## Section A. Musculoskeletal Conditions

#### Overview

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| In This Section | This section contains the following topics: |

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| 3 | Evaluating Musculoskeletal Disabilities of Spine and Lower Extremities |
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#### 1. Evaluating Joint Conditions, Painful Motion, and Functional Loss

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| Introduction | This topic contains information on evaluating joint conditions, painful motion, and functional loss, including   * assigning multiple LOM evaluations for a joint * assigning a noncompensable evaluation when schedular 0-percent criteria are not specified * considering pain when assigning multiple LOM evaluations for a joint * example of compensable limitation of two joint motions * example of compensable limitation of one motion with pain in another motion * example of noncompensable limitation of two motions with pain * considering functional loss due to pain when evaluating joint conditions * assessing medical evidence for functional loss due to pain * entering *DeLuca* and *Mitchell* data in Evaluation Builder * example of evaluating a joint with full range of motion (ROM) and functional loss due to pain * example of evaluating a joint with LOM and functional loss due to pain * inappropriate situations for using functional loss to evaluate musculoskeletal conditions, and * example of evaluating joints with arthritis by x-ray evidence only with other joint(s) affected by non-arthritic condition. |

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| a. Assigning Multiple LOM Evaluations for a Joint | In [VAOPGCPREC 9-2004](http://www.va.gov/ogc/docs/2004/PREC92004.doc) Office of General Counsel (OGC) held that separate evaluations under [38 CFR 4.71a, Diagnostic Code (DC) 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=pt38.1.4&rgn=div5#se38.1.4_171a), (limitation of knee flexion) and [38 CFR 4.71a, DC 5261](http://www.ecfr.gov/cgi-bin/text-idx?SID=b8e31f70e0772b5c2ffd9035fa3b132d&mc=true&node=se38.1.4_171a&rgn=div8), (limitation of knee extension) can be assigned without pyramiding. Despite the fact that knee flexion and extension both occur in the same plane of motion, limitation of flexion (bending the knee) and limitation of extension (straightening the knee) represent distinct disabilities.  ***Important***:   * The same principle and handling apply ***only*** to * qualifying elbow and forearm movement DCs, flexion ([38 CFR 4.71a, DC 5206](http://www.ecfr.gov/cgi-bin/text-idx?SID=b8e31f70e0772b5c2ffd9035fa3b132d&mc=true&node=se38.1.4_171a&rgn=div8)), extension ([38 CFR 4.71a, DC 5207](http://www.ecfr.gov/cgi-bin/text-idx?SID=b8e31f70e0772b5c2ffd9035fa3b132d&mc=true&node=se38.1.4_171a&rgn=div8)), and impairment of either supination or pronation ([38 CFR 4.71a, DC 5213](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8)), and * qualifying hip movement DCs, extension ([38 CFR 4.71a, DC 5251](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8)), flexion ([38 CFR 4.71a, DC 5252](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8)), and abduction, adduction or rotation ([38 CFR 4.71a, DC 5253](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8)). * Always ensure that multiple evaluations do not violate the amputation rule in [38 CFR 4.68](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_168&rgn=div8).   ***Note***: The Federal Circuit has definitively ruled that multiple evaluations for the shoulder under [38 CFR 4.71a, DC 5201](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), are not permitted. In [*Yonek v. Shinseki*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmy)*,* 22 F.3d 1355 (Fed. Cir. 2013) the court held that a Veteran is entitled to a single rating under [38 CFR 4.71a, DC 5201](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), even though a shoulder disability results in limitation of motion (LOM) in both flexion (raising the arm in front of the body) and abduction (raising the arm away from the side of the body).  ***References***: For more information on   * pyramiding of evaluations, see * [38 CFR 4.14](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_114&rgn=div8), and * [*Esteban v. Brown*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bme), 6 Vet.App. 259 (1994) * painful motion in multiple evaluations for joint LOM, see M21-1, Part III, Subpart iv, 4.A.1.c * assignment of separate evaluations for disabilities of the elbow, forearm, and wrist, see M21-1, Part III, Subpart iv, 4.A.2.c, and * examples of actual LOM of two knee motions, see M21-1, Part III, Subpart iv, 4.A.1.d. |

