma	50

With permanent hypertrophy of turbinates and with greater than 50-percent obstruction of nasal passage on both sides or complete obstruction on one side	10
6524 Granulomatous rhinitis:	
Wegener's granulomatosis, lethal midline granuloma	100
Other types of granulomatous infection	20
DISEASES OF THE TRACHEA AND BRONCHI	
6600 Bronchitis, chronic:	
FEV-1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV-1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy	100
FEV-1 of 40- to 55-percent predicted, or; FEV-1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
FEV-1 of 56- to 70-percent predicted, or; FEV-1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
FEV-1 of 71- to 80-percent predicted, or; FEV-1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
6601 Bronchiectasis:	
With incapacitating episodes of infection of at least six weeks total duration per year	100
With incapacitating episodes of infection of four to six weeks total duration per year, or; near constant findings of cough with purulent sputum associated with anorexia, weight loss, and frank hemoptysis and requiring antibiotic usage almost continuously	60
With incapacitating episodes of infection of two to four weeks total duration per year, or; daily productive cough with sputum that is at times purulent or blood-tinged and that requires prolonged (lasting four to six weeks) antibiotic usage more than twice a year	30
Intermittent productive cough with acute infection requiring a course of antibiotics at least twice a year	10
Or rate according to pulmonary impairment as for chronic bronchitis (DC 6600).	
Note: An incapacitating episode is one that requires bedrest and treatment by a physician.	
6602 Asthma, bronchial:	
FEV-1 less than 40-percent predicted, or; FEV-1/FVC less than 40 percent, or; more than one attack per week with episodes of respiratory failure, or; requires daily use of systemic (oral or parenteral) high dose corticosteroids or immuno-suppressive medications	100

FEV-1 of 40- to 55-percent predicted, or; FEV-1/FVC of 40 to 55 percent, or; at least monthly visits to a physician for required care of exacerbations, or; intermittent (at least three per year) courses of systemic (oral or parenteral) corticosteroids	60
FEV-1 of 56- to 70-percent predicted, or; FEV-1/FVC of 56 to 70 percent, or; daily inhalational or oral bronchodilator therapy, or; inhalational anti-inflammatory medication	30
FEV-1 of 71- to 80-percent predicted, or; FEV-1/FVC of 71 to 80 percent, or; intermittent inhalational or oral bronchodilator therapy	10
Note: In the absence of clinical findings of asthma at time of examination, a verified history of asthmatic attacks must be of record.	
6603 Emphysema, pulmonary:	
FEV-1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV-1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy	100
FEV-1 of 40- to 55-percent predicted, or; FEV-1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
FEV-1 of 56- to 70-percent predicted, or; FEV-1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
FEV-1 of 71- to 80-percent predicted, or; FEV-1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
6604 Chronic obstructive pulmonary disease:	
FEV-1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV-1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy.	100
FEV-1 of 40- to 55-percent predicted, or; FEV-1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
FEV-1 of 56- to 70-percent predicted, or; FEV-1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
FEV-1 of 71- to 80-percent predicted, or; FEV-1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
DISEASES OF THE LUNGS AND PLEURA - TUBERCULOSIS	

Ratings for Pulmonary Tuberculosis Entitled on August 19, 1968	
6701 Tuberculosis, pulmonary, chronic, far advanced, active	100
6702 Tuberculosis, pulmonary, chronic, moderately advanced, active	100
6703 Tuberculosis, pulmonary, chronic, minimal, active	100
6704 Tuberculosis, pulmonary, chronic, active, advancement unspecified	100
6721 Tuberculosis, pulmonary, chronic, far advanced, inactive	
6722 Tuberculosis, pulmonary, chronic, moderately advanced, inactive	
6723 Tuberculosis, pulmonary, chronic, minimal, inactive	
6724 Tuberculosis, pulmonary, chronic, inactive, advancement unspecified	
General Rating Formula for Inactive Pulmonary Tuberculosis: For two years after date of inactivity, following active tuberculosis, which was clinically identified during service or subsequently	100
Thereafter for four years, or in any event, to six years after date of inactivity	50
Thereafter, for five years, or to eleven years after date of inactivity	30
Following far advanced lesions diagnosed at any time while the disease process was active, minimum	30
Following moderately advanced lesions, provided there is continued disability, emphysema, dyspnea on exertion, impairment of health, etc.	20
Otherwise	0
Note (1): The 100-percent rating under codes 6701 through 6724 is not subject to a requirement of precedent hospital treatment. It will be reduced to 50 percent for failure to submit to examination or to follow prescribed treatment upon report to that effect from the medical authorities. When a veteran is placed on the 100-percent rating for inactive tuberculosis, the medical authorities will be appropriately notified of the fact, and of the necessity, as given in footnote 1 to 38 U.S.C. 1156 (and formerly in 38 U.S.C. 356, which has been repealed by Public Law 90-493), to notify the Veterans Service Center in the event of failure to submit to examination or to follow treatment	
Note (2): The graduated 50-percent and 30-percent ratings and the permanent 30 percent and 20 percent ratings for inactive pulmonary tuberculosis are not to be combined with ratings for other respiratory disabilities. Following thoracoplasty the rating will be for removal of ribs combined with the rating for collapsed lung. Resection of the ribs incident to thoracoplasty will be rated as removal	
Ratings for Pulmonary Tuberculosis Initially Evaluated After August 19, 1968	
6730 Tuberculosis, pulmonary, chronic, active	100
Note: Active pulmonary tuberculosis will be considered permanently and totally disabling for non-service-connected pension purposes in the following circumstances:	
(a) Associated with active tuberculosis involving other than the respiratory system.	
(b) With severe associated symptoms or with extensive cavity formation.	
(c) Reactivated cases, generally.	
(d) With advancement of lesions on successive examinations or while under treatment.	

(e) Without retrogression of lesions or other evidence of material improvement at the end of six months hospitalization or without change of diagnosis from "active" at the end of 12 months hospitalization. Material improvement means lessening or absence of clinical symptoms, and X-ray findings of a stationary or retrogressive lesion.	
6731 Tuberculosis, pulmonary, chronic, inactive:	
Depending on the specific findings, rate residuals as interstitial lung disease, restrictive lung disease, or, when obstructive lung disease is the major residual, as chronic bronchitis (DC 6600). Rate thoracoplasty as removal of ribs under DC 5297.	
Note: A mandatory examination will be requested immediately following notification that active tuberculosis evaluated under DC 6730 has become inactive. Any change in evaluation will be carried out under the provisions of § 3.105(e).	
6732 Pleurisy, tuberculous, active or inactive:	
Rate under §§ 4.88c or 4.89, whichever is appropriate.	
NONTUBERCULOSIS DISEASES	
6817 Pulmonary Vascular Disease:	
Primary pulmonary hypertension, or; chronic pulmonary thromboembolism with evidence of pulmonary hypertension, right ventricular hypertrophy, or cor pulmonale, or; pulmonary hypertension secondary to other obstructive disease of pulmonary arteries or veins with evidence of right ventricular hypertrophy or cor pulmonale	100
Chronic pulmonary thromboembolism requiring anticoagulant therapy, or; following inferior vena cava surgery without evidence of pulmonary hypertension or right ventricular dysfunction	60
Symptomatic, following resolution of acute pulmonary embolism	30
Asymptomatic, following resolution of pulmonary thromboembolism	0
Note: Evaluate other residuals following pulmonary embolism under the most appropriate diagnostic code, such as chronic bronchitis (DC 6600) or chronic pleural effusion or fibrosis (DC 6844), but do not combine that evaluation with any of the above evaluations	
6819 Neoplasms, malignant, any specified part of respiratory system exclusive of skin growths	10
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
6820 Neoplasms, benign, any specified part of respiratory system. Evaluate using an appropriate respiratory analogy.	
Bacterial Infections of the Lung	
6822 Actinomycosis.	
6823 Nocardiosis.	

6824 Chronic lung abscess.	
General Rating Formula for Bacterial Infections of the Lung (diagnostic codes 6822 through 6824):	
Active infection with systemic symptoms such as fever, night sweats, weight loss, or hemoptysis	100
Depending on the specific findings, rate residuals as interstitial lung disease, restrictive lung disease, or, when obstructive lung disease is the major residual, as chronic bronchitis (DC 6600).	
Interstitial Lung Disease	
6825 Diffuse interstitial fibrosis (interstitial pneumonitis, fibrosing alveolitis).	
6826 Desquamative interstitial pneumonitis.	
6827 Pulmonary alveolar proteinosis	
6828 Eosinophilic granuloma of lung.	
6829 Drug-induced pulmonary pneumonitis and fibrosis.	
6830 Radiation-induced pulmonary pneumonitis and fibrosis.	
6831 Hypersensitivity pneumonitis (extrinsic allergic alveolitis).	
6832 Pneumoconiosis (silicosis, anthracosis, etc.).	
6833 Asbestosis.	
General Rating Formula for Interstitial Lung Disease (diagnostic codes 6825 through 6833):	
Forced Vital Capacity (FVC) less than 50-percent predicted, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption with cardiorespiratory limitation, or; cor pulmonale or pulmonary hypertension, or; requires outpatient oxygen therapy	100
FVC of 50- to 64-percent predicted, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum exercise capacity of 15 to 20 ml/kg/min oxygen consumption with cardiorespiratory limitation	60
FVC of 65- to 74-percent predicted, or; DLCO (SB) of 56- to 65-percent predicted	30
FVC of 75- to 80-percent predicted, or; DLCO (SB) of 66- to 80-percent predicted	10
Mycotic Lung Disease	
6834 Histoplasmosis of lung.	
6835 Coccidioidomycosis.	
6836 Blastomycosis.	
6837 Cryptococcosis.	
6838 Aspergillosis.	
6839 Mucormycosis.	
General Rating Formula for Mycotic Lung Disease (diagnostic codes 6834 through 6839):	
Chronic pulmonary mycosis with persistent fever, weight loss, night sweats, or massive hemoptysis	100

Chronic pulmonary mycosis requiring suppressive therapy with no more than minimal symptoms such as occasional minor hemoptysis or productive cough	50
Chronic pulmonary mycosis with minimal symptoms such as occasional minor hemoptysis or productive cough	30
Healed and inactive mycotic lesions, asymptomatic	0
Note: Coccidioidomycosis has an incubation period up to 21 days, and the disseminated phase is ordinarily manifest within six months of the primary phase. However, there are instances of dissemination delayed up to many years after the initial infection which may have been unrecognized. Accordingly, when service connection is under consideration in the absence of record or other evidence of the disease in service, service in southwestern United States where the disease is endemic and absence of prolonged residence in this locality before or after service will be the deciding factor	
Restrictive Lung Disease	
6840 Diaphragm paralysis or paresis.	
6841 Spinal cord injury with respiratory insufficiency	
6842 Kyphoscoliosis, pectus excavatum, pectus carinatum.	
6843 Traumatic chest wall defect, pneumothorax, hernia, etc.	
6844 Post-surgical residual (lobectomy, pneumonectomy, etc.).	
6845 Chronic pleural effusion or fibrosis.	
General Rating Formula for Restrictive Lung Disease (diagnostic codes 6840 through 6845):	
FEV-1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV-1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy	100
FEV-1 of 40- to 55-percent predicted, or; FEV-1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
FEV-1 of 56- to 70-percent predicted, or; FEV-1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
FEV-1 of 71- to 80-percent predicted, or; FEV-1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
Or rate primary disorder.	
Note (1): A 100-percent rating shall be assigned for pleurisy with empyema, with or without pleurocutaneous fistula, until resolved.	
Note (2): Following episodes of total spontaneous pneumothorax, a rating of 100 percent shall be assigned as of the date of hospital admission and shall continue for three months from the first day of the month after hospital discharge.	

	Note (3): Gunshot wounds of the pleural cavity with bullet or missile retained in lung, pain or discomfort on exertion, or with scattered rales or some limitation of excursion of diaphragm or of lower chest expansion shall be rated at least 20-percent disabling. Disabling injuries of shoulder girdle muscles (Groups I to IV) shall be separately rated and combined with ratings for respiratory involvement. Involvement of Muscle Group XXI (DC 5321), however, will not be separately rated	
6846 Sarcoidosis:		
	Cor pulmonale, or; cardiac involvement with congestive heart failure, or; progressive pulmonary disease with fever, night sweats, and weight loss despite treatment	100
	Pulmonary involvement requiring systemic high dose (therapeutic) corticosteroids for control	60
	Pulmonary involvement with persistent symptoms requiring chronic low dose (maintenance) or intermittent corticosteroids	30
	Chronic hilar adenopathy or stable lung infiltrates without symptoms or physiologic impairment	0
	Or rate active disease or residuals as chronic bronchitis (DC 6600) and extra-pulmonary involvement under specific body system involved	
6847 Sleep Apnea Syndromes (Obstructive, Central, Mixed):		
	Chronic respiratory failure with carbon dioxide retention or cor pulmonale, or; requires tracheostomy	100
	Requires use of breathing assistance device such as continuous airway pressure (CPAP) machine	50
	Persistent day-time hypersomnolence	30
	Asymptomatic but with documented sleep disorder breathing	0

[1]Review for entitlement to special monthly compensation under § 3.350 of this chapter.

[61 FR 46728, Sept. 5, 1996, as amended at 71 FR 28586, May 17, 2006]

THE CARDIOVASCULAR SYSTEM

§ 4.100 Application of the general rating formula for diseases of the heart.

a) Whether or not cardiac hypertrophy or dilatation (documented by electrocardiogram, echocardiogram, or X-ray) is present and whether or not there is a need for continuous medication must be ascertained in all cases.
b) Even if the requirement for a 10% (based on the need for continuous medication) or 30% (based on the presence of cardiac hypertrophy or dilatation) evaluation is met, METs testing is required in all cases except:
    1) When there is a medical contraindication.
    2) When a 100% evaluation can be assigned on another basis.

(Authority: 38 U.S.C. 1155)

[71 FR 52460, Sept. 6, 2006, as amended at 86 FR 54093, Sept. 30, 2021; 86 FR 67654, Nov. 29, 2021]

§ 4.101 – 4.103 [Reserved]

38 CFR 4.104

§ 4.104 Schedule of ratings – cardiovascular system.

Diseases of the Heart

Unless otherwise directed, use this general rating formula to evaluate diseases of the heart.]

	Rating
Note (1): Evaluate cor pulmonale, which is a form of secondary heart disease, as part of the pulmonary condition that causes it.	
Note (2): One MET (metabolic equivalent) is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. When the level of METs at which breathlessness, fatigue, angina, dizziness, or syncope develops is required for evaluation, and a laboratory determination of METs by exercise testing cannot be done for medical reasons, a medical examiner may estimate the level of activity (expressed in METs and supported by specific examples, such as slow stair climbing or shoveling snow) that results in those symptoms.	
Note (3): For this general formula, heart failure symptoms include, but are not limited to, breathlessness, fatigue, angina, dizziness, arrhythmia, palpitations, or syncope.	
GENERAL RATING FORMULA FOR DISEASES OF THE HEART	
Workload of 3.0 METs or less results in heart failure symptoms	100
Workload of 3.1-5.0 METs results in heart failure symptoms	60
Workload of 5.1-7.0 METs results in heart failure symptoms; or evidence of cardiac hypertrophy or dilatation confirmed by echocardiogram or equivalent (e.g., multigated acquisition scan or magnetic resonance imaging)	30
Workload of 7.1-10.0 METs results in heart failure symptoms; or continuous medication required for control	10
7000 Valvular heart disease (including rheumatic heart disease),	
7001 Endocarditis, or	
7002 Pericarditis:	
During active infection with cardiac involvement and for three months following cessation of therapy for the active infection	100
Thereafter, with diagnosis confirmed by findings on physical examination and either echocardiogram, Doppler echocardiogram, or cardiac catheterization, use the General Rating Formula.	

7003 Pericardial adhesions.	
7004 Syphilitic heart disease:	
7005 Arteriosclerotic heart disease (coronary artery disease).	
Note: If non-service-connected arteriosclerotic heart disease is superimposed on service-connected valvular or other non-arteriosclerotic heart disease, request a medical opinion as to which condition is causing the current signs and symptoms.	
7006 Myocardial infarction:	
During and for three months following myocardial infarction, confirmed by laboratory tests	100
Thereafter, use the General Rating Formula.	
7007 Hypertensive heart disease.	
7008 Hyperthyroid heart disease:	
Rate under the appropriate cardiovascular diagnostic code, depending on particular findings.	
For DCs 7009, 7010, 7011, and 7015, a single evaluation will be assigned under the diagnostic code that reflects the predominant disability picture.	
7009 Bradycardia (Bradyarrhythmia), symptomatic, requiring permanent pacemaker implantation:	
For one month following hospital discharge for implantation or re-implantation	100
Thereafter, use the General Rating Formula.	
Note (1): Bradycardia (bradyarrhythmia) refers to conduction abnormalities that produce a heart rate less than 60 beats/min. There are five general classes of bradyarrhythmia: Sinus bradycardia, including sinoatrial block; atrioventricular (AV) junctional (nodal) escape rhythm; AV heart block (second or third degree) or AV dissociation; atrial fibrillation or flutter with a slow ventricular response; and, idioventricular escape rhythm	
Note (2): Asymptomatic bradycardia (bradyarrhythmia) is a medical finding only. It is not a disability subject to compensation.	
7010 Supraventricular tachycardia:	
Confirmed by ECG, with five or more treatment interventions per year	30
Confirmed by ECG, with one to four treatment interventions per year; or, confirmed by ECG with either continuous use of oral medications to control or use of vagal maneuvers to control	10
Note (1): Examples of supraventricular tachycardia include, but are not limited to: Atrial fibrillation, atrial flutter, sinus tachycardia, sinoatrial nodal reentrant tachycardia, atrioventricular nodal reentrant tachycardia, atrioventricular reentrant tachycardia, atrial tachycardia, junctional tachycardia, and multifocal atrial tachycardia.	
Note (2): For the purposes of this diagnostic code, a treatment intervention occurs whenever a symptomatic patient requires intravenous pharmacologic adjustment, cardioversion, and/or ablation for symptom relief.	
7011 Ventricular arrhythmias (sustained):	
For an indefinite period from the date of inpatient hospital admission for initial medical therapy for a sustained ventricular arrhythmia; or, for an	100

indefinite period from the date of inpatient hospital admission for ventricular aneurysmectomy; or, with an automatic implantable cardioverterdefibrillator (AICD) in place	
Note: When inpatient hospitalization for sustained ventricular arrhythmia or ventricular aneurysmectomy is required, a 100-percent evaluation begins on the date of hospital admission with a mandatory VA examination six months following hospital discharge. Evaluate post-surgical residuals under the General Rating Formula. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination.	
7015 Atrioventricular block:	
Benign (First-Degree and Second-Degree, Type I):	
Evaluate under the General Rating Formula.	
Non-Benign (Second-Degree, Type II and Third-Degree):	
Evaluate under DC 7018 (implantable cardiac pacemakers).	
7016 Heart valve replacement (prosthesis):	
For an indefinite period following date of hospital admission for valve replacement	100
Thereafter, use the General Rating Formula.	
Note: Six months following discharge from inpatient hospitalization, disability evaluation shall be conducted by mandatory VA examination using the General Rating Formula. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination.	
7017 Coronary bypass surgery:	
For three months following hospital admission for surgery	100
Thereafter, use the General Rating Formula.	
7018 Implantable cardiac pacemakers:	
For one month following hospital discharge for implantation or re-implantation	100
Thereafter:	
Evaluate as supraventricular tachycardia (DC 7010), ventricular arrhythmias (DC 7011), or atrioventricular block (DC 7015).	
Minimum	10
Note: Evaluate automatic implantable cardioverter-defibrillators (AICDs) under DC 7011.	
7019 Cardiac transplantation:	
For a minimum of one year from the date of hospital admission for cardiac transplantation	100
Thereafter:	
Evaluate under the General Rating Formula.	
Minimum	30
Note: One year following discharge from inpatient hospitalization, determine the appropriate disability rating by mandatory VA examination. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination	

7020 Cardiomyopathy.	
Diseases of the Arteries and Veins	
7101 Hypertensive vascular disease (hypertension and isolated systolic hypertension):	
Diastolic pressure predominantly 130 or more	60
Diastolic pressure predominantly 120 or more	40
Diastolic pressure predominantly 110 or more, or; systolic pressure predominantly 200 or more	20
Diastolic pressure predominantly 100 or more, or; systolic pressure predominantly 160 or more, or; minimum evaluation for an individual with a history of diastolic pressure predominantly 100 or more who requires continuous medication for control	10
Note (1): Hypertension or isolated systolic hypertension must be confirmed by readings taken two or more times on at least three different days. For purposes of this section, the term hypertension means that the diastolic blood pressure is predominantly 90mm. or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm. or greater with a diastolic blood pressure of less than 90mm.	
Note (2): Evaluate hypertension due to aortic insufficiency or hyperthyroidism, which is usually the isolated systolic type, as part of the condition causing it rather than by a separate evaluation.	
Note (3): Evaluate hypertension separately from hypertensive heart disease and other types of heart disease.	
7110 Aortic aneurysm: Ascending, thoracic, or abdominal:	
Evaluate at 100 percent if the aneurysm is any one of the following: Five centimeters or larger in diameter; symptomatic (e.g., precludes exertion); or requires surgery	100
Otherwise	0
Evaluate non-cardiovascular residuals of surgical correction according to organ systems affected.	
Note: When surgery is required, a 100-percent evaluation begins on the date a physician recommends surgical correction with a mandatory VA examination six months following hospital discharge. Evaluate post-surgical residuals under the General Rating Formula. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
7111 Aneurysm, any large artery:	
If symptomatic; or, for the period beginning on the date a physician recommends surgical correction and continuing for six months following discharge from inpatient hospital admission for surgical correction	100
Following surgery: Evaluate under DC 7114 (peripheral arterial disease).	
Note: Six months following discharge from inpatient hospitalization for surgery, determine the appropriate disability rating by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
7112 Aneurysm, any small artery:	

Asymptomatic	0
Note: If symptomatic, evaluate according to body system affected. Following surgery, evaluate residuals under the body system affected.	
7113 Arteriovenous fistula, traumatic:	
With high-output heart failure	100
Without heart failure but with enlarged heart, wide pulse pressure, and tachycardia	60
Without cardiac involvement but with chronic edema, stasis dermatitis, and either ulceration or cellulitis:	
Lower extremity	50
Upper extremity	40
Without cardiac involvement but with chronic edema or stasis dermatitis:	
Lower extremity	30
Upper extremity	20
7114 Peripheral arterial disease:	
At least one of the following: Ankle/brachial index less than or equal to 0.39; ankle pressure less than 50 mm Hg; toe pressure less than 30 mm Hg; or transcutaneous oxygen tension less than 30 mm Hg	100
At least one of the following: Ankle/brachial index of 0.40-0.53; ankle pressure of 50-65 mm Hg; toe pressure of 30-39 mm Hg; or transcutaneous oxygen tension of 30-39 mm Hg	60
At least one of the following: Ankle/brachial index of 0.54-0.66; ankle pressure of 66-83 mm Hg; toe pressure of 40-49 mm Hg; or transcutaneous oxygen tension of 40-49 mm Hg	40
At least one of the following: Ankle/brachial index of 0.67-0.79; ankle pressure of 84-99 mm Hg; toe pressure of 50-59 mm Hg; or transcutaneous oxygen tension of 50-59 mm Hg	20
Note (1): The ankle/brachial index (ABI) is the ratio of the systolic blood pressure at the ankle divided by the simultaneous brachial artery systolic blood pressure. For the purposes of this diagnostic code, normal ABI will be greater than or equal to 0.80. The ankle pressure (AP) is the systolic blood pressure measured at the ankle. Normal AP is greater than or equal to 100 mm Hg. The toe pressure (TP) is the systolic blood pressure measured at the great toe. Normal TP is greater than or equal to 60 mm Hg. Transcutaneous oxygen tension (TcPO2) is measured at the first intercostal space on the foot. Normal TcPO2 is greater than or equal to 60 mm Hg. All measurements must be determined by objective testing	
Note (2): If AP, TP, and TcPO2 testing are not of record, evaluate based on ABI unless the examiner states that an AP, TP, or TcPO2 test is needed in a particular case because ABI does not sufficiently reflect the severity of the veteran's peripheral arterial disease. In all other cases, evaluate based on the test that provides the highest impairment value	
Note (3): Evaluate residuals of aortic and large arterial bypass surgery or arterial graft as peripheral arterial disease.	

Note (4): These evaluations involve a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.	
7115 Thrombo-angiitis obliterans (Buerger's Disease):	
Lower extremity: Rate under DC 7114.	
Upper extremity:	
Deep ischemic ulcers and necrosis of the fingers with persistent coldness of the extremity, trophic changes with pains in the hand during physical activity, and diminished upper extremity pulses	100
Persistent coldness of the extremity, trophic changes with pains in the hands during physical activity, and diminished upper extremity pulses	60
Trophic changes with numbness and paresthesia at the tips of the fingers, and diminished upper extremity pulses	40
Diminished upper extremity pulses	20
Note (1): These evaluations involve a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.	
Note (2): Trophic changes include, but are not limited to, skin changes (thinning, atrophy, fissuring, ulceration, scarring, absence of hair) as well as nail changes (clubbing, deformities).	
7117 Raynaud's syndrome (also known as secondary Raynaud's phenomenon or secondary Raynaud's):	
With two or more digital ulcers plus auto-amputation of one or more digits and history of characteristic attacks	100
With two or more digital ulcers and history of characteristic attacks	60
Characteristic attacks occurring at least daily	40
Characteristic attacks occurring four to six times a week	20
Characteristic attacks occurring one to three times a week	10
Note (1): For purposes of this section, characteristic attacks consist of sequential color changes of the digits of one or more extremities lasting minutes to hours, sometimes with pain and paresthesias, and precipitated by exposure to cold or by emotional upsets. These evaluations are for Raynaud's syndrome as a whole, regardless of the number of extremities involved or whether the nose and ears are involved	
Note (2): This section is for evaluating Raynaud's syndrome (secondary Raynaud's phenomenon or secondary Raynaud's). For evaluation of Raynaud's disease (primary Raynaud's), see DC 7124	
7118 Angioneurotic edema:	
Attacks without laryngeal involvement lasting one to seven days or longer and occurring more than eight times a year, or; attacks with laryngeal involvement of any duration occurring more than twice a year	40
Attacks without laryngeal involvement lasting one to seven days and occurring five to eight times a year, or; attacks with laryngeal involvement of any duration occurring once or twice a year	20
Attacks without laryngeal involvement lasting one to seven days and occurring two to four times a year	10

7119 Erythromelalgia:	
Characteristic attacks that occur more than once a day, last an average of more than two hours each, respond poorly to treatment, and that restrict most routine daily activities	100
Characteristic attacks that occur more than once a day, last an average of more than two hours each, and respond poorly to treatment, but that do not restrict most routine daily activities	60
Characteristic attacks that occur daily or more often but that respond to treatment	30
Characteristic attacks that occur less than daily but at least three times a week and that respond to treatment	10
Note: For purposes of this section, a characteristic attack of erythromelalgia consists of burning pain in the hands, feet, or both, usually bilateral and symmetrical, with increased skin temperature and redness, occurring at warm ambient temperatures. These evaluations are for the disease as a whole, regardless of the number of extremities involved.	
7120 Varicose veins:	
Evaluate under diagnostic code 7121.	
7121 Post-phlebitic syndrome of any etiology:	
With the following findings attributed to venous disease:	
Massive board-like edema with constant pain at rest	100
Persistent edema or subcutaneous induration, stasis pigmentation or eczema, and persistent ulceration	60
Persistent edema and stasis pigmentation or eczema, with or without intermittent ulceration	40
Persistent edema, incompletely relieved by elevation of extremity, with or without beginning stasis pigmentation or eczema	20
Intermittent edema of extremity or aching and fatigue in leg after prolonged standing or walking, with symptoms relieved by elevation of extremity or compression hosiery	10
Asymptomatic palpable or visible varicose veins	0
Note: These evaluations are for involvement of a single extremity. If more than one extremity is involved, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.	
7122 Cold injury residuals:	
With the following in affected parts:	
Arthralgia or other pain, numbness, or cold sensitivity plus two or more of the following: Tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, anhydrosis, X-ray abnormalities (osteoporosis, subarticular punched-out lesions, or osteoarthritis), atrophy or fibrosis of the affected musculature, flexion or extension deformity of distal joints, volar fat pad loss in fingers or toes, avascular necrosis of bone, chronic ulceration, carpal or tarsal tunnel syndrome	30
Arthralgia or other pain, numbness, or cold sensitivity plus one of the following: Tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, anhydrosis, X-ray abnormalities (osteoporosis,	20

subarticular punched-out lesions, or osteoarthritis), atrophy or fibrosis of the affected musculature, flexion or extension deformity of distal joints, volar fat pad loss in fingers or toes, avascular necrosis of bone, chronic ulceration, carpal or tarsal tunnel syndrome	
Arthralgia or other pain, numbness, or cold sensitivity	10
Note (1): Separately evaluate amputations of fingers or toes, and complications such as squamous cell carcinoma at the site of a cold injury scar or peripheral neuropathy, under other diagnostic codes. Separately evaluate other disabilities diagnosed as the residual effects of cold injury, such as Raynaud's syndrome (which is otherwise known as secondary Raynaud's phenomenon), muscle atrophy, etc., unless they are used to support an evaluation under diagnostic code 7122.	
Note (2): Evaluate each affected part (e.g., hand, foot, ear, nose) separately and combine the ratings in accordance with §§ 4.25 and 4.26.	
7123 Soft tissue sarcoma (of vascular origin)	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
7124 Raynaud's disease (also known as primary Raynaud's):	
Characteristic attacks associated with trophic change(s), such as tight, shiny skin	10
Characteristic attacks without trophic change(s)	0
Note (1): For purposes of this section, characteristic attacks consist of intermittent and episodic color changes of the digits of one or more extremities, lasting minutes or longer, with occasional pain and paresthesias, and precipitated by exposure to cold or by emotional upsets. These evaluations are for the disease as a whole, regardless of the number of extremities involved or whether the nose and ears are involved.	
Note (2): Trophic changes include, but are not limited to, skin changes (thinning, atrophy, fissuring, ulceration, scarring, absence of hair) as well as nail changes (clubbing, deformities).	
Note (3): This section is for evaluating Raynaud's disease (primary Raynaud's). For evaluation of Raynaud's syndrome (also known as secondary Raynaud's phenomenon, or secondary Raynaud's), see DC 7117.	

(Authority: 38 U.S.C. 1155)

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THE DIGESTIVE SYSTEM

§ 4.110 Ulcers.

Experience has shown that the term “peptic ulcer” is not sufficiently specific for rating purposes. Manifest differences in ulcers of the stomach or duodenum in comparison with those at an anastomotic stoma are sufficiently recognized as to warrant two separate graduated descriptions. In evaluating the ulcer, care should be taken that the findings adequately identify the particular location.

§ 4.111 Post-gastrectomy syndromes.

There are various post-gastrectomy symptoms which may occur following anastomotic operations of the stomach. When present, those occurring during or immediately after eating and known as the “dumping syndrome” are characterized by gastrointestinal complaints and generalized symptoms simulating hypoglycemia; those occurring from 1 to 3 hours after eating usually present definite manifestations of hypoglycemia.

§ 4.112 Weight loss.

For purposes of evaluating conditions in § 4.114, the term “substantial weight loss” means a loss of greater than 20 percent of the individual's baseline weight, sustained for three months or longer; and the term “minor weight loss” means a weight loss of 10 to 20 percent of the individual's baseline weight, sustained for three months or longer. The term “inability to gain weight” means that there has been substantial weight loss with inability to regain it despite appropriate therapy. “Baseline weight” means the average weight for the two-year-period preceding onset of the disease.

§ 4.113 Coexisting abdominal conditions.

There are diseases of the digestive system, particularly within the abdomen, which, while differing in the site of pathology, produce a common disability picture characterized in the main by varying degrees of abdominal distress or pain, anemia and disturbances in nutrition. Consequently, certain coexisting diseases in this area, as indicated in the instruction under the title “Diseases of the Digestive System,” do not lend themselves to distinct and separate disability evaluations without violating the fundamental principle relating to pyramiding as outlined in § 4.14.

38 CFR 4.114

§ 4.114 Schedule of ratings - digestive system.

Ratings under diagnostic codes 7301 to 7329, inclusive, 7331, 7342, and 7345 to 7348 inclusive will not be combined with each other. A single evaluation will be assigned under the diagnostic code which reflects the predominant disability picture, with elevation to the next higher evaluation where the severity of the overall disability warrants such elevation.

	Rating

7200 Mouth, injuries of.	
Rate as for disfigurement and impairment of function of mastication.	
7201 Lips, injuries of.	
Rate as for disfigurement of face.	
7202 Tongue, loss of whole or part:	
With inability to communicate by speech	100
One-half or more	60
With marked speech impairment	30
7203 Esophagus, stricture of:	
Permitting passage of liquids only, with marked impairment of general health	80
Severe, permitting liquids only	50
Moderate	30
7204 Esophagus, spasm of (cardiospasm).	
If not amenable to dilation, rate as for the degree of obstruction (stricture).	
7205 Esophagus, diverticulum of, acquired.	
Rate as for obstruction (stricture).	
7301 Peritoneum, adhesions of:	
Severe; definite partial obstruction shown by X-ray, with frequent and prolonged episodes of severe colic distension, nausea or vomiting, following severe peritonitis, ruptured appendix, perforated ulcer, or operation with drainage	50
Moderately severe; partial obstruction manifested by delayed motility of barium meal and less frequent and less prolonged episodes of pain	30
Moderate; pulling pain on attempting work or aggravated by movements of the body, or occasional episodes of colic pain, nausea, constipation (perhaps alternating with diarrhea) or abdominal distension	10
Mild	0
Note: Ratings for adhesions will be considered when there is history of operative or other traumatic or infectious (intraabdominal) process, and at least two of the following: disturbance of motility, actual partial obstruction, reflex disturbances, presence of pain.	
7304 Ulcer, gastric.	
7305 Ulcer, duodenal:	
Severe; pain only partially relieved by standard ulcer therapy, periodic vomiting, recurrent hematemesis or melena, with manifestations of anemia and weight loss productive of definite impairment of health	60
Moderately severe; less than severe but with impairment of health manifested by anemia and weight loss; or recurrent incapacitating episodes averaging 10 days or more in duration at least four or more times a year	40
Moderate; recurring episodes of severe symptoms two or three times a year averaging 10 days in duration; or with continuous moderate manifestations	20
Mild; with recurring symptoms once or twice yearly	10
7306 Ulcer, marginal (gastrojejunal):	