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| **b. Assigning a Noncompensable Evaluation When Schedular 0-Percent Criteria Are Not Specified** | For those joint motions where the 0-percent evaluation criteria is not defined by regulation, any LOM for that specific movement will be assigned a separate noncompensable disability evaluation. The motions include   * [38 CFR 4.71a, DC 5207](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), limitation of extension of the elbow * [38 CFR 4.71a, DC 5213](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), impairment of supination and pronation of the forearm * [38 CFR 4.71a, DC 5251](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), limitation of extension of the hip * [38 CFR 4.71a, DC 5252](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), limitation of flexion of the hip, and * [38 CFR 4.71a, DC 5253](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), impairment of rotation, adduction, or abduction of the hip.   ***Example***: A Department of Veterans Affairs(VA) examination shows a Veteran has flexion of the hip limited to 60 degrees. [38 CFR 4.71a, DC 5252](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8) does not define the criteria for assignment of a 0-percent disability evaluation. Normal range of motion (ROM) for flexion of the hip is 125 degrees. Since there is limited flexion, but not to the extent that the criteria for the schedular 10-percent evaluation is met, and because there is no defined schedular 0-percent evaluation criteria, a 0-percent evaluation is warranted for limited flexion of the hip under [38 CFR 4.71a, DC 5252](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8). |

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| c. Considering Pain When Assigning Multiple LOM Evaluations for a Joint | When considering the role of pain in evaluations for multiple motions of a single joint, the following guidelines apply.   * When more than one qualifying joint motion is actually limited to a compensable degree and there is painful but otherwise noncompensable limitation of the complementary movement(s), ***only one compensable evaluation can be assigned***. * [*Mitchell v. Shinseki*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmm), 25 Vet.App. 32 (2011) reinforced that painful motion is the equivalent of limited motion only based on the specific language and structure of [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), not for the purpose of [38 CFR 4.71a, DC 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), and [38 CFR 4.71a, 5261](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8). For arthritis, if one motion is actually compensable under its 52XX-series DC, then a 10-percent evaluation under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), is not available and the complementary motion cannot be treated as limited at the point where it is painful. * [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_159&rgn=div8) does not permit separate compensable evaluations for each painful joint *motion*. It only provides that VA policy is to recognize actually painful motion as entitled to at least the minimum compensable evaluation for the *joint*. * When each qualifying joint motion is painful but motion is not actually limited to a compensable degree under its applicable 52XX-series DC, ***only one compensable evaluation can be assigned***. * Assigning multiple compensable evaluations for pain is pyramiding. * A joint affected by arthritis established by x-ray may be evaluated as 10-percent disabling under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8). * For common joint conditions that are not evaluated under the arthritis criteria such as a knee strain or chondromalacia patella, a 10-percent evaluation can be assigned for the joint based on pain on motion under [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_159&rgn=div8). Do not apply instructions from Note (1) under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), for non-arthritic conditions, since the instructions are strictly limited to arthritic conditions. See example in M21-1, Part III, Subpart iv, 4.A.1.m.   ***References***:   * For more information on pyramiding of evaluations, see * [38 CFR 4.14](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_114&rgn=div8), and * [*Esteban v. Brown*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bme), 6 Vet.App. 259 (1994). * For more information on assigning multiple evaluations for a single joint, see M21-1, Part III, Subpart iv, 4.A.1.a. * For examples of evaluations for which one or both joint motions are not actually limited to a compensable degree but there is painful motion, see M21-1, Part III, Subpart iv, 4.A.1.e and f. |

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| d. Example 1: Compensable Limitation of Two Joint Motions | ***Situation***: Evaluation of chronic knee strain with the following examination findings   * Flexion is limited to 45 degrees. * Extension is limited by 10 degrees. * There is no pain on motion. * There is no additional limitation of flexion or extension on additional repetitions or during flare-ups.   ***Result***: Assign a 10-percent evaluation under [38 CFR 4.71a, DC 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), and a separate 10-percent evaluation under [38 CFR 4.71a, DC 5261](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8).  ***Explanation***: Each disability (limitation of flexion and limitation of extension) warrants a separate evaluation and the evaluations are for distinct disability. |