Pronounced; periodic or continuous pain unrelieved by standard ulcer therapy with periodic vomiting, recurring melena or hematemesis, and weight loss. Totally incapacitating	100
Severe; same as pronounced with less pronounced and less continuous symptoms with definite impairment of health	60
Moderately severe; intercurrent episodes of abdominal pain at least once a month partially or completely relieved by ulcer therapy, mild and transient episodes of vomiting or melena	40
Moderate; with episodes of recurring symptoms several times a year	20
Mild; with brief episodes of recurring symptoms once or twice yearly	10
7307 Gastritis, hypertrophic (identified by gastroscope):	
Chronic; with severe hemorrhages, or large ulcerated or eroded areas	60
Chronic; with multiple small eroded or ulcerated areas, and symptoms	30
Chronic; with small nodular lesions, and symptoms	10
Gastritis, atrophic.	
A complication of a number of diseases, including pernicious anemia.	
Rate the underlying condition.	
7308 Post-gastrectomy syndromes:	
Severe; associated with nausea, sweating, circulatory disturbance after meals, diarrhea, hypoglycemic symptoms, and weight loss with malnutrition and anemia	60
Moderate; less frequent episodes of epigastric disorders with characteristic mild circulatory symptoms after meals but with diarrhea and weight loss	40
Mild; infrequent episodes of epigastric distress with characteristic mild circulatory symptoms or continuous mild manifestations	20
7309 Stomach, stenosis of.	
Rate as for gastric ulcer.	
7310 Stomach, injury of, residuals.	
Rate as peritoneal adhesions.	
7311 Residuals of injury of the liver:	
Depending on the specific residuals, separately evaluate as adhesions of peritoneum (diagnostic code 7301), cirrhosis of liver (diagnostic code 7312), and chronic liver disease without cirrhosis (diagnostic code 7345).	
7312 Cirrhosis of the liver, primary biliary cirrhosis, or cirrhotic phase of sclerosing cholangitis:	
Generalized weakness, substantial weight loss, and persistent jaundice, or; with one of the following refractory to treatment: ascites, hepatic encephalopathy, hemorrhage from varices or portal gastropathy (erosive gastritis)	100
History of two or more episodes of ascites, hepatic encephalopathy, or hemorrhage from varices or portal gastropathy (erosive gastritis), but with periods of remission between attacks	70
History of one episode of ascites, hepatic encephalopathy, or hemorrhage from varices or portal gastropathy (erosive gastritis)	50

Portal hypertension and splenomegaly, with weakness, anorexia, abdominal pain, malaise, and at least minor weight loss	30
Symptoms such as weakness, anorexia, abdominal pain, and malaise	10
Note: For evaluation under diagnostic code 7312, documentation of cirrhosis (by biopsy or imaging) and abnormal liver function tests must be present.	
7314 Cholecystitis, chronic:	
Severe; frequent attacks of gall bladder colic	30
Moderate; gall bladder dyspepsia, confirmed by X-ray technique, and with infrequent attacks (not over two or three a year) of gall bladder colic, with or without jaundice	10
Mild	0
7315 Cholelithiasis, chronic.	
Rate as for chronic cholecystitis.	
7316 Cholangitis, chronic.	
Rate as for chronic cholecystitis.	
7317 Gall bladder, injury of.	
Rate as for peritoneal adhesions.	
7318 Gall bladder, removal of:	
With severe symptoms	30
With mild symptoms	10
Non-symptomatic	0
Spleen, disease or injury of.	
See Hemic and Lymphatic Systems.	
7319 Irritable colon syndrome (spastic colitis, mucous colitis, etc.):	
Severe; diarrhea, or alternating diarrhea and constipation, with more or less constant abdominal distress	30
Moderate; frequent episodes of bowel disturbance with abdominal distress	10
Mild; disturbances of bowel function with occasional episodes of abdominal distress	0
7321 Amebiasis:	
Mild gastrointestinal disturbances, lower abdominal cramps, nausea, gaseous distention, chronic constipation interrupted by diarrhea	10
Asymptomatic	0
Note: Amebiasis with or without liver abscess is parallel in symptomatology with ulcerative colitis and should be rated on the scale provided for the latter. Similarly, lung abscess due to amebiasis will be rated under the respiratory system schedule, diagnostic code 6809.	
7322 Dysentery, bacillary.	
Rate as for ulcerative colitis.	
7323 Colitis, ulcerative:	
Pronounced; resulting in marked malnutrition, anemia, and general debility, or with serious complication as liver abscess	100
Severe; with numerous attacks a year and malnutrition, the health only fair during remissions	60
Moderately severe; with frequent exacerbations	30

Moderate; with infrequent exacerbations	10
7324 Distomiasis, intestinal or hepatic:	
Severe symptoms	30
Moderate symptoms	10
Mild or no symptoms	0
7325 Enteritis, chronic.	
Rate as for irritable colon syndrome.	
7326 Enterocolitis, chronic.	
Rate as for irritable colon syndrome.	
7327 Diverticulitis.	
Rate as for irritable colon syndrome, peritoneal adhesions, or colitis, ulcerative, depending upon the predominant disability picture.	
7328 Intestine, small, resection of:	
With marked interference with absorption and nutrition, manifested by severe impairment of health objectively supported by examination findings including material weight loss	60
With definite interference with absorption and nutrition, manifested by impairment of health objectively supported by examination findings including definite weight loss	40
Symptomatic with diarrhea, anemia and inability to gain weight	20
Note: Where residual adhesions constitute the predominant disability, rate under diagnostic code 7301.	
7329 Intestine, large, resection of:	
With severe symptoms, objectively supported by examination findings	40
With moderate symptoms	20
With slight symptoms	10
Note: Where residual adhesions constitute the predominant disability, rate under diagnostic code 7301.	
7330 Intestine, fistula of, persistent, or after attempt at operative closure:	
Copious and frequent, fecal discharge	100
Constant or frequent, fecal discharge	60
Slight infrequent, fecal discharge	30
Healed; rate for peritoneal adhesions.	
7331 Peritonitis, tuberculous, active or inactive:	
Active	100
Inactive: See §§ 4.88b and 4.89.	
7332 Rectum and anus, impairment of sphincter control:	
Complete loss of sphincter control	100
Extensive leakage and fairly frequent involuntary bowel movements	60
Occasional involuntary bowel movements, necessitating wearing of pad	30
Constant slight, or occasional moderate leakage	10
Healed or slight, without leakage	0
7333 Rectum and anus, stricture of:	
Requiring colostomy	100
Great reduction of lumen, or extensive leakage	50

Moderate reduction of lumen, or moderate constant leakage	30
7334 Rectum, prolapse of:	
Severe (or complete), persistent	50
Moderate, persistent or frequently recurring	30
Mild with constant slight or occasional moderate leakage	10
7335 Ano, fistula in.	
Rate as for impairment of sphincter control.	
7336 Hemorrhoids, external or internal:	
With persistent bleeding and with secondary anemia, or with fissures	20
Large or thrombotic, irreducible, with excessive redundant tissue, evidencing frequent recurrences	10
Mild or moderate	0
7337 Pruritus ani.	
Rate for the underlying condition.	
7338 Hernia, inguinal:	
Large, postoperative, recurrent, not well supported under ordinary conditions and not readily reducible, when considered inoperable	60
Small, postoperative recurrent, or unoperated irremediable, not well supported by truss, or not readily reducible	30
Postoperative recurrent, readily reducible and well supported by truss or belt	10
Not operated, but remediable	0
Small, reducible, or without true hernia protrusion	0
Note: Add 10 percent for bilateral involvement, provided the second hernia is compensable. This means that the more severely disabling hernia is to be evaluated, and 10 percent, only, added for the second hernia, if the latter is of compensable degree.	
7339 Hernia, ventral, postoperative:	
Massive, persistent, severe diastasis of recti muscles or extensive diffuse destruction or weakening of muscular and fascial support of abdominal wall so as to be inoperable	100
Large, not well supported by belt under ordinary conditions	40
Small, not well supported by belt under ordinary conditions, or healed ventral hernia or postoperative wounds with weakening of abdominal wall and indication for a supporting belt	20
Wounds, postoperative, healed, no disability, belt not indicated	0
7340 Hernia, femoral.	
Rate as for inguinal hernia.	
7342 Visceroptosis, symptomatic, marked	10
7343 Malignant neoplasms of the digestive system, exclusive of skin growths	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to	

the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
7344 Benign neoplasms, exclusive of skin growths:	
Evaluate under an appropriate diagnostic code, depending on the predominant disability or the specific residuals after treatment.	
7345 Chronic liver disease without cirrhosis (including hepatitis B, chronic active hepatitis, autoimmune hepatitis, hemochromatosis, drug-induced hepatitis, etc., but excluding bile duct disorders and hepatitis C):	
Near-constant debilitating symptoms (such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain)	100
Daily fatigue, malaise, and anorexia, with substantial weight loss (or other indication of malnutrition), and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least six weeks during the past 12-month period, but not occurring constantly	60
Daily fatigue, malaise, and anorexia, with minor weight loss and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least four weeks, but less than six weeks, during the past 12-month period	40
Daily fatigue, malaise, and anorexia (without weight loss or hepatomegaly), requiring dietary restriction or continuous medication, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least two weeks, but less than four weeks, during the past 12-month period	20
Intermittent fatigue, malaise, and anorexia, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least one week, but less than two weeks, during the past 12-month period	10
Non-symptomatic	0
Note (1): Evaluate sequelae, such as cirrhosis or malignancy of the liver, under an appropriate diagnostic code, but do not use the same signs and symptoms as the basis for evaluation under DC 7354 and under a diagnostic code for sequelae. (See § 4.14.).	
Note (2): For purposes of evaluating conditions under diagnostic code 7345, "incapacitating episode" means a period of acute signs and symptoms severe enough to require bed rest and treatment by a physician.	
Note (3): Hepatitis B infection must be confirmed by serologic testing in order to evaluate it under diagnostic code 7345.	
7346 Hernia hiatal:	
Symptoms of pain, vomiting, material weight loss and hematemesis or melena with moderate anemia; or other symptom combinations productive of severe impairment of health	60
Persistently recurrent epigastric distress with dysphagia, pyrosis, and regurgitation, accompanied by substernal or arm or shoulder pain, productive of considerable impairment of health	30

With two or more of the symptoms for the 30 percent evaluation of less severity	10
7347 Pancreatitis:	
With frequently recurrent disabling attacks of abdominal pain with few pain free intermissions and with steatorrhea, malabsorption, diarrhea and severe malnutrition	100
With frequent attacks of abdominal pain, loss of normal body weight and other findings showing continuing pancreatic insufficiency between acute attacks	60
Moderately severe; with at least 4-7 typical attacks of abdominal pain per year with good remission between attacks	30
With at least one recurring attack of typical severe abdominal pain in the past year	10
Note 1: Abdominal pain in this condition must be confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies.	
Note 2: Following total or partial pancreatectomy, rate under above, symptoms, minimum rating 30 percent.	
7348 Vagotomy with pyloroplasty or gastroenterostomy:	
Followed by demonstrably confirmative postoperative complications of stricture or continuing gastric retention	40
With symptoms and confirmed diagnosis of alkaline gastritis, or of confirmed persisting diarrhea	30
Recurrent ulcer with incomplete vagotomy	20
Note: Rate recurrent ulcer following complete vagotomy under diagnostic code 7305, minimum rating 20 percent; and rate dumping syndrome under diagnostic code 7308.	
7351 Liver transplant:	
For an indefinite period from the date of hospital admission for transplant surgery	100
Minimum	30
Note: A rating of 100 percent shall be assigned as of the date of hospital admission for transplant surgery and shall continue. One year following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
7354 Hepatitis C (or non-A, non-B hepatitis):	
With serologic evidence of hepatitis C infection and the following signs and symptoms due to hepatitis C infection:	
Near-constant debilitating symptoms (such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain)	100
Daily fatigue, malaise, and anorexia, with substantial weight loss (or other indication of malnutrition), and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least six weeks during the past 12-month period, but not occurring constantly	60

	Daily fatigue, malaise, and anorexia, with minor weight loss and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least four weeks, but less than six weeks, during the past 12-month period	40
	Daily fatigue, malaise, and anorexia (without weight loss or hepatomegaly), requiring dietary restriction or continuous medication, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least two weeks, but less than four weeks, during the past 12-month period	20
	Intermittent fatigue, malaise, and anorexia, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least one week, but less than two weeks, during the past 12-month period	10
	Non-symptomatic	0
	Note (1): Evaluate sequelae, such as cirrhosis or malignancy of the liver, under an appropriate diagnostic code, but do not use the same signs and symptoms as the basis for evaluation under DC 7354 and under a diagnostic code for sequelae. (See § 4.14.).	
	Note (2): For purposes of evaluating conditions under diagnostic code 7354, "incapacitating episode" means a period of acute signs and symptoms severe enough to require bed rest and treatment by a physician.	

(Authority: 38 U.S.C. 1155)

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THE GENITOURINARY SYSTEM

§ 4.115 Nephritis.

Albuminuria alone is not nephritis, nor will the presence of transient albumin and casts following acute febrile illness be taken as nephritis. The glomerular type of nephritis is usually preceded by or associated with severe infectious disease; the onset is sudden, and the course marked by red blood cells, salt retention, and edema; it may clear up entirely or progress to a chronic condition. The nephrosclerotic type, originating in hypertension or arteriosclerosis, develops slowly, with minimum laboratory findings, and is associated with natural progress. Separate ratings are not to be assigned for disability from disease of the heart and any form of nephritis, on account of the close interrelationships of cardiovascular disabilities. If, however, absence of a kidney is the sole renal disability, even if removal was required because of nephritis, the absent kidney and any hypertension or heart disease will be separately rated. Also, in the event that chronic renal disease has progressed to the point where regular dialysis is required, any coexisting hypertension or heart disease will be separately rated.

38 CFR 4.115a

§ 4.115a Ratings of the genitourinary system - dysfunctions.

Diseases of the genitourinary system generally result in disabilities related to renal or voiding dysfunctions, infections, or a combination of these. The following section provides descriptions of various levels of disability in each of these symptom areas. Where diagnostic codes refer the decision maker to these specific areas of dysfunction, only the predominant area of dysfunction shall be considered for rating purposes. Distinct disabilities may be evaluated separately under this section, pursuant to § 4.14, if the symptoms do not overlap. Since the areas of dysfunction described below do not cover all symptoms resulting from genitourinary diseases, specific diagnoses may include a description of symptoms assigned to that diagnosis.

	Rating
Renal dysfunction:	
Chronic kidney disease with glomerular filtration rate (GFR) less than 15 mL/min/1.73 m2 for at least 3 consecutive months during the past 12 months; or requiring regular routine dialysis; or eligible kidney transplant recipient	100
Chronic kidney disease with GFR from 15 to 29 mL/min/1.73 m2 for at least 3 consecutive months during the past 12 months	80
Chronic kidney disease with GFR from 30 to 44 mL/min/1.73 m2 for at least 3 consecutive months during the past 12 months	60
Chronic kidney disease with GFR from 45 to 59 mL/min/1.73 m2 for at least 3 consecutive months during the past 12 months	30
GFR from 60 to 89 mL/min/1.73 m2 and either recurrent red blood cell (RBC) casts, white blood cell (WBC) casts, or granular casts for at least 3 consecutive months during the past 12 months; or	
GFR from 60 to 89 mL/min/1.73 m2 and structural kidney abnormalities (cystic, obstructive, or glomerular) for at least 3 consecutive months during the past 12 months; or	
GFR from 60 to 89 mL/min/1.73 m2 and albumin/creatinine ratio (ACR) ≥30 mg/g for at least 3 consecutive months during the past 12 months	0
Note: GFR, estimated GFR (eGFR), and creatinine-based approximations of GFR will be accepted for evaluation purposes under this section when determined to be appropriate and calculated by a medical professional.	
Voiding dysfunction:	
Rate particular condition as urine leakage, frequency, or obstructed voiding	
Continual Urine Leakage, Post Surgical Urinary Diversion, Urinary Incontinence, or Stress Incontinence:	
Requiring the use of an appliance or the wearing of absorbent materials which must be changed more than 4 times per day	60
Requiring the wearing of absorbent materials which must be changed 2 to 4 times per day	40
Requiring the wearing of absorbent materials which must be changed less than 2 times per day	20
Urinary frequency:	

Daytime voiding interval less than one hour, or; awakening to void five or more times per night	40
Daytime voiding interval between one and two hours, or; awakening to void three to four times per night	20
Daytime voiding interval between two and three hours, or; awakening to void two times per night	10
Obstructed voiding:	
Urinary retention requiring intermittent or continuous catheterization	30
Marked obstructive symptomatology (hesitancy, slow or weak stream, decreased force of stream) with any one or combination of the following:	
1. Post void residuals greater than 150 cc.	
2. Uroflowmetry; markedly diminished peak flow rate (less than 10 cc/sec).	
3. Recurrent urinary tract infections secondary to obstruction.	
4. Stricture disease requiring periodic dilatation every 2 to 3 months	10
Obstructive symptomatology with or without stricture disease requiring dilatation 1 to 2 times per year	0
Urinary tract infection:	
Poor renal function: Rate as renal dysfunction.	
Recurrent symptomatic infection requiring drainage by stent or nephrostomy tube; or requiring greater than 2 hospitalizations per year; or requiring continuous intensive management	30
Recurrent symptomatic infection requiring 1-2 hospitalizations per year or suppressive drug therapy lasting six months or longer	10
Recurrent symptomatic infection not requiring hospitalization, but requiring suppressive drug therapy for less than 6 months	0

[59 FR 2527, Jan. 18, 1994; 59 FR 10676, Mar. 7, 1994; 86 FR 54085, Sept. 30, 2021]

38 CFR 4.115b

§ 4.115b Ratings of the genitourinary system - diagnoses.

	Rating
Note: When evaluating any claim involving loss or loss of use of one or more creative organs, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, there are other conditions in this section which under certain circumstances also establish entitlement to special monthly compensation.	
7500 Kidney, removal of one:	
Minimum evaluation	30
Or rate as renal dysfunction if there is nephritis, infection, or pathology of the other.	
7501 Kidney, abscess of:	

Rate as urinary tract infection	
7502 Nephritis, chronic:	
Rate as renal dysfunction.	
7504 Pyelonephritis, chronic:	
Rate as renal dysfunction or urinary tract infection, whichever is predominant.	
7505 Kidney, tuberculosis of:	
Rate in accordance with §§ 4.88b or 4.89, whichever is appropriate.	
7507 Nephrosclerosis, arteriolar:	
Rate according to predominant symptoms as renal dysfunction, hypertension or heart disease. If rated under the cardiovascular schedule, however, the percentage rating which would otherwise be assigned will be elevated to the next higher evaluation.	
7508 Nephrolithiasis/Ureterolithiasis/Nephrocalcinosis:	
Rate as hydronephrosis, except for recurrent stone formation requiring invasive or non-invasive procedures more than two times/year	30
7509 Hydronephrosis:	
Severe; Rate as renal dysfunction.	
Frequent attacks of colic with infection (pyonephrosis), kidney function impaired	30
Frequent attacks of colic, requiring catheter drainage	20
Only an occasional attack of colic, not infected and not requiring catheter drainage	10
7511 Ureter, stricture of:	
Rate as hydronephrosis, *except for* recurrent stone formation requiring one or more of the following:	
1. diet therapy	
2. drug therapy	
3. invasive or non-invasive procedures more than two times/year	30
7512 Cystitis, chronic, includes interstitial and all etiologies, infectious and non-infectious:	
Rate as voiding dysfunction.	
7515 Bladder, calculus in, with symptoms interfering with function:	
Rate as voiding dysfunction	
7516 Bladder, fistula of:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	
Postoperative, suprapubic cystotomy	100
7517 Bladder, injury of:	
Rate as voiding dysfunction.	
7518 Urethra, stricture of:	
Rate as voiding dysfunction.	
7519 Urethra, fistual of:	
Rate as voiding dysfunction.	
Multiple urethroperineal fistulae	100

7520 Penis, removal of half or more	[1]30
7521 Penis, removal of glans	[1]20
7522 Erectile dysfunction, with or without penile deformity	[1]0
Note: For the purpose of VA disability evaluation, a disease or traumatic injury of the penis resulting in scarring or deformity shall be rated under diagnostic code 7522.	
7523 Testis, atrophy complete:	
Both – 20[1]	
One – 0[1]	
7524 Testis, removal:	
Both	[1]30
One	[1]0
Note: In cases of the removal of one testis as the result of a service-incurred injury or disease, other than an undescended or congenitally undeveloped testis, with the absence or nonfunctioning of the other testis unrelated to service, an evaluation of 30 percent will be assigned for the service-connected testicular loss. Testis, undescended, or congenitally undeveloped is not a ratable disability.	
7525 Prostatitis, urethritis, epididymitis, orchitis (unilateral or bilateral), chronic only:	
Rate as urinary tract infection.	
For tubercular infections: Rate in accordance with §§ 4.88b or 4.89, whichever is appropriate.	
7527 Prostate gland injuries, infections, hypertrophy, postoperative residuals, bladder outlet obstruction:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	
7528 Malignant neoplasms of the genitourinary system	100
Note - Following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure, the rating of 100 percent shall continue with a mandatory VA examination at the expiration of six months. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local reoccurrence or metastasis, rate on residuals as voiding dysfunction or renal dysfunction, whichever is predominant.	
7529 Benign neoplasms of the genitourinary system:	
Rate as voiding dysfunction or renal dysfunction, whichever is predominant.	
7530 Chronic renal disease requiring regular dialysis:	
Rate as renal dysfunction.	
7531 Kidney transplant:	
Following transplant surgery	100
Thereafter: Rate on residuals as renal dysfunction, minimum rating	30
Note - The 100 percent evaluation shall be assigned as of the date of hospital admission for transplant surgery and shall continue with a mandatory VA examination one year following hospital discharge. Any change in evaluation	

based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
7532 Renal tubular disorders (such as renal glycosurias, aminoaciduria, renal tubular acidosis, Fanconi's syndrome, Bartter's syndrome, related disorders of Henle's loop and proximal or distal nephron function, etc.):	
Minimum rating for symptomatic condition	20
Or rate as renal dysfunction.	
7533 Cystic diseases of the kidneys:	
Rate as renal dysfunction.	
Note: Cystic diseases of the kidneys include, but are not limited to, polycystic disease, uremic medullary cystic disease, medullary sponge kidney, and similar conditions such as Alport's syndrome, cystinosis, primary oxalosis, and Fabry's disease.	
7534 Atherosclerotic renal disease (renal artery stenosis, atheroembolic renal disease, or large vessel disease, unspecified):	
Rate as renal dysfunction.	
7535 Toxic nephropathy (antibotics, radiocontrast agents, nonsteroidal anti-inflammatory agents, heavy metals, and similar agents):	
Rate as renal dysfunction.	
7536 Glomerulonephritis:	
Rate as renal dysfunction.	
7537 Interstitial nephritis, including gouty nephropathy, disorders of calcium metabolism:	
Rate as renal dysfunction.	
7538 Papillary necrosis:	
Rate as renal dysfunction.	
7539 Renal amyloid disease:	
Rate as renal dysfunction.	
Note: This diagnostic code pertains to renal involvement secondary to all glomerulonephritis conditions, all vasculitis conditions and their derivatives, and other renal conditions caused by systemic diseases, such as Lupus erythematosus, systemic lupus erythematosus nephritis, Henoch-Schonlein syndrome, scleroderma, hemolytic uremic syndrome, polyarthritis, Wegener's granulomatosis, Goodpasture's syndrome, and sickle cell disease.	
7540 Disseminated intravascular coagulation with renal cortical necrosis:	
Rate as renal dysfunction.	
7541 Renal involvement in diabetes mellitus type I or II:	
Rate as renal dysfunction.	
7542 Neurogenic bladder:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	
7543 Varicocele/Hydrocele	[1]0
7544 Renal disease caused by viral infection such as human immunodeficiency virus (HIV), Hepatitis B, and Hepatitis C:	
Rate as renal dysfunction.	

7545 Bladder, diverticulum of:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	

[1]Review for entitlement to special monthly compensation under § 3.350 of this chapter.

[59 FR 2527, Jan. 18, 1994; 59 FR 14567, Mar. 29, 1994, as amended at 59 FR 46339, Sept. 8, 1994; 86 FR 54086, Sept. 30, 2021]

38 CFR 4.116

GYNECOLOGICAL CONDITIONS AND DISORDERS OF THE BREAST

§ 4.116 Schedule of ratings - gynecological conditions and disorders of the breast.

	Rating
Note 1: Natural menopause, primary amenorrhea, and pregnancy and childbirth are not disabilities for rating purposes. Chronic residuals of medical or surgical complications of pregnancy may be disabilities for rating purposes	
Note 2: When evaluating any claim involving loss or loss of use of one or more creative organs or anatomical loss of one or both breasts, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, almost any condition in this section might, under certain circumstances, establish entitlement to special monthly compensation.	
7610 Vulva or clitoris, disease or injury of (including vulvovaginitis)	
7611 Vagina, disease or injury of.	
7612 Cervix, disease or injury of.	
7613 Uterus, disease, injury, or adhesions of.	
7614 Fallopian tube, disease, injury, or adhesions of (including pelvic inflammatory disease (PID)).	
7615 Ovary, disease, injury, or adhesions of.	
General Rating Formula for Disease, Injury, or Adhesions of Female Reproductive Organs (diagnostic codes 7610 through 7615):	
Symptoms not controlled by continuous treatment	30
Symptoms that require continuous treatment	10
Symptoms that do not require continuous treatment	0
Note: For the purpose of VA disability evaluation, a disease, injury, or adhesions of the ovaries resulting in ovarian dysfunction affecting the menstrual cycle, such as dysmenorrhea and secondary amenorrhea, shall be rated under diagnostic code 7615	
7617 Uterus and both ovaries, removal of, complete:	
For three months after removal	[1]100
Thereafter	[1]50

7618 Uterus, removal of, including corpus:	
For three months after removal	[1]100
Thereafter	[1]30
7619 Ovary, removal of:	
For three months after removal	[1]100
Thereafter	
Complete removal of both ovaries	[1]30
Removal of one with or without partial removal of the other	[1]0
Note: In cases of the removal of one ovary as the result of a service-connected injury or disease, with the absence or nonfunctioning of a second ovary unrelated to service, an evaluation of 30 percent will be assigned for the service-connected ovarian loss	
7620 Ovaries, atrophy of both, complete	[1]20
7621 Complete or incomplete pelvic organ prolapse due to injury, disease, or surgical complications of pregnancy	10
Note: Pelvic organ prolapse occurs when a pelvic organ such as bladder, urethra, uterus, vagina, small bowel, or rectum drops (prolapse) from its normal place in the abdomen. Conditions associated with pelvic organ prolapse include: uterine or vaginal vault prolapse, cystocele, urethrocele, rectocele, enterocele, or any combination thereof. Evaluate pelvic organ prolapse under DC 7621. Evaluate separately any genitourinary, digestive, or skin symptoms under the appropriate diagnostic code(s) and combine all evaluations with the 10 percent evaluation under DC 7621	
7624 Fistula, rectovaginal:	
Vaginal fecal leakage at least once a day requiring wearing of pad	100
Vaginal fecal leakage four or more times per week, but less than daily, requiring wearing of pad	60
Vaginal fecal leakage one to three times per week requiring wearing of pad	30
Vaginal fecal leakage less than once a week	10
Without leakage	0
7625 Fistula, urethrovaginal:	
Multiple urethrovaginal fistulae	100
Requiring the use of an appliance or the wearing of absorbent materials which must be changed more than four times per day	60
Requiring the wearing of absorbent materials which must be changed two to four times per day	40
Requiring the wearing of absorbent materials which must be changed less than two times per day	20
7626 Breast, surgery of:	
Following radical mastectomy:	
Both	[1]80
One	[1]50
Following modified radical mastectomy:	
Both	[1]60
One	[1]40

Following simple mastectomy or wide local excision with significant alteration of size or form:	
Both	[1]50
One	[1]30
Following wide local excision without significant alteration of size or form:	
Both or one	0
Note: For VA purposes:	
(1) *Radical mastectomy* means removal of the entire breast, underlying pectoral muscles, and regional lymph nodes up to the coracoclavicular ligament.	
(2) *Modified radical mastectomy* means removal of the entire breast and axillary lymph nodes (in continuity with the breast). Pectoral muscles are left intact.	
(3) *Simple (or total) mastectomy* means removal of all of the breast tissue, nipple, and a small portion of the overlying skin, but lymph nodes and muscles are left intact.	
(4) Wide local excision (including partial mastectomy, lumpectomy, tylectomy, segmentectomy, and quadrantectomy) means removal of a portion of the breast tissue.	
7627 Malignant neoplasms of gynecological system	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. Rate chronic residuals to include scars, lymphedema, disfigurement, and/or other impairment of function under the appropriate diagnostic code(s) within the appropriate body system	
7628 Benign neoplasms of gynecological system. Rate chronic residuals to include scars, lymphedema, disfigurement, and/or other impairment of function under the appropriate diagnostic code(s) within the appropriate body system	
7629 Endometriosis:	
Lesions involving bowel or bladder confirmed by laparoscopy, pelvic pain or heavy or irregular bleeding not controlled by treatment, and bowel or bladder symptoms	50
Pelvic pain or heavy or irregular bleeding not controlled by treatment	30
Pelvic pain or heavy or irregular bleeding requiring continuous treatment for control	10
Note: Diagnosis of endometriosis must be substantiated by laparoscopy	
7630 Malignant neoplasms of the breast	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. Rate chronic residuals according to impairment of function due to scars, lymphedema, or	

disfigurement (e.g., limitation of arm, shoulder, and wrist motion, or loss of grip strength, or loss of sensation, or residuals from harvesting of muscles for reconstructive purposes), and/or under diagnostic code 7626	
7631 Benign neoplasms of the breast and other injuries of the breast. Rate chronic residuals according to impairment of function due to scars, lymphedema, or disfigurement (e.g., limitation of arm, shoulder, and wrist motion, or loss of grip strength, or loss of sensation, or residuals from harvesting of muscles for reconstructive purposes), and/or under diagnostic code 7626	
7632 Female sexual arousal disorder (FSAD)	[1]0

[1]Review for entitlement to special monthly compensation under § 3.350 of this chapter.

(Authority: 38 U.S.C. 1155)

[60 FR 19855, Apr. 21, 1995, as amended at 67 FR 6874, Feb. 14, 2002; 67 FR 37695, May 30, 2002; 83 FR 15071, Apr. 9, 2018]

38 CFR 4.117

THE HEMATOLOGIC AND LYMPHATIC SYSTEMS

§ 4.117 Schedule of ratings – hemic and lymphatic systems.

	Rating
7702 Agranulocytosis, acquired:	
Requiring bone marrow transplant; or infections recurring, on average, at least once every six weeks per 12-month period	100
Requiring intermittent myeloid growth factors (granulocyte colony-stimulating factor (G-CSF) or granulocyte-macrophage colony-stimulating factor (GM-CSF) or continuous immunosuppressive therapy such as cyclosporine to maintain absolute neutrophil count (ANC) greater than 500/ microliter (µl) but less than 1000/µl; or infections recurring, on average, at least once every three months per 12-month period	60
Requiring intermittent myeloid growth factors to maintain ANC greater than 1000/µl; or infections recurring, on average, at least once per 12-month period but less than once every three months per 12-month period	30
Requiring continuous medication (e.g., antibiotics) for control; or requiring intermittent use of a myeloid growth factor to maintain ANC greater than or equal to 1500/µl	10
Note: A 100 percent evaluation for bone marrow transplant shall be assigned as of the date of hospital admission and shall continue with a mandatory VA examination six months following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	
7703 Leukemia (except for chronic myelogenous leukemia):	
When there is active disease or during a treatment phase	100

	Otherwise rate residuals under the appropriate diagnostic code(s)	
	Chronic lymphocytic leukemia or monoclonal B-cell lymphocytosis (MBL), asymptomatic, Rai Stage 0	0
	Note (1): A 100 percent evaluation shall continue beyond the cessation of any surgical therapy, radiation therapy, antineoplastic chemotherapy, or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no recurrence, rate on residuals	
	Note (2): Evaluate symptomatic chronic lymphocytic leukemia that is at Rai Stage I, II, III, or IV the same as any other leukemia evaluated under this diagnostic code	
	Note (3): Evaluate residuals of leukemia or leukemia therapy under the appropriate diagnostic code(s). Myeloproliferative Disorders: (Diagnostic Codes 7704, 7718, 7719)	
7704 Polycythemia vera:		
	Requiring peripheral blood or bone marrow stem-cell transplant or chemotherapy (including myelosuppressants) for the purpose of ameliorating the symptom burden	100
	Requiring phlebotomy 6 or more times per 12-month period or molecularly targeted therapy for the purpose of controlling RBC count	60
	Requiring phlebotomy 4-5 times per 12-month period, or if requiring continuous biologic therapy or myelosuppressive agents, to include interferon, to maintain platelets <200,000 or white blood cells (WBC) <12,000	30
	Requiring phlebotomy 3 or fewer times per 12-month period or if requiring biologic therapy or interferon on an intermittent basis as needed to maintain all blood values at reference range levels	10
	Note (1): Rate complications such as hypertension, gout, stroke, or thrombotic disease as separately	
	Note (2): If the condition undergoes leukemic transformation, evaluate as leukemia under diagnostic code 7703	
	Note (3): A 100 percent evaluation shall be assigned as of the date of hospital admission for peripheral blood or bone marrow stem cell transplant; or during the period of treatment with chemotherapy (including myelosuppressants). Six months following hospital discharge or, in the case of chemotherapy treatment, six months after completion of treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	
7705 Immune thrombocytopenia:		
	Requiring chemotherapy for chronic refractory thrombocytopenia; or a platelet count 30,000 or below despite treatment	100
	Requiring immunosuppressive therapy; or for a platelet count higher than 30,000 but not higher than 50,000, with history of hospitalization because of	70

severe bleeding requiring intravenous immune globulin, high-dose parenteral corticosteroids, and platelet transfusions	
Platelet count higher than 30,000 but not higher than 50,000, with either immune thrombocytopenia or mild mucous membrane bleeding which requires oral corticosteroid therapy or intravenous immune globulin	30
Platelet count higher than 30,000 but not higher than 50,000, not requiring treatment	10
Platelet count above 50,000 and asymptomatic; or for immune thrombocytopenia in remission	0
Note (1): Separately evaluate splenectomy under diagnostic code 7706 and combine with an evaluation under this diagnostic code	
Note (2): A 100 percent evaluation shall continue beyond the cessation of chemotherapy. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	
7706 Splenectomy	20
Note: Separately rate complications such as systemic infections with encapsulated bacteria	
7707 Spleen, injury of, healed**.**	
Rate for any residuals.	
7709 Hodgkin's lymphoma:	
With active disease or during a treatment phase	100
Note: A 100 percent evaluation shall continue beyond the cessation of any surgical therapy, radiation therapy, antineoplastic chemotherapy, or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals under the appropriate diagnostic code(s)	
7710 Adenitis, tuberculous, active or inactive:	
Rate under § 4.88c or 4.89 of this part, whichever is appropriate	
7712 Multiple myeloma:	
Symptomatic multiple myeloma	100
Asymptomatic, smoldering, or monoclonal gammopathy of undetermined significance (MGUS)	0
Note (1): Current validated biomarkers of symptomatic multiple myeloma and asymptomatic multiple myeloma, smoldering, or monoclonal gammopathy of undetermined significance (MGUS) are acceptable for the diagnosis of multiple myeloma as defined by the American Society of Hematology (ASH) and International Myeloma Working Group (IMWG)	
Note (2): The 100 percent evaluation shall continue for five years after the diagnosis of symptomatic multiple myeloma, at which time the appropriate disability evaluation shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall	

be subject to the provisions of § 3.105(e) and § 3.344 (a) and (b) of this chapter	
7714 Sickle cell anemia:	
With at least 4 or more painful episodes per 12-month period, occurring in skin, joints, bones, or any major organs, caused by hemolysis and sickling of red blood cells, with anemia, thrombosis, and infarction, with residual symptoms precluding even light manual labor	100
With 3 painful episodes per 12-month period or with symptoms precluding other than light manual labor	60
With 1 or 2 painful episodes per 12-month period	30
Asymptomatic, established case in remission, but with identifiable organ impairment	10
Note: Sickle cell trait alone, without a history of directly attributable pathological findings, is not a ratable disability. Cases of symptomatic sickle cell trait will be forwarded to the Director, Compensation Service, for consideration under § 3.321(b)(1) of this chapter	
7715 Non-Hodgkin's lymphoma:	
When there is active disease, during treatment phase, or with indolent and non-contiguous phase of low grade NHL	100
Note: A 100 percent evaluation shall continue beyond the cessation of any surgical therapy, radiation therapy, antineoplastic chemotherapy, or other therapeutic procedures. Two years after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no recurrence, rate on residuals under the appropriate diagnostic code(s)	
7716 Aplastic anemia:	
Requiring peripheral blood or bone marrow stem cell transplant; or requiring transfusion of platelets or red cells, on average, at least once every six weeks per 12-month period; or infections recurring, on average, at least once every six weeks per 12-month period	100
Requiring transfusion of platelets or red cells, on average, at least once every three months per 12-month period; or infections recurring, on average, at least once every three months per 12-month period; or using continuous therapy with immunosuppressive agent or newer platelet stimulating factors	60
Requiring transfusion of platelets or red cells, on average, at least once per 12-month period; or infections recurring, on average, at least once per 12-month period	30
Note (1): A 100 percent evaluation for peripheral blood or bone marrow stem cell transplant shall be assigned as of the date of hospital admission and shall continue with a mandatory VA examination six months following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	