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| e. Example 2: Compensable Limitation of One Motion With Pain in Another Motion | ***Situation***: Evaluation of knee tenosynovitis with the following examination findings   * Flexion is limited to 45 degrees with pain at that point and no additional loss with repetitive motion. * Extension is full to the 0-degree position, but active extension was limited by pain to 5 degrees.   ***Result***: Assign one 10-percent evaluation under [38 CFR 4.71a, DC 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8).  ***Explanation***:   * Flexion is compensable under [38 CFR 4.71a, DC 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), but extension remains limited to a noncompensable degree under [38 CFR 4.71a, DC 5261](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8). * Under [*Mitchell v. Shinseki*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmm), 25 Vet.App. 32 (2011), the painful extension could only be considered limited for the purpose of whether a 10-percent evaluation can be assigned for the joint under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), which is not applicable in this example because a compensable evaluation was already assigned for flexion under [38 CFR 4.71a, DC 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8). * [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_159&rgn=div8) does not support a separate compensable evaluation for painful extension. The regulation states that the intention of the rating schedule is to recognize actually painful joints due to healed injury as entitled to at least the minimum compensable evaluation for the joint, not for each painful movement. * If the fact pattern involved chondromalacia patella or a knee strain rather than tenosynovitis the result would be the same. |

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| f. Example 3: Noncompensable Limitation of Two Motions With Pain | ***Situation***: Evaluation of knee arthritis shown on x-ray with the following examination findings.   * Flexion is limited to 135 degrees with pain at that point. * Extension is full to the 0-degree position with pain at that point. * There is no additional loss of flexion or extension on repetitive motion.   ***Result***: Assign one 10-percent evaluation for the knee under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8).  ***Explanation***:   * There is limitation of major joint motion to a noncompensable degree under [38 CFR 4.71a, DC 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), and [38 CFR 4.71a, DC 5261](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), x-ray evidence of arthritis and satisfactory evidence of painful motion. Painful motion is limited motion for the purpose of applying [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8). Therefore, a 10-percent evaluation is warranted for the joint. * Assigning two compensable evaluations, each for pain, would be pyramiding. * Neither [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), nor [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_159&rgn=div8) permits separate 10-percent evaluations for painful flexion and extension; they provide for a 10-percent evaluation for a joint. * If the fact pattern involved chondromalacia patella or a knee strain rather than arthritis you would still assign a 10-percent evaluation, not separate evaluations. However, the authority would be [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_159&rgn=div8) and you should use [38 CFR 4.71a, DC 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), rather than [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8). |