Note (2): The term "newer platelet stimulating factors" includes medication, factors, or other agents approved by the United States Food and Drug Administration	
7717 AL amyloidosis (primary amyloidosis)	100
7718 Essential thrombocythemia and primary myelofibrosis:	
Requiring either continuous myelosuppressive therapy or, for six months following hospital admission, peripheral blood or bone marrow stem cell transplant, or chemotherapy, or interferon treatment	100
Requiring continuous or intermittent myelosuppressive therapy, or chemotherapy, or interferon treatment to maintain platelet count <500 × 109/L	70
Requiring continuous or intermittent myelosuppressive therapy, or chemotherapy, or interferon treatment to maintain platelet count of 200,000-400,000, or white blood cell (WBC) count of 4,000-10,000	30
Asymptomatic	0
Note (1): If the condition undergoes leukemic transformation, evaluate as leukemia under diagnostic code 7703	
Note (2): A 100 percent evaluation shall be assigned as of the date of hospital admission for peripheral blood or bone marrow stem cell transplant; or during the period of treatment with chemotherapy (including myelosuppressants). Six months following hospital discharge or, in the case of chemotherapy treatment, six months after completion of treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	
7719 Chronic myelogenous leukemia (CML) (chronic myeloid leukemia or chronic granulocytic leukemia):	
Requiring peripheral blood or bone marrow stem cell transplant, or continuous myelosuppressive or immunosuppressive therapy treatment	100
Requiring intermittent myelosuppressive therapy, or molecularly targeted therapy with tyrosine kinase inhibitors, or interferon treatment when not in apparent remission	60
In apparent remission on continuous molecularly targeted therapy with tyrosine kinase inhibitors	30
Note (1): If the condition undergoes leukemic transformation, evaluate as leukemia under diagnostic code 7703	
Note (2): A 100 percent evaluation shall be assigned as of the date of hospital admission for peripheral blood or bone marrow stem cell transplant; or during the period of treatment with chemotherapy (including myelosuppressants). Six months following hospital discharge or, in the case of chemotherapy treatment, six months after completion of treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105 of this chapter	
7720 Iron deficiency anemia:	
Requiring intravenous iron infusions 4 or more times per 12-month period	30

Requiring intravenous iron infusions at least 1 time but less than 4 times per 12-month period, or requiring continuous treatment with oral supplementation	10
Asymptomatic or requiring treatment only by dietary modification	0
Note: Do not evaluate iron deficiency anemia due to blood loss under this diagnostic code. Evaluate iron deficiency anemia due to blood loss under the criteria for the condition causing the blood loss	
7721 Folic acid deficiency:	
Requiring continuous treatment with high-dose oral supplementation	10
Asymptomatic or requiring treatment only by dietary modification	0
7722 Pernicious anemia and Vitamin B12 deficiency anemia:	
For initial diagnosis requiring transfusion due to severe anemia, or if there are signs or symptoms related to central nervous system impairment, such as encephalopathy, myelopathy, or severe peripheral neuropathy, requiring parenteral B12 therapy	100
Requiring continuous treatment with Vitamin B12 injections, Vitamin B12 sublingual or high-dose oral tablets, or Vitamin B12 nasal spray or gel	10
Note: A 100 percent evaluation for pernicious anemia and Vitamin B12 deficiency shall be assigned as of the date of the initial diagnosis requiring transfusion due to severe anemia or parenteral B12 therapy and shall continue with a mandatory VA examination six months following hospital discharge or cessation of parenteral B12 therapy. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. Thereafter, evaluate at 10 percent and separately evaluate any residual effects of pernicious anemia, such as neurologic involvement causing peripheral neuropathy, myelopathy, dementia, or related gastrointestinal residuals, under the most appropriate diagnostic code	
7723 Acquired hemolytic anemia:	
Requiring a bone marrow transplant or continuous intravenous or immunosuppressive therapy (e.g., prednisone, Cytoxan, azathioprine, or rituximab)	100
Requiring immunosuppressive medication 4 or more times per 12-month period	60
Requiring at least 2 but less than 4 courses of immunosuppressive therapy per 12-month period	30
Requiring one course of immunosuppressive therapy per 12-month period	10
Asymptomatic	0
Note (1): A 100 percent evaluation for bone marrow transplant shall be assigned as of the date of hospital admission and shall continue for six months after hospital discharge with a mandatory VA examination six months following hospital discharge. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter	
Note (2): Separately evaluate splenectomy under diagnostic code 7706 and combine with an evaluation under diagnostic code 7723	
7724 Solitary plasmacytoma:	

	Solitary plasmacytoma, when there is active disease or during a treatment phase	100
	Note (1): A 100 percent evaluation shall continue beyond the cessation of any surgical therapy, radiation therapy, antineoplastic chemotherapy, or other therapeutic procedures (including autologous stem cell transplantation). Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no recurrence, rate residuals under the appropriate diagnostic codes	
	Note (2): Rate a solitary plasmacytoma that has developed into multiple myeloma as symptomatic multiple myeloma	
	Note (3): Rate residuals of plasma cell dysplasia (e.g., thrombosis) and adverse effects of medical treatment (e.g., neuropathy) under the appropriate diagnostic codes	
7725 Myelodysplastic syndromes:		
	Requiring peripheral blood or bone marrow stem cell transplant; or requiring chemotherapy	100
	Requiring 4 or more blood or platelet transfusions per 12-month period; or infections requiring hospitalization 3 or more times per 12-month period	60
	Requiring at least 1 but no more than 3 blood or platelet transfusions per 12-month period; infections requiring hospitalization at least 1 but no more than 2 times per 12-month period; or requiring biologic therapy on an ongoing basis or erythropoiesis stimulating agent (ESA) for 12 weeks or less per 12-month period	30
	Note (1): If the condition progresses to leukemia, evaluate as leukemia under diagnostic code 7703	
	Note (2): A 100 percent evaluation shall be assigned as of the date of hospital admission for peripheral blood or bone marrow stem cell transplant, or during the period of treatment with chemotherapy, and shall continue with a mandatory VA examination six months following hospital discharge or, in the case of chemotherapy treatment, six months after completion of treatment. Any reduction in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no recurrence, residuals will be rated under the appropriate diagnostic codes	

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38 CFR 4.118(b)

THE SKIN

§ 4.118 Schedule of ratings – skin

a) For the purposes of this section, systemic therapy is treatment that is administered through any route (orally, injection, suppository, intranasally) other than the skin, and topical therapy is treatment that is administered through the skin.

b) Two or more skin conditions may be combined in accordance with § 4.25 only if separate areas of skin are involved. If two or more skin conditions involve the same area of skin, then only the highest evaluation shall be used.

	Rating
7800 Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck:	
With visible or palpable tissue loss and either gross distortion or asymmetry of three or more features or paired sets of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with six or more characteristics of disfigurement	80
With visible or palpable tissue loss and either gross distortion or asymmetry of two features or paired sets of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with four or five characteristics of disfigurement	50
With visible or palpable tissue loss and either gross distortion or asymmetry of one feature or paired set of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with two or three characteristics of disfigurement	30
With one characteristic of disfigurement	10
Note (1): The 8 characteristics of disfigurement, for purposes of evaluation under § 4.118, are:	
Scar 5 or more inches (13 or more cm.) in length.	
Scar at least one-quarter inch (0.6 cm.) wide at widest part.	
Scar adherent to underlying tissue.	
Skin hypo-or hyper-pigmented in an area exceeding six square inches (39 sq. cm.).	
Skin texture abnormal (irregular, atrophic, shiny, scaly, etc.) in an area exceeding six square inches (39 sq. cm.).	
Underlying soft tissue missing in an area exceeding six square inches (39 sq. cm.).	
Skin indurated and inflexible in an area exceeding six square inches (39 sq. cm.).	
Note (2): Rate tissue loss of the auricle under DC 6207 (loss of auricle) and anatomical loss of the eye under DC 6061 (anatomical loss of both eyes) or DC 6063 (anatomical loss of one eye), as appropriate.	
Note (3): Take into consideration unretouched color photographs when evaluating under these criteria	
Note (4): Separately evaluate disabling effects other than disfigurement that are associated with individual scar(s) of the head, face, or neck, such as pain, instability, and residuals of associated muscle or nerve injury, under the	

appropriate diagnostic code(s) and apply § 4.25 to combine the evaluation(s) with the evaluation assigned under this diagnostic code.	
Note (5): The characteristic(s) of disfigurement may be caused by one scar or by multiple scars; the characteristic(s) required to assign a particular evaluation need not be caused by a single scar in order to assign that evaluation	
7801 Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck, that are associated with underlying soft tissue damage:	
Area or areas of 144 square inches (929 sq. cm.) or greater	40
Area or areas of at least 72 square inches (465 sq. cm.) but less than 144 square inches (929 sq. cm.)	30
Area or areas of at least 12 square inches (77 sq. cm.) but less than 72 square inches (465 sq. cm.)	20
Area or areas of at least 6 square inches (39 sq. cm.) but less than 12 square inches (77 sq. cm.)	10
Note (1): For the purposes of DCs 7801 and 7802, the six (6) zones of the body are defined as each extremity, anterior trunk, and posterior trunk. The midaxillary line divides the anterior trunk from the posterior trunk	
Note (2): A separate evaluation may be assigned for each affected zone of the body under this diagnostic code if there are multiple scars, or a single scar, affecting multiple zones of the body. Combine the separate evaluations under § 4.25. Alternatively, if a higher evaluation would result from adding the areas affected from multiple zones of the body, a single evaluation may also be assigned under this diagnostic code	
7802 Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck, that are not associated with underlying soft tissue damage:	
Area or areas of 144 square inches (929 sq. cm.) or greater	10
Note (1): For the purposes of DCs 7801 and 7802, the six (6) zones of the body are defined as each extremity, anterior trunk, and posterior trunk. The midaxillary line divides the anterior trunk from the posterior trunk	
Note (2): A separate evaluation may be assigned for each affected zone of the body under this diagnostic code if there are multiple scars, or a single scar, affecting multiple zones of the body. Combine the separate evaluations under § 4.25. Alternatively, if a higher evaluation would result from adding the areas affected from multiple zones of the body, a single evaluation may also be assigned under this diagnostic code	
7804 Scar(s), unstable or painful:	
Five or more scars that are unstable or painful	30
Three or four scars that are unstable or painful	20
One or two scars that are unstable or painful	10
Note (1): An unstable scar is one where, for any reason, there is frequent loss of covering of skin over the scar.	
Note (2): If one or more scars are both unstable and painful, add 10 percent to the evaluation that is based on the total number of unstable or painful scars	
Note (3): Scars evaluated under diagnostic codes 7800, 7801, 7802, or 7805 may also receive an evaluation under this diagnostic code, when applicable	

7805 Scars, other; and other effects of scars evaluated under diagnostic codes 7800, 7801, 7802, or 7804:	
Evaluate any disabling effect(s) not considered in a rating provided under diagnostic codes 7800-04 under an appropriate diagnostic code	
General Rating Formula For The Skin For DCs 7806, 7809, 7813-7816, 7820-7822, and 7824:	
At least one of the following	60
Characteristic lesions involving more than 40 percent of the entire body or more than 40 percent of exposed areas affected; or	
Constant or near-constant systemic therapy including, but not limited to, corticosteroids, phototherapy, retinoids, biologics, photochemotherapy, psoralen with long-wave ultraviolet-A light (PUVA), or other immunosuppressive drugs required over the past 12-month period	60
At least one of the following	30
Characteristic lesions involving 20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected; or Systemic therapy including, but not limited to, corticosteroids, phototherapy, retinoids, biologics, photochemotherapy, PUVA, or other immunosuppressive drugs required for a total duration of 6 weeks or more, but not constantly, over the past 12-month period	
At least one of the following	10
Characteristic lesions involving at least 5 percent, but less than 20 percent, of the entire body affected; or	
At least 5 percent, but less than 20 percent, of exposed areas affected; or	
Intermittent systemic therapy including, but not limited to, corticosteroids, phototherapy, retinoids, biologics, photochemotherapy, PUVA, or other immunosuppressive drugs required for a total duration of less than 6 weeks over the past 12-month period	
No more than topical therapy required over the past 12-month period and at least one of the following	0
Characteristic lesions involving less than 5 percent of the entire body affected; or	
Characteristic lesions involving less than 5 percent of exposed areas affected	
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability. This rating instruction does not apply to DC 7824	
7806 Dermatitis or eczema	
Evaluate under the General Rating Formula for the Skin	
7807 American (New World) leishmaniasis (mucocutaneous, espundia):	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability	
Note: Evaluate non-cutaneous (visceral) leishmaniasis under DC 6301 (visceral leishmaniasis).	
7808 Old World leishmaniasis (cutaneous, Oriental sore):	

Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's, 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disabililty	
Note: Evaluate non-cutaneous (visceral) leishmaniasis under DC 6301 (visceral leishmaniasis).	
7809 Discoid lupus erythematosus.	
Evaluate under the General Rating Formula for the Skin	
Note: Do not combine with ratings under DC 6350	
7811 Tuberculosis luposa (lupus vulgaris), active or inactive:	
Rate under §§ 4.88c or 4.89, whichever is appropriate	
7813 Dermatophytosis (ringworm: Of body, tinea corporis; of head, tinea capitis; of feet, tinea pedis; of beard area, tinea barbae; of nails, tinea unguium (onychomycosis); of inguinal area (jock itch), tinea cruris; tinea versicolor).	
Evaluate under the General Rating Formula for the Skin	
7815 Bullous disorders (including pemphigus vulgaris, pemphigus foliaceous, bullous pemphigoid, dermatitis herpetiformis, epidermolysis bullosa acquisita, benign chronic familial pemphigus (Hailey-Hailey), and porphyria cutanea tarda).	
Evaluate under the General Rating Formula for the Skin	
Note: Rate complications and residuals of mucosal involvement (ocular, oral, gastrointestinal, respiratory, or genitourinary) separately under the appropriate diagnostic code	
7816 Psoriasis.	
Evaluate under the General Rating Formula for the Skin	
Note: Rate complications such as psoriatic arthritis and other clinical manifestations (e.g., oral mucosa, nails) separately under the appropriate diagnostic code	
7817 Erythroderma:	
Generalized involvement of the skin with systemic manifestations (such as fever, weight loss, or hypoproteinemia) AND one of the following	100
Constant or near-constant systemic therapy such as therapeutic doses of corticosteroids, other immunosuppressive drugs, retinoids, PUVA (psoralen with long-wave ultraviolet-A light), UVB (ultraviolet-B light) treatments, biologics, or electron beam therapy required over the past 12 month period; or	
No current treatment due to a documented history of treatment failure with 2 or more treatment regimens	100
Generalized involvement of the skin without systemic manifestations and one of the following	
Constant or near-constant systemic therapy such as therapeutic doses of corticosteroids, other immunosuppressive drugs, retinoids, PUVA, UVB treatments, biologics, or electron beam therapy required over the past 12-month period; or	
No current treatment due to a documented history of treatment failure with 1 treatment regimen	60

Any extent of involvement of the skin, and any of the following therapies required for a total duration of 6 weeks or more, but not constantly, over the past 12-month period: systemic therapy such as therapeutic doses of corticosteroids, other immunosuppressive drugs, retinoids, PUVA, UVB treatments, biologics, or electron beam therapy	30
Any extent of involvement of the skin, and any of the following therapies required for a total duration of less than 6 weeks over the past 12-month period: systemic therapy such as therapeutic doses of corticosteroids, other immunosuppressive drugs, retinoids, PUVA, UVB treatments, biologics, or electron beam therapy	10
Any extent of involvement of the skin, and no more than topical therapy required over the past 12-month period	0
Note: Treatment failure is defined as either disease progression, or less than a 25 percent reduction in the extent and severity of disease after four weeks of prescribed therapy, as documented by medical records	
7818 Malignant skin neoplasms (other than malignant melanoma):	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or impairment of function	
Note: If a skin malignancy requires therapy that is comparable to that used for systemic malignancies, i.e., systemic chemotherapy, X-ray therapy more extensive than to the skin, or surgery more extensive than wide local excision, a 100-percent evaluation will be assigned from the date of onset of treatment, and will continue, with a mandatory VA examination six months following the completion of such antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination will be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, evaluation will then be made on residuals. If treatment is confined to the skin, the provisions for a 100-percent evaluation do not apply	
7819 Benign skin neoplasms:	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or impairment of function	
7820 Infections of the skin not listed elsewhere (including bacterial, fungal, viral, treponemal, and parasitic diseases).	
Evaluate under the General Rating Formula for the Skin	
7821 Cutaneous manifestations of collagen-vascular diseases not listed elsewhere (including scleroderma, calcinosis cutis, subacute cutaneous lupus erythematosus, and dermatomyositis)	
Evaluate under the General Rating Formula for the Skin	
7822 Papulosquamous disorders not listed elsewhere (including lichen planus, large or small plaque parapsoriasis, pityriasis lichenoides et varioliformis acuta (PLEVA), lymphomatoid papulosus, mycosis fungoides, and pityriasis rubra pilaris (PRP))	
Evaluate under the General Rating Formula for the Skin	
7823 Vitiligo:	
With exposed areas affected	10

With no exposed areas affected	0
7824 Diseases of keratinization (including icthyoses, Darier's disease, and palmoplantar keratoderma).	
Evaluate under the General Rating Formula for the Skin	
7825 Chronic urticaria:	
For the purposes of this diagnostic code, chronic urticaria is defined as continuous urticaria at least twice per week, off treatment, for a period of six weeks or more	
Chronic refractory urticaria that requires third line treatment for control (e.g., plasmapheresis, immunotherapy, immunosuppressives) due to ineffectiveness with first and second line treatments	60
Chronic urticaria that requires second line treatment (e.g., corticosteroids, sympathomimetics, leukotriene inhibitors, neutrophil inhibitors, thyroid hormone) for control	30
Chronic urticaria that requires first line treatment (antihistamines) for control	10
7826 Vasculitis, primary cutaneous:	
Persistent documented vasculitis episodes refractory to continuous immunosuppressive therapy	60
All of the following:	30
Recurrent documented vasculitic episodes occurring four or more times over the past 12-month period; and	
Requiring intermittent systemic immunosuppressive therapy for control	30
At least one of the following	10
Recurrent documented vasculitic episodes occurring one to three times over the past 12-month period, and requiring intermittent systemic immunosuppressive therapy for control; or	
Without recurrent documented vasculitic episodes but requiring continuous systemic medication for control	
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability	
7827 Erythema multiforme; Toxic epidermal necrolysis:	
Recurrent mucosal, palmar, or plantar involvement impairing mastication, use of hands, or ambulation occurring four or more times over the past 12-month period despite ongoing immunosuppressive therapy	60
All of the following:	30
Recurrent mucosal, palmar, or plantar involvement not impairing mastication, use of hands, or ambulation, occurring four or more times over the past 12-month period; and requiring intermittent systemic therapy	
At least one of the following:	10
One to three episodes of mucosal, palmar, or plantar involvement not impairing mastication, use of hands, or ambulation, occurring over the past 12-month period AND requiring intermittent systemic therapy; or	
Without recurrent episodes, but requiring continuous systemic medication for control	
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability	

Note: For the purposes of this DC only, systemic therapy may consist of one or more of the following treatment agents: immunosuppressives, antihistamines, or sympathomimetics	
7828 Acne:	
Deep acne (deep inflamed nodules and pus-filled cysts) affecting 40 percent or more of the face and neck	30
Deep acne (deep inflamed nodules and pus-filled cysts) affecting less than 40 percent of the face and neck, or deep acne other than on the face and neck	10
Superficial acne (comedones, papules, pustules) of any extent	0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability	
7829 Chloracne:	
Deep acne (deep inflamed nodules and pus-filled cysts) affecting 40 percent or more of the face and neck	30
Deep acne (deep inflamed nodules and pus-filled cysts) affecting the intertriginous areas (the axilla of the arm, the anogenital region, skin folds of the breasts, or between digits)	20
Deep acne (deep inflamed nodules and pus-filled cysts) affecting less than 40 percent of the face and neck; or deep acne affecting non-intertriginous areas of the body (other than the face and neck)	10
Superficial acne (comedones, papules, pustules) of any extent	0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DCs 7801, 7802, 7804, or 7805), depending upon the predominant disability	
7830 Scarring alopecia:	
Affecting more than 40 percent of the scalp	20
Affecting 20 to 40 percent of the scalp	10
Affecting less than 20 percent of the scalp	0
7831 Alopecia areata:	
With loss of all body hair	10
With loss of hair limited to scalp and face	0
7832 Hyperhidrosis:	
Unable to handle paper or tools because of moisture, and unresponsive to therapy	30
Able to handle paper or tools after therapy	0
7833 Malignant melanoma:	
Rate as scars (DC's 7801, 7802, 7803, 7804, or 7805), disfigurement of the head, face, or neck (DC 7800), or impairment of function (under the appropriate body system)	
Note: If a skin malignancy requires therapy that is comparable to that used for systemic malignancies, i.e., systemic chemotherapy, X-ray therapy more extensive than to the skin, or surgery more extensive than wide local excision, a 100-percent evaluation will be assigned from the date of onset of treatment, and will continue, with a mandatory VA examination six months following the completion of such antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination will be subject to the provisions of § 3.105(e). If there has been no local recurrence or	

metastasis, evaluation will then be made on residuals. If treatment is confined to the skin, the provisions for a 100-percent evaluation do not apply.	

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38 CFR 4.119

THE ENDOCRINE SYSTEM

§ 4.119 Schedule of ratings – endocrine system.

	Rating
7900 Hyperthyroidism, including, but not limited to, Graves' disease:	
For six months after initial diagnosis	30
Thereafter, rate residuals of disease or complications of medical treatment within the appropriate diagnostic code(s) within the appropriate body system.	
Note (1): If hyperthyroid cardiovascular or cardiac disease is present, separately evaluate under DC 7008 (hyperthyroid heart disease).	
Note (2): Separately evaluate eye involvement occurring as a manifestation of Graves' Disease as diplopia (DC 6090); impairment of central visual acuity (DCs 6061-6066); or under the most appropriate DCs in § 4.79	
7901 Thyroid enlargement, toxic:	
Note (1): Evaluate symptoms of hyperthyroidism under DC 7900, hyperthyroidism, including, but not limited to, Graves' disease.	
Note (2): If disfigurement of the neck is present due to thyroid disease or enlargement, separately evaluate under DC 7800 (burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck).	
7902 Thyroid enlargement, nontoxic:	
Note (1): Evaluate symptoms due to pressure on adjacent organs (such as the trachea, larynx, or esophagus) under the appropriate diagnostic code(s) within the appropriate body system.	
Note (2): If disfigurement of the neck is present due to thyroid disease or enlargement, separately evaluate under DC 7800 (burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck).	
7903 Hypothyroidism:	
Hypothyroidism manifesting as myxedema (cold intolerance, muscular weakness, cardiovascular involvement (including, but not limited to hypotension, bradycardia, and pericardial effusion), and mental disturbance (including, but not limited to dementia, slowing of thought and depression))	100
Note (1): This evaluation shall continue for six months beyond the date that an examining physician has determined crisis stabilization. Thereafter, the	

residual effects of hypothyroidism shall be rated under the appropriate diagnostic code(s) within the appropriate body system(s) (e.g., eye, digestive, and mental disorders).	
Hypothyroidism without myxedema	30
Note (2): This evaluation shall continue for six months after initial diagnosis. Thereafter, rate residuals of disease or medical treatment under the most appropriate diagnostic code(s) under the appropriate body system (e.g., eye, digestive, mental disorders).	
Note (3): If eye involvement, such as exophthalmos, corneal ulcer, blurred vision, or diplopia, is also present due to thyroid disease, also separately evaluate under the appropriate diagnostic code(s) in § 4.79, Schedule of Ratings - Eye (such as diplopia (DC 6090) or impairment of central visual acuity (DCs 6061-6066)).	
7904 Hyperparathyroidism:	
For six months from date of discharge following surgery	100
Note (1): After six months, rate on residuals under the appropriate diagnostic code(s) within the appropriate body system(s) based on a VA examination.	
Hypercalcemia (indicated by at least one of the following: Total Ca greater than 12 mg/dL (3-3.5 mmol/L), Ionized Ca greater than 5.6 mg/dL (2-2.5 mmol/L), creatinine clearance less than 60 mL/ min, bone mineral density T-score less than 2.5 SD (below mean) at any site or previous fragility fracture)	60
Note (2): Where surgical intervention is indicated, this evaluation shall continue until the day of surgery, at which time the provisions pertaining to a 100-percent evaluation shall apply.	
Note (3): Where surgical intervention is not indicated, this evaluation shall continue for six months after pharmacologic treatment begins. After six months, rate on residuals under the appropriate diagnostic code(s) within the appropriate body system(s) based on a VA examination.	
Symptoms such as fatigue, anorexia, nausea, or constipation that occur despite surgery; or in individuals who are not candidates for surgery but require continuous medication for control	10
Asymptomatic	0
Note (4): Following surgery or other treatment, evaluate chronic residuals, such as nephrolithiasis (kidney stones), decreased renal function, fractures, vision problems, and cardiovascular complications, under the appropriate diagnostic codes.	
7905 Hypoparathyroidism:	
For three months after initial diagnosis	100
Thereafter, evaluate chronic residuals, such as nephrolithiasis (kidney stones), cataracts, decreased renal function, and congestive heart failure under the appropriate diagnostic codes.	
7906 Thyroiditis:	
With normal thyroid function (euthyroid)	0
Note: Manifesting as hyperthyroidism, evaluate as hyperthyroidism, including, but not limited to, Graves' disease (DC 7900); manifesting as hypothyroidism, evaluate as hypothyroidism (DC 7903).	

7907 Cushing's syndrome:	
As active, progressive disease, including areas of osteoporosis, hypertension, and proximal upper and lower extremity muscle wasting that results in inability to rise from squatting position, climb stairs, rise from a deep chair without assistance, or raise arms	100
Proximal upper or lower extremity muscle wasting that results in inability to rise from squatting position, climb stairs, rise from a deep chair without assistance, or raise arms	60
With striae, obesity, moon face, glucose intolerance, and vascular fragility	30
Note: The evaluations specifically indicated under this diagnostic code shall continue for six months following initial diagnosis. After six months, rate on residuals under the appropriate diagnostic code(s) within the appropriate body system(s)	
7908 Acromegaly:	
Evidence of increased intracranial pressure (such as visual field defect), arthropathy, glucose intolerance, and either hypertension or cardiomegaly	100
Arthropathy, glucose intolerance, and hypertension	60
Enlargement of acral parts or overgrowth of long bones	30
7909 Diabetes insipidus:	
For three months after initial diagnosis	30
Note: Thereafter, if diabetes insipidus has subsided, rate residuals under the appropriate diagnostic code(s) within the appropriate body system.	
With persistent polyuria or requiring continuous hormonal therapy	10
7911 Addison's disease (adrenocortical insufficiency):	
Four or more crises during the past year	60
Three crises during the past year, or; five or more episodes during the past year	40
One or two crises during the past year, or; two to four episodes during the past year, or; weakness and fatigability, or; corticosteroid therapy required for control	20
Note (1): An Addisonian “crisis” consists of the rapid onset of peripheral vascular collapse (with acute hypotension and shock), with findings that may include: anorexia; nausea; vomiting; dehydration; profound weakness; pain in abdomen, legs, and back; fever; apathy, and depressed mentation with possible progression to coma, renal shutdown, and death.	
Note (2): An Addisonian “episode,” for VA purposes, is a less acute and less severe event than an Addisonian crisis and may consist of anorexia, nausea, vomiting, diarrhea, dehydration, weakness, malaise, orthostatic hypotension, or hypoglycemia, but no peripheral vascular collapse.	
Note (3): Tuberculous Addison's disease will be evaluated as active or inactive tuberculosis. If inactive, these evaluations are not to be combined with the graduated ratings of 50 percent or 30 percent for non-pulmonary tuberculosis specified under § 4.88b. Assign the higher rating.	
7912 Polyglandular syndrome (multiple endocrine neoplasia, autoimmune polyglandular syndrome):	

Evaluate according to major manifestations to include, but not limited to, Type I diabetes mellitus, hyperthyroidism, hypothyroidism, hypoparathyroidism, or Addison's disease.	
7913 Diabetes mellitus:	
Requiring more than one daily injection of insulin, restricted diet, and regulation of activities (avoidance of strenuous occupational and recreational activities) with episodes of ketoacidosis or hypoglycemic reactions requiring at least three hospitalizations per year or weekly visits to a diabetic care provider, plus either progressive loss of weight and strength or complications that would be compensable if separately evaluated	100
Requiring one or more daily injection of insulin, restricted diet, and regulation of activities with episodes of ketoacidosis or hypoglycemic reactions requiring one or two hospitalizations per year or twice a month visits to a diabetic care provider, plus complications that would not be compensable if separately evaluated	60
Requiring one or more daily injection of insulin, restricted diet, and regulation of activities	40
Requiring one or more daily injection of insulin and restricted diet, or; oral hypoglycemic agent and restricted diet	20
Manageable by restricted diet only	10
Note (1): Evaluate compensable complications of diabetes separately unless they are part of the criteria used to support a 100-percent evaluation. Non-compensable complications are considered part of the diabetic process under DC 7913.	
Note (2): When diabetes mellitus has been conclusively diagnosed, do not request a glucose tolerance test solely for rating purposes.	
7914 Neoplasm, malignant, any specified part of the endocrine system	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
7915 Neoplasm, benign, any specified part of the endocrine system:	
Rate as residuals of endocrine dysfunction.	
7916 Hyperpituitarism (prolactin secreting pituitary dysfunction):	
Note: Evaluate as malignant or benign neoplasm, as appropriate.	
7917 Hyperaldosteronism (benign or malignant):	
Note: Evaluate as malignant or benign neoplasm, as appropriate.	
7918 Pheochromocytoma (benign or malignant):	
Note: Evaluate as malignant or benign neoplasm as appropriate.	
7919 C-cell hyperplasia of the thyroid:	
If antineoplastic therapy is required, evaluate as a malignant neoplasm under DC 7914. If a prophylactic thyroidectomy is performed (based upon genetic	

testing) and antineoplastic therapy is not required, evaluate as hypothyroidism under DC 7903.	

[61 FR 20446, May 7, 1996, as amended at 82 FR 50804, Nov. 2, 2017]

NEUROLOGICAL CONDITIONS AND CONVULSIVE DISORDERS

§ 4.120 Evaluations by comparison.

Disability in this field is ordinarily to be rated in proportion to the impairment of motor, sensory or mental function. Consider especially psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, injury to the skull, etc. In rating disability from the conditions in the preceding sentence refer to the appropriate schedule. In rating peripheral nerve injuries and their residuals, attention should be given to the site and character of the injury, the relative impairment in motor function, trophic changes, or sensory disturbances.

§ 4.121 Identification of epilepsy.

When there is doubt as to the true nature of epileptiform attacks, neurological observation in a hospital adequate to make such a study is necessary. To warrant a rating for epilepsy, the seizures must be witnessed or verified at some time by a physician. As to frequency, competent, consistent lay testimony emphasizing convulsive and immediate post-convulsive characteristics may be accepted. The frequency of seizures should be ascertained under the ordinary conditions of life (while not hospitalized).

§ 4.122 Psychomotor epilepsy.

The term psychomotor epilepsy refers to a condition that is characterized by seizures and not uncommonly by a chronic psychiatric disturbance as well.

(a) Psychomotor seizures consist of episodic alterations in conscious control that may be associated with automatic states, generalized convulsions, random motor movements (chewing, lip smacking, fumbling), hallucinatory phenomena (involving taste, smell, sound, vision), perceptual illusions (deja vu, feelings of loneliness, strangeness, macropsia, micropsia, dreamy states), alterations in thinking (not open to reason), alterations in memory, abnormalities of mood or affect (fear, alarm, terror, anger, dread, wellbeing), and autonomic disturbances (sweating, pallor, flushing of the face, visceral phenomena such as nausea, vomiting, defecation, a rising feeling of warmth in the abdomen). Automatic states or automatisms are characterized by episodes of irrational, irrelevant, disjointed, unconventional, asocial, purposeless though seemingly coordinated and purposeful, confused or inappropriate activity of one to several minutes (or, infrequently, hours) duration with subsequent amnesia for the seizure. Examples: A person of high social standing remained seated, muttered angrily, and rubbed the arms of his chair while the National Anthem was being played; an apparently normal person suddenly disrobed in public; a man traded an expensive automobile for an antiquated automobile in poor mechanical condition and after regaining conscious control, discovered that he had signed an agreement to pay an additional sum of money in the

trade. The seizure manifestations of psychomotor epilepsy vary from patient to patient and in the same patient from seizure to seizure.

(b) A chronic mental disorder is not uncommon as an interseizure manifestation of psychomotor epilepsy and may include psychiatric disturbances extending from minimal anxiety to severe personality disorder (as distinguished from developmental) or almost complete personality disintegration (psychosis). The manifestations of a chronic mental disorder associated with psychomotor epilepsy, like those of the seizures, are protean in character.

§ 4.123 Neuritis, cranial or peripheral.

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

§ 4.124 Neuralgia, cranial or peripheral.

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

§ 4.124a Schedule of ratings - neurological conditions and convulsive disorders.

[With the exceptions noted, disability from the following diseases and their residuals may be rated from 10 percent to 100 percent in proportion to the impairment of motor, sensory, or mental function. Consider especially psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, etc., referring to the appropriate bodily system of the schedule. With partial loss of use of one or more extremities from neurological lesions, rate by comparison with the mild, moderate, severe, or complete paralysis of peripheral nerves]

38 CFR 4.124a

Organic Diseases of the Central Nervous System

	Rating
8000 Encephalitis, epidemic, chronic:	
As active febrile disease	100
Rate residuals, minimum	10
Brain, new growth of:	
8002 Malignant	100
Note: The rating in code 8002 will be continued for 2 years following cessation of surgical, chemotherapeutic or other treatment modality. At this point, if the residuals have stabilized, the rating will be made on neurological residuals according to symptomatology.	

Minimum rating	30
8003 Benign, minimum	60
Rate residuals, minimum	10
8004 Paralysis agitans:	
Minimum rating	30
8005 Bulbar palsy	100
8007 Brain, vessels, embolism of.	
8008 Brain, vessels, thrombosis of	
8009 Brain, vessels, hemorrhage from:	
Rate the vascular conditions under Codes 8007 through 8009, for 6 months	100
Rate residuals, thereafter, minimum	10
8010 Myelitis:	
Minimum rating	10
8011 Poliomyelitis, anterior:	
As active febrile disease	100
Rate residuals, minimum	10
8012 Hematomyelia:	
For 6 months	100
Rate residu8als, minimum	10
8013 Syphilis, cerebrospinal.	
8014 Syphilis, meningovascular.	
8015 Tabes dorsalis.	
Note: Rate upon the severity of convulsions, paralysis, visual impairment or psychotic involvement, etc.	
8017 Amyotrophic lateral sclerosis	100
Note: Consider the need for special monthly compensation	
8018 Multiple sclerosis:	
Minimum rating	30
8019 Meningitis, cerebrospinal, epidemic:	
As active febrile disease	100
Rate residuals, minimum	10
8020 Brain, abscess of:	
As active disease	100
Rate residuals, minimum	10
Spinal cord, new growths of:	
8021 Malignant	100
Note: The rating in code 8021 will be continued for 2 years following cessation of surgical, chemotherapeutic or other treatment modality. At this point, if the residuals have stabilized, the rating will be made on neurological residuals according to symptomatology.	
Minimum rating	30
8022 Benign, minimum rating	60
Rate residuals, minimum	10
8023 Progressive muscular atrophy:	
Minimum rating	30

8024 Syringomyelia:	
Minimum rating	30
8025 Myasthenia gravis:	
Minimum rating	30
Note: It is required for the minimum ratings for residuals under diagnostic codes 8000-8025, that there be ascertainable residuals. Determinations as to the presence of residuals not capable of objective verification, i.e., headaches, dizziness, fatigability, must be approached on the basis of the diagnosis recorded; subjective residuals will be accepted when consistent with the disease and not more likely attributable to other disease or no disease. It is of exceptional importance that when ratings in excess of the prescribed minimum ratings are assigned, the diagnostic codes utilized as bases of evaluation be cited, in addition to the codes identifying the diagnoses.	
8045 Residuals of traumatic brain injury (TBI):	
There are three main areas of dysfunction that may result from TBI and have profound effects on functioning: cognitive (which is common in varying degrees after TBI), emotional/behavioral, and physical. Each of these areas of dysfunction may require evaluation	
Cognitive impairment is defined as decreased memory, concentration, attention, and executive functions of the brain. Executive functions are goal setting, speed of information processing, planning, organizing, prioritizing, self-monitoring, problem solving, judgment, decision making, spontaneity, and flexibility in changing actions when they are not productive. Not all of these brain functions may be affected in a given individual with cognitive impairment, and some functions may be affected more severely than others. In a given individual, symptoms may fluctuate in severity from day to day. Evaluate cognitive impairment under the table titled “Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.”	
Subjective symptoms may be the only residual of TBI or may be associated with cognitive impairment or other areas of dysfunction. Evaluate subjective symptoms that are residuals of TBI, whether or not they are part of cognitive impairment, under the subjective symptoms facet in the table titled “Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.” However, separately evaluate any residual with a distinct diagnosis that may be evaluated under another diagnostic code, such as migraine headache or Meniere's disease, even if that diagnosis is based on subjective symptoms, rather than under the “Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified” table	
Evaluate emotional/behavioral dysfunction under § 4.130 (Schedule of ratings - mental disorders) when there is a diagnosis of a mental disorder. When there is no diagnosis of a mental disorder, evaluate emotional/behavioral symptoms under the criteria in the table titled “Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.”	
Evaluate physical (including neurological) dysfunction based on the following list, under an appropriate diagnostic code: Motor and sensory	

dysfunction, including pain, of the extremities and face; visual impairment; hearing loss and tinnitus; loss of sense of smell and taste; seizures; gait, coordination, and balance problems; speech and other communication difficulties, including aphasia and related disorders, and dysarthria; neurogenic bladder; neurogenic bowel; cranial nerve dysfunctions; autonomic nerve dysfunctions; and endocrine dysfunctions.	
The preceding list of types of physical dysfunction does not encompass all possible residuals of TBI. For residuals not listed here that are reported on an examination, evaluate under the most appropriate diagnostic code. Evaluate each condition separately, as long as the same signs and symptoms are not used to support more than one evaluation, and combine under § 4.25 the evaluations for each separately rated condition. The evaluation assigned based on the "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" table will be considered the evaluation for a single condition for purposes of combining with other disability evaluations	
Consider the need for special monthly compensation for such problems as loss of use of an extremity, certain sensory impairments, erectile dysfunction, the need for aid and attendance (including for protection from hazards or dangers incident to the daily environment due to cognitive impairment), being housebound, etc	
Evaluation of Cognitive Impairment and Subjective Symptoms	
The table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" contains 10 important facets of TBI related to cognitive impairment and subjective symptoms. It provides criteria for levels of impairment for each facet, as appropriate, ranging from 0 to 3, and a 5th level, the highest level of impairment, labeled "total." However, not every facet has every level of severity. The Consciousness facet, for example, does not provide for an impairment level other than "total," since any level of impaired consciousness would be totally disabling. Assign a 100-percent evaluation if "total" is the level of evaluation for one or more facets. If no facet is evaluated as "total," assign the overall percentage evaluation based on the level of the highest facet as follows: 0 = 0 percent; 1 = 10 percent; 2 = 40 percent; and 3 = 70 percent. For example, assign a 70 percent evaluation if 3 is the highest level of evaluation for any facet.	
Note (1): There may be an overlap of manifestations of conditions evaluated under the table titled "Evaluation Of Cognitive Impairment And Other Residuals Of TBI Not Otherwise Classified" with manifestations of a comorbid mental or neurologic or other physical disorder that can be separately evaluated under another diagnostic code. In such cases, do not assign more than one evaluation based on the same manifestations. If the manifestations of two or more conditions cannot be clearly separated, assign a single evaluation under whichever set of diagnostic criteria allows the better assessment of overall impaired functioning due to both conditions. However, if the manifestations are clearly separable, assign a separate evaluation for each condition	
Note (2): Symptoms listed as examples at certain evaluation levels in the table are only examples and are not symptoms that must be present in order to assign a particular evaluation.	

Note (3): "Instrumental activities of daily living" refers to activities other than self-care that are needed for independent living, such as meal preparation, doing housework and other chores, shopping, traveling, doing laundry, being responsible for one's own medications, and using a telephone. These activities are distinguished from "Activities of daily living," which refers to basic self-care and includes bathing or showering, dressing, eating, getting in or out of bed or a chair, and using the toilet.	
Note (4): The terms "mild," "moderate," and "severe" TBI, which may appear in medical records, refer to a classification of TBI made at, or close to, the time of injury rather than to the current level of functioning. This classification does not affect the rating assigned under diagnostic code 8045.	
Note (5): A veteran whose residuals of TBI are rated under a version of § 4.124a, diagnostic code 8045, in effect before October 23, 2008 may request review under diagnostic code 8045, irrespective of whether his or her disability has worsened since the last review. VA will review that veteran's disability rating to determine whether the veteran may be entitled to a higher disability rating under diagnostic code 8045. A request for review pursuant to this note will be treated as a claim for an increased rating for purposes of determining the effective date of an increased rating awarded as a result of such review; however, in no case will the award be effective before October 23, 2008. For the purposes of determining the effective date of an increased rating awarded as a result of such review, VA will apply 38 CFR 3.114, if applicable.	
8046 Cerebral arteriosclerosis:	
Purely neurological disabilities, such as hemiplegia, cranial nerve paralysis, etc., due to cerebral arteriosclerosis will be rated under the diagnostic codes dealing with such specific disabilities, with citation of a hyphenated diagnostic code (e.g., 8046-8207).	
Purely subjective complaints such as headache, dizziness, tinnitus, insomnia and irritability, recognized as symptomatic of a properly diagnosed cerebral arteriosclerosis, will be rated 10 percent and no more under diagnostic code 9305. This 10 percent rating will not be combined with any other rating for a disability due to cerebral or generalized arteriosclerosis. Ratings in excess of 10 percent for cerebral arteriosclerosis under diagnostic code 9305 are not assignable in the absence of a diagnosis of multi-infarct dementia with cerebral arteriosclerosis.	
Note: The ratings under code 8046 apply only when the diagnosis of cerebral arteriosclerosis is substantiated by the entire clinical picture and not solely on findings of retinal arteriosclerosis.	

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Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified

Faces of cognitive impairment and other residuals of	Level of impairment	Criteria

TBI not otherwise classified		
Memory, attention, concentration, executive functions	0	No complaints of impairment of memory, attention, concentration, or executive functions
	1	A complaint of mild loss of memory (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing.
	2	Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment.
	3	Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment.
	Total	Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment
Judgment	0	Normal.
	1	Mildly impaired judgment. For complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision
	2	Moderately impaired judgment. For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions.
	3	Moderately severely impaired judgment. For even routine and familiar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision
	Total	Severely impaired judgment. For even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision. For example, unable to determine appropriate clothing for current weather conditions or judge when to avoid dangerous situations or activities.
Social interaction	0	Social interaction is routinely appropriate.
	1	Social interaction is occasionally inappropriate.
	2	Social interaction is frequently inappropriate.

	3	Social interaction is inappropriate most or all of the time.
Orientation	0	Always oriented to person, time, place, and situation.
	1	Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation.
	2	Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation.
	3	Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation.
	Total	Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation.
Motor activity (with intact motor and sensory system)	0	Motor activity normal.
	1	Motor activity normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function).
	2	Motor activity mildly decreased or with moderate slowing due to apraxia.
	3	Motor activity moderately decreased due to apraxia.
	Total	Motor activity severely decreased due to apraxia.
Visual spatial orientation	0	Normal.
	1	Mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system).
	2	Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system).
	3	Moderately severely impaired. Gets lost even in familiar surroundings, unable to use assistive devices such as GPS (global positioning system).
	Total	Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment
Subjective symptoms	0	Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples are: mild or occasional headaches, mild anxiety.

	1	Three or more subjective symptoms that mildly interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light.
	2	Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days.
Neurobehavioral effects	0	One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction. Examples of neurobehavioral effects are: Irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, belligerence, apathy, lack of empathy, moodiness, lack of cooperation, inflexibility, and impaired awareness of disability. Any of these effects may range from slight to severe, although verbal and physical aggression are likely to have a more serious impact on workplace interaction and social interaction than some of the other effects
	1	One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them.
	2	One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them.
	3	One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others.
Communication	0	Able to communicate by spoken and written language (expressive communication), and to comprehend spoken and written language.
	1	Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.
	2	Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than

		occasionally but less than half of the time. Can generally communicate complex ideas.
	3	Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs.
	Total	Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs.
Consciousness	Total	Persistently altered state of consciousness, such as vegetative state, minimally responsive state, coma

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Miscellaneous Diseases

	Rating
8100 Migraine:	
With very frequent completely prostrating and prolonged attacks productive of severe economic inadaptability	50
With characteristic prostrating attacks occurring on an average once a month over last several months	30
With characteristic prostrating attacks averaging one in 2 months over last several months	10
With less frequent attacks	0
8103 Tic, convulsive:	
Severe	30
Moderate	10
Mild	0
Note: Depending upon frequency, severity, muscle groups involved.	
8104 Paramyoclonus multiplex (convulsive state, myoclonic type):	
Rate as tic; convulsive; severe cases	60
8105 Chorea, Sydenham's:	
Pronounced, progressive grave types	100
Severe	80
Moderately severe	50
Moderate	30
Mild	10
Note: Consider rheumatic etiology and complications.	
8106 Chorea, Huntington's.	

Rate as Sydenham's chorea. This, though a familial disease, has its onset in late adult life, and is considered a ratable disability.	
8107 Athetosis, acquired.	
Rate as chorea.	
8108 Narcolepsy.	
Rate as for epilepsy, petit mal.	

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Diseases of the Cranial Nerves

	Rating
Disability from lesions of peripheral portions of first, second, third, fourth, sixth, and eighth nerves will be rated under the Organs of Special Sense. The ratings for the cranial nerves are for unilateral involvement; when bilateral, combine but without the bilateral factor.	
Fifth (trigeminal) cranial nerve	
8205 Paralysis of:	
Complete	50
Incomplete, severe	30
Incomplete, moderate	10
Note: Dependent upon relative degree of sensory manifestation or motor loss.	
8305 Neuritis.	
8405 Neuralgia	
Note: Tic douloureux may be rated in accordance with severity, up to complete paralysis	
Seventh (facial) cranial nerve	
8207 Paralysis of:	
Complete	30
Incomplete, severe	20
Incomplete, moderate	10
Note: Dependent upon relative loss of innervation of facial muscles.	
8307 Neuritis.	
8407 Neuralgia	
Ninth (glossopharyngeal) cranial nerve	
8209 Paralysis of:	
Complete	30
Incomplete, severe	20
Incomplete, moderate	10
Note: Dependent upon relative loss of ordinary sensation in mucous membrane of the pharynx, fauces, and tonsils.	
8309 Neuritis.	
8409 Neuralgia	

Tenth (pneumogastric, vagus) cranial nerve	
8210 Paralysis of:	
Complete	50
Incomplete, severe	30
Incomplete, moderate	10
Note: Dependent upon extent of sensory and motor loss to organs of voice, respiration, pharynx, stomach and heart.	
8310 Neuritis.	
8410 Neuralgia	
Eleventh (spinal accessory, external branch) cranial nerve.	
8211 Paralysis of:	
Complete	30
Incomplete, severe	20
Incomplete, moderate	10
Note: Dependent upon loss of motor function of sternomastoid and trapezius muscles.	
8311 Neuritis.	
8411 Neuralgia	
Twelfth (hypoglossal) cranial nerve.	
8212 Paralysis of:	
Complete	50
Incomplete, severe	30
Incomplete, moderate	10
Note: Dependent upon loss of motor function of tongue.	
8312 Neuritis.	
8412 Neuralgia	

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Diseases of the Peripheral Nerves

Schedule of ratings	Rating	
	Major	Minor
The term "incomplete paralysis," with this and other peripheral nerve injuries, indicates a degree of lost or impaired function substantially less than the type picture for complete paralysis given with each nerve, whether due to varied level of the nerve lesion or to partial regeneration. When the involvement is wholly sensory, the rating should be for the mild, or at most, the moderate degree. The ratings for the peripheral nerves are for unilateral involvement; when bilateral, combine with application of the bilateral factor.		
8510 Paralysis of:		
Complete; all shoulder and elbow movements lost or severely affected, hand and wrist movements not affected	70	60

Incomplete:		
Severe	50	40
Moderate	40	30
Mild	20	20
8610 Neuritis.		
8710 Neuralgia		
Middle radicular group		
8511 Paralysis of:		
Complete; adduction, abduction and rotation of arm, flexion of elbow, and extension of wrist lost or severely affected	70	60
Incomplete:		
Severe	50	40
Moderate	40	30
Mild	20	20
8611 Neuritis.		
8711 Neuralgia		
Lower radicular group		
8521 Paralysis of:		
Complete; all intrinsic muscles of hand, and some or all of flexors of wrist and fingers, paralyzed (substantial loss of use of hand)	70	60
Incomplete:		
Severe	50	40
Moderate	40	30
Mild	20	20
8612 Neuritis.		
8712 Neuralgia		
All radicular groups		
8513 Paralysis of:		
Complete	90	80
Incomplete:		
Severe	70	60
Moderate	40	30
Mild	20	20
8613 Neuritis.		
8713 Neuralgia		
The musculospiral nerve (radial nerve)		
8514 Paralysis of:		
Complete; drop of hand and fingers, wrist and fingers perpetually flexed, the thumb adducted falling within the line of the outer border of the index finger; cannot extend hand at wrist, extend proximal phalanges of fingers, extend thumb, or make lateral movement of wrist; supination of hand, extension and flexion of elbow weakened, the loss of synergic motion of extensors impairs the hand grip seriously; total paralysis of the triceps occurs only as the greatest rarity	70	60
Incomplete:		

Severe	50	40
Moderate	30	20
Mild	20	20
8614 Neuritis.		
8714 Neuralgia		
Note: Lesions involving only "dissociation of extensor communis digitorum" and "paralysis below the extensor communis digitorum," will not exceed the moderate rating under code 8514.		
The median nerve		
8515 Paralysis of:		
Complete; the hand inclined to the ulnar side, the index and middle fingers more extended than normally, considerable atrophy of the muscles of the thenar eminence, the thumb in the plane of the hand (ape hand); pronation incomplete and defective, absence of flexion of index finger and feeble flexion of middle finger, cannot make a fist, index and middle fingers remain extended; cannot flex distal phalanx of thumb, defective opposition and abduction of the thumb, at right angles to palm; flexion of wrist weakened; pain with trophic disturbances	70	60
Incomplete:		
Severe	50	40
Moderate	30	20
Mild	10	10
8615 Neuritis.		
8715 Neuralgia		
The ulnar nerve		
8516 Paralysis of:		
Complete; the "griffin claw" deformity, due to flexor contraction of ring and little fingers, atrophy very marked in dorsal interspace and thenar and hypothenar eminences; loss of extension of ring and little fingers cannot spread the fingers (or reverse), cannot adduct the thumb; flexion of wrist weakened	60	50
Incomplete:		
Severe	40	30
Moderate	30	20
Mild	10	10
8616 Neuritis.		
8716 Neuralgia		
Musculocutaneous nerve		
8517 Paralysis of:		
Complete; weakness but not loss of flexion of elbow and supination of forearm	30	20
Incomplete:		
Severe	20	20
Moderate	10	10
Mild	0	0

8617 Neuritis.		
8717 Neuralgia		
Circumflex nerve		
8518 Paralysis of:		
Complete; abduction of arm is impossible, outward rotation is weakened; muscles supplied are deltoid and teres minor	50	40
Incomplete:		
Severe	30	20
Moderate	10	10
Mild	0	0
8618 Neuritis.		
8718 Neuralgia		
Long thoracic nerve		
8519 Paralysis of:		
Complete; inability to raise arm above shoulder level, winged scapula deformity	30	20
Incomplete:		
Severe	20	20
Moderate	10	10
Mild	0	0
Note: Not to be combined with lost motion above shoulder level		
8619 Neuritis.		
8719 Neuralgia		
Note: Combined nerve injuries should be rated by reference to the major involvement, or if sufficient in extent, consider radicular group ratings		
Sciatic nerve		
8520 Paralysis of:		
Complete; the foot dangles and drops, no active movement possible of muscles below the knee, flexion of knee weakened or (very rarely) lost	80	
Incomplete:		
Severe, with marked muscular atrophy	60	
Moderate severe	40	
Moderate	20	
Mild	10	
8620 Neuritis.		
8720 Neuralgia		

	Rating
External popliteal nerve (common peroneal)	
8521 Paralysis of:	
Complete; foot drop and slight droop of first phalanges of all toes, cannot dorsiflex the foot, extension (dorsal flexion) of proximal phalanges of toes	40

lost; abduction of foot lost, adduction weakened; anesthesia covers entire dorsum of foot and toes	
Incomplete:	
Severe	30
Moderate	20
Mild	10
8621 Neuritis.	
8721 Neuralgia	
Musculocutaneous nerve (superficial peroneal)	
8522 Paralysis of:	
Complete; eversion of foot weakened	30
Incomplete:	
Severe	20
Moderate	10
Mild	0
8622 Neuritis.	
8722 Neuralgia	
Anterior tibial nerve (deep peroneal)	
8523 Paralysis of:	
Complete; dorsal flexion of foot lost	30
Incomplete:	
Severe	20
Moderate	10
Mild	0
8623 Neuritis.	
8723 Neuralgia	
Internal popliteal nerve (tibial)	
8524 Paralysis of:	
Complete; plantar flexion lost, frank adduction of foot impossible, flexion and separation of toes abolished; no muscle in sole can move; in lesions of the nerve high in popliteal fossa, plantar flexion of foot is lost	40
Incomplete:	
Severe	30
Moderate	20
Mild	10
8624 Neuritis.	
8724 Neuralgia	
Posterior tibial nerve	
8525 Paralysis of:	
Complete; paralysis of all muscles of sole of foot, frequently with painful paralysis of a causalgic nature; toes cannot be flexed; adduction is weakened; plantar flexion is impaired	30
Incomplete:	
Severe	20
Moderate	10

Mild	10
8625 Neuritis.	
8725 Neuralgia	
Anterior crural nerve (femoral)	
8526 Paralysis of:	
Complete; paralysis of quadriceps extensor muscles	40
Incomplete:	
Severe	30
Moderate	20
Mild	10
8626 Neuritis.	
8726 Neuralgia	
Internal saphenous nerve	
8527 Paralysis of:	
Severe to complete	10
Mild to moderate	0
8627 Neuritis.	
8727 Neuralgia	
Obturator nerve	
8528 Paralysis of:	
Severe to complete	10
Mild to moderate	0
8628 Neuritis.	
8728 Neuralgia	
External cutaneous nerve of thigh	
8529 Paralysis of:	
Severe to complete	10
Mild to moderate	0
8629 Neuritis.	
8729 Neuralgia	
Ilio-inguinal nerve	
8530 Paralysis of:	
Severe to complete	10
Mild to moderate	0
8630 Neuritis.	
8730 Neuralgia	
8540 Soft-tissue sarcoma (of neurogenic origin)	100
Note: The 100 percent rating will be continued for 6 months following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. At this point, if there has been no local recurrence or metastases, the rating will be made on residuals.	

The Epilepsies

	Rating
A thorough study of all material in §§ 4.121 and 4.122 of the preface and under the ratings for epilepsy is necessary prior to any rating action	
8910 Epilepsy, grand mal.	
Rate under the general rating formula for major seizures.	
8911 Epilepsy, petit mal.	
Rate under the general rating formula for minor seizures.	
Note (1): A major seizure is characterized by the generalized tonic-clonic convulsion with unconsciousness.	
Note (2): A minor seizure consists of a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head ("pure" petit mal), or sudden jerking movements of the arms, trunk, or head (myoclonic type) or sudden loss of postural control (akinetic type)	
General Rating Formula for Major and Minor Epileptic Seizures:	
Averaging at least 1 major seizure per month over the last year	100
Averaging at least 1 major seizure in 3 months over the last year; or more than 10 minor seizures weekly	80
Averaging at least 1 major seizure in 4 months over the last year; or 9-10 minor seizures per week	60
At least 1 major seizure in the last 6 months or 2 in the last year; or averaging at least 5 to 8 minor seizures weekly	40
At least 1 major seizure in the last 2 years; or at least 2 minor seizures in the last 6 months	20
A confirmed diagnosis of epilepsy with a history of seizures	10
Note (1): When continuous medication is shown necessary for the control of epilepsy, the minimum evaluation will be 10 percent. This rating will not be combined with any other rating for epilepsy.	
Note (2): In the presence of major and minor seizures, rate the predominating type.	
Note (3): There will be no distinction between diurnal and nocturnal major seizures.	
8912 Epilepsy, Jacksonian and focal motor or sensory.	
8913 Epilepsy, diencephalic	
Rate as minor seizures, except in the presence of major and minor seizures, rate the predominating type.	
8914 Epilepsy, psychomotor	
Major seizures:	
Psychomotor seizures will be rated as major seizures under the general rating formula when characterized by automatic states and/or generalized convulsions with unconsciousness.	
Minor seizures:	
Psychomotor seizures will be rated as minor seizures under the general rating formula when characterized by brief transient episodes of random motor	

movements, hallucinations, perceptual illusions, abnormalities of thinking, memory or mood, or autonomic disturbances.	

Mental Disorders in Epilepsies: A nonpsychotic organic brain syndrome will be rated separately under the appropriate diagnostic code (e.g., 9304 or 9326). In the absence of a diagnosis of nonpsychotic organic psychiatric disturbance (psychotic, psychoneurotic or personality disorder) if diagnosed and shown to be secondary to or directly associated with epilepsy will be rated separately. The psychotic or psychoneurotic disorder will be rated under the appropriate diagnostic code. The personality disorder will be rated as a dementia (e.g., diagnostic code 9304 or 9326).

Epilepsy and Unemployability:

1. Rating specialists must bear in mind that the epileptic, although his or her seizures are controlled, may find employment and rehabilitation difficult of attainment due to employer reluctance to the hiring of the epileptic.
2. Where a case is encountered with a definite history of unemployment, full and complete development should be undertaken to ascertain whether the epilepsy is the determining factor in his or her inability to obtain employment.
3. The assent of the claimant should first be obtained for permission to conduct this economic and social survey. The purpose of this survey is to secure all the relevant facts and data necessary to permit of a true judgment as to the reason for his or her unemployment and should include information as to:
    a. Education;
    b. Occupations prior and subsequent to service;
    c. Places of employment and reasons for termination;
    d. Wages received;
    e. Number of seizures.
4. Upon completion of this survey and current examination, the case should have rating board consideration. Where in the judgment of the rating board the veteran's unemployability is due to epilepsy and jurisdiction is not vested in that body by reason of schedular evaluations, the case should be submitted to the Compensation Service or the Director, Pension and Fiduciary Service.

(Authority: 38 U.S.C. 1155)
[29 FR 6718, May 22, 1964, as amended at 40 FR 42540, Sept. 15, 1975; 41 FR 11302, Mar. 18, 1976; 43 FR 45362, Oct. 2, 1978; 54 FR 4282, Jan. 30, 1989; 54 FR 49755, Dec. 1, 1989; 55 FR 154, Jan. 3, 1990; 56 FR 51653, Oct. 15, 1991; 57 FR 24364, June 9, 1992; 70 FR 75399, Dec. 20, 2005; 73 FR 54705, Sept. 23, 2008; 73 FR 69554, Nov. 19, 2008; 76 FR 78824, Dec. 20, 2011; 79 FR 2100, Jan. 13, 2014]

MENTAL DISORDERS

§ 4.125 Diagnosis of mental disorders.

a) If the diagnosis of a mental disorder does not conform to DSM-5 or is not supported by the findings on the examination report, the rating agency shall return the report to the examiner to substantiate the diagnosis. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association (2013), is incorporated by reference into this section with the approval of the Director of the Federal Register under 5 U.S.C. 552(a) and 1 CFR part 51. To enforce any edition other than that specified in this section, the Department of Veterans Affairs must publish notice of change in the FEDERAL REGISTER and the material must be available to the public. All approved material is available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901, 703-907-7300, http://www.dsm5.org. It is also available for inspection at the Office of Regulation Policy and Management, Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420. It is also available for inspection at the National Archives and Records Administration (NARA). For information on the availability of this information at NARA, call 202-741-6030 or go to http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_publications.html.

b) If the diagnosis of a mental disorder is changed, the rating agency shall determine whether the new diagnosis represents progression of the prior diagnosis, correction of an error in the prior diagnosis, or development of a new and separate condition. If it is not clear from the available records what the change of diagnosis represents, the rating agency shall return the report to the examiner for a determination.

(Authority: 38 U.S.C. 1155) [61 FR 52700, Oct. 8, 1996, as amended at 79 FR 45099, Aug. 4, 2014]

§ 4.126 Evaluation of disability from mental disorders.

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

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

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

d) When a single disability has been diagnosed both as a physical condition and as a mental disorder, the rating agency shall evaluate it using a diagnostic code which represents the dominant (more disabling) aspect of the condition (see § 4.14).

(Authority: 38 U.S.C. 1155)

[61 FR 52700, Oct. 8, 1996, as amended at 79 FR 45099, Aug. 4, 2014]

§ 4.127 Intellectual disability (intellectual developmental disorder) and personality disorders

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

(Authority: 38 U.S.C. 1155) [79 FR 45100, Aug. 4, 2014]

§ 4.128 Convalescence ratings following extended hospitalization.

If a mental disorder has been assigned a total evaluation due to a continuous period of hospitalization lasting six months or more, the rating agency shall continue the total evaluation indefinitely and schedule a mandatory examination six months after the veteran is discharged or released to non-bed care. A change in evaluation based on that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

(Authority: 38 U.S.C. 1155) [61 FR 52700, Oct. 8, 1996]

§ 4.129 Mental disorders due to traumatic stress.

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

(Authority: 38 U.S.C. 1155) [61 FR 52700, Oct. 8, 1996]

§ 4.130 Schedule of ratings – Mental disorders.

The nomenclature employed in this portion of the rating schedule is based upon the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (see § 4.125 for availability information). Rating agencies must be thoroughly familiar with this manual to properly implement the directives in § 4.125 through § 4.129 and to apply the general rating formula for mental disorders in § 4.130. The schedule for rating for mental disorders is set forth as follows:

9201 Schizophrenia

9202 [Removed]

9203 [Removed]

9204 [Removed]

9205 [Removed]

9208 Delusional disorder

9210 Other specified and unspecified schizophrenia spectrum and other psychotic disorders

9211 Schizoaffective disorder

9300 Delirium

9301 Major or mild neurocognitive disorder due to HIV or other infections

9304 Major or mild neurocognitive disorder due to traumatic brain injury

9305 Major or mild vascular neurocognitive disorder

9310 Unspecified neurocognitive disorder

9312 Major or mild neurocognitive disorder due to Alzheimer's disease

9326 Major or mild neurocognitive disorder due to another medical condition or substance/medication-induced major or mild neurocognitive disorder

9327 [Removed]

9400 Generalized anxiety disorder

9403 Specific phobia; social anxiety disorder (social phobia)

9404 Obsessive compulsive disorder

9410 Other specified anxiety disorder

9411 Posttraumatic stress disorder

9412 Panic disorder and/or agoraphobia

9413 Unspecified anxiety disorder

9416 Dissociative amnesia; dissociative identity disorder

9417 Depersonalization/Derealization disorder

9421 Somatic symptom disorder

9422 Other specified somatic symptom and related disorder

9423 Unspecified somatic symptom and related disorder

9424 Conversion disorder (functional neurological symptom disorder)

9425 Illness anxiety disorder

9431 Cyclothymic disorder

9432 Bipolar disorder

9433 Persistent depressive disorder (dysthymia)

9434 Major depressive disorder

9435 Unspecified depressive disorder

9440 Chronic adjustment disorder

38 CFR 4.130

General Rating Formula for Mental Disorders

	Rating
Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name.	100
Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a work-like setting); inability to establish and maintain effective relationships.	70
Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships.	50
Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events).	30
Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or symptoms controlled by continuous medication.	10
A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication.	0

9520 Anorexia nervosa

9521 Bulimia nervosa

Rating Formula for Eating Disorders

	Rating
Self-induced weight loss to less than 80 percent of expected minimum weight, with incapacitating episodes of at least six weeks total duration per year, and requiring hospitalization more than twice a year for parenteral nutrition or tube feeding.	100
Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of six or more weeks total duration per year	60
Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of more than two but less than six weeks total duration per year.	30
Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder and incapacitating episodes of up to two weeks total duration per year.	10
Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder but without incapacitating episodes	0

Note 1: An incapacitating episode is a period during which bed rest and treatment by a physician are required.

Note 2: Ratings under diagnostic codes 9201 to 9440 will be evaluated using the General Rating Formula for Mental Disorders. Ratings under diagnostic codes 9520 and 9521 will be evaluated using the General Rating Formula for Eating Disorders.

(Authority: 38 U.S.C. 1155) [79 FR 45100, Aug. 4, 2014]

DENTAL AND ORAL CONDITIONS

§ 4.149 (Reserved)

38 CFR 4.150

§ 4.150 Schedule of ratings – dental and oral conditions.

	Rating
Note (1): For VA compensation purposes, diagnostic imaging studies include, but are not limited to, conventional radiography (X-ray), computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), radionuclide bone scanning, or ultrasonography	
Note (2): Separately evaluate loss of vocal articulation, loss of smell, loss of taste, neurological impairment, respiratory dysfunction, and other impairments under the appropriate diagnostic code and combine under § 4.25 for each separately rated condition	
9900 Maxilla or mandible, chronic osteomyelitis, osteonecrosis or osteoradionecrosis of:	

Rate as osteomyelitis, chronic under diagnostic code 5000.	
9901 Mandible, loss of, complete, between angles	100
9902 Mandible, loss of, including ramus, unilaterally or bilaterally:	
Loss of one-half or more,	
Involving temporomandibular articulation	
Not replaceable by prosthesis	70
Replaceable by prosthesis	50
Not involving temporomandibular articulation.	
Not replaceable by prosthesis	40
Replaceable by prosthesis	30
Loss of less than one-half,	
Involving temporomandibular articulation.	
Not replaceable by prosthesis	70
Replaceable by prosthesis	50
Not involving temporomandibular articulation.	
Not replaceable by prosthesis	20
Replaceable by prosthesis	10
9903 Mandible, nonunion of, confirmed by diagnostic imaging studies:	
Severe, with false motion	30
Moderate, without false motion	10
9904 Mandible, malunion of:	
Displacement, causing severe anterior or posterior open bite	20
Displacement, causing moderate anterior or posterior open bite	10
Displacement, not causing anterior or posterior open bite	0
9905 Temporomandibular disorder (TMD):	
Interincisal range:	
0 to 10 millimeters (mm) of maximum unassisted vertical opening.	
With dietary restrictions to all mechanically altered foods	50
Without dietary restrictions to mechanically altered foods	40
11 to 20 mm of maximum unassisted vertical opening	
With dietary restrictions to all mechanically altered foods	40
Without dietary restrictions to mechanically altered foods	30
21 to 29 mm of maximum unassisted vertical opening	
With dietary restrictions to full liquid and pureed foods	40
With dietary restrictions to soft and semi-solid foods	30
Without dietary restrictions to mechanically altered foods	
30 to 34 mm of maximum unassisted vertical opening	
With dietary restrictions to full liquid and pureed foods	30
With dietary restrictions to soft and semi-solid foods	20
Without dietary restrictions to mechanically altered foods	10
Lateral excursion range of motion:	
0 to 4 mm	10
Note (1): Ratings for limited interincisal movement shall not be combined with ratings for limited lateral excursion	

Note (2): For VA compensation purposes, the normal maximum unassisted range of vertical jaw opening is from 35 to 50 mm	
Note (3): For VA compensation purposes, mechanically altered foods are defined as altered by blending, chopping, grinding or mashing so that they are easy to chew and swallow. There are four levels of mechanically altered foods: full liquid, puree, soft, and semisolid foods. To warrant elevation based on mechanically altered foods, the use of texture-modified diets must be recorded or verified by a physician	
9908 Condyloid process, loss of, one or both sides	30
Bilateral	20
Unilateral	10
9911 Hard palate, loss of:	
Loss of half or more, not replaceable by prosthesis	30
Loss of less than half, not replaceable by prosthesis	20
Loss of half or more, replaceable by prosthesis	10
Loss of less than half, replaceable by prosthesis	0
9913 Teeth, loss of, due to loss of substance of body of maxilla or mandible without loss of continuity:	
Where the lost masticatory surface cannot be restored by suitable prosthesis:	
Loss of all teeth	40
Loss of all upper teeth	30
Loss of all lower teeth	30
All upper and lower posterior teeth missing	20
All upper and lower anterior teeth missing	20
All upper anterior teeth missing	10
All lower anterior teeth missing	10
All upper and lower teeth on one side missing	10
Where the loss of masticatory surface can be restored by suitable prosthesis	0
Note - These ratings apply only to bone loss through trauma or disease such as osteomyelitis, and not to the loss of the alveolar process as a result of periodontal disease, since such loss is not considered disabling	
9914 Maxilla, loss of more than half:	
Not replaceable by prosthesis	100
Replaceable by prosthesis	50
9915 Maxilla, loss of half or less:	
Loss of 25 to 50 percent:	
Not replaceable by prosthesis	40
Replaceable by prosthesis	30
Loss of less than 25 percent:	
Not replaceable by prosthesis	20
Replaceable by prosthesis	0
9916 Maxilla, malunion or nonunion of:	
Nonunion,	
With false motion	30
Without false motion	10

Malunion,	
With displacement, causing severe anterior or posterior open bite	30
With displacement, causing moderate anterior or posterior open bite	10
With displacement, causing mild anterior or posterior open bite	0
Note: For VA compensation purposes, the severity of maxillary nonunion is dependent upon the degree of abnormal mobility of maxilla fragments following treatment (i.e., presence or absence of false motion), and maxillary nonunion must be confirmed by diagnostic imaging studies	
9917 Neoplasm, hard and soft tissue, benign:	
Rate as loss of supporting structures (bone or teeth) and/or functional impairment due to scarring.	
9918 Neoplasm, hard and soft tissue, malignant	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals such as loss of supporting structures (bone or teeth) and/or functional impairment due to scarring	

[59 FR 2530, Jan. 18, 1994, as amended at 82 FR 36083, Aug. 3, 2017]