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| g. Considering Functional Loss Due to Pain When Evaluating Joint Conditions | Functional loss due to pain is a factor in the evaluation of musculoskeletal conditions under any DC that involves LOM. Consider the following factors when evaluating functional loss due to pain.   * Painful motion of a joint is indicative of disability and warrants at least the minimum compensable evaluation for the joint. * The pain may be caused by the actual joint, connective tissues, nerves, or muscles. * The medical nature of the particular disability determines whether the DC is based on LOM. * Pain on palpation is not the same as painful motion of a joint and does not warrant assignment of a compensable evaluation under [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=ff07c75cd57bc7c5816feafc92fa44e0&node=se38.1.4_159&rgn=div8) for painful motion. However, pain on palpation of the joint may be considered in determining the evaluation to be assigned for the joint.      * Pain on weight bearing or nonweight-bearing is not the same as painful motion of a joint, and does not warrant assignment of a compensable evaluation under [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=ff07c75cd57bc7c5816feafc92fa44e0&node=se38.1.4_159&rgn=div8) for painful motion. Medical evidence must demonstrate actual painful motion to warrant a compensable evaluation under [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=ff07c75cd57bc7c5816feafc92fa44e0&node=se38.1.4_159&rgn=div8). * When pain results in loss of motion of a joint, the joint should be evaluated based on the additional loss of motion. * For joint conditions where multiple evaluations are possible due to LOM in different motions, assignment of an additional separate evaluation for LOM due to pain of a joint requires that the limitation must at least meet the level of the minimum schedular evaluation for the affected joint. * For painful motion to be the basis for a higher evaluation than the one based solely on actual LOM, the pain must actually limit motion at the corresponding compensable level. * When pain results in additional functional loss during flare-ups or upon repeated use over a period of time, evaluate the joint based on the resulting LOM.   ***References***: For more information on   * functional loss, see * [38 CFR 4.40](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_140&rgn=div8) * [*DeLuca v. Brown*](http://vbaw.vba.va.gov/bl/21/Advisory/CAVCDAD.htm#bmd)*,* 8 Vet.App. 202 (1995), and * [*Mitchell v. Shinseki*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmm), 25 Vet.App. 32 (2011) * disability of the joints, see [38 CFR 4.45](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_145&rgn=div8) * painful motion, see [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_159&rgn=div8), and * multiple evaluations for musculoskeletal disability, see * [VAOPGCPREC 9-98](http://www.va.gov/ogc/docs/1998/prc09-98.doc), and * [VAOPGCPREC 9-2004](http://www.va.gov/ogc/docs/2004/PREC92004.doc). |

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| **h. Assessing Medical Evidence for Functional Loss Due to Pain** | Medical evidence used to evaluate functional impairment due to pain must account for painful motion, pain on use, and pain during flare-ups or with repeated use over a period of time.  As a part of the assessment conducted in accordance with [*DeLuca v. Brown*](http://vbaw.vba.va.gov/bl/21/Advisory/CAVCDAD.htm#bmd), 8 Vet.App. 202 (1995), the medical evidence must   * clearly indicate the exact degree of movement at which pain limits motion in the affected joint, and * include the findings of at least three repetitions of ROM.   Per [*Mitchell v. Shinseki*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmm), 25 Vet.App. 32 (2011),when pain is associated with movement, an examiner must opine or the medical evidence must show whether pain could significantly limit functional ability   * during flare-ups, or * when the joint is used repeatedly over a period of time, and * if there is functional impairment found during flare-ups or with repeated use over a period of time, the examiner must provide, if feasible, the degree of additional LOM due to pain on use or during flare-ups.   ***Important***: If the examiner is unable to provide any of the above findings, he or she must   * indicate that he/she cannot determine, without resort to mere speculation, whether any of these factors cause additional functional loss, and * provide the rationale for this opinion.   ***Note***: Per [*Jones (M.) v. Shinseki*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmj)*,* 23 Vet.App. 382 (2010), the VA may only accept a medical examiner’s conclusion that an opinion would be speculative if   * the examiner has explained the basis for such an opinion, identifying what facts cannot be determined, or * the basis for the opinion is otherwise apparent in VA’s review of the evidence.   ***Reference***: For more information on evaluating functional impairment due to pain, see M21-1, Part III, Subpart iv, 4.A.1.g. |

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| **i. Entering *DeLuca* and *Mitchell* Data in the Evaluation Builder** | The findings of De*Luca* repetitive ROM testing or the functional loss expressed in the *Mitchell* opinion will be used to evaluate the functional impairment of a joint due to pain.   * Only the most advantageous finding will be utilized to evaluate the joint condition. * Do not “add” the LOM on *DeLuca* exam to the LOM expressed in a *Mitchell* opinion.   ***Note***: For purposes of data entry in the Evaluation Builder tool, if evaluating a joint where data fields are present for only initial ROM and for *DeLuca* (but not for *Mitchell*), enter either the *DeLuca* or the *Mitchell* data in the *DeLuca* field, whichever results in the higher disability evaluation.  ***Examples***: For examples of how to evaluate functional loss due to pain, refer to M21-1, Part III, Subpart iv, 4.A.1.j-k.  ***Reference***: For more information on the *Deluca* and *Mitchell* cases, see M21-1, Part III, Subpart iv, 4.A.1.h. |

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| **j. Example of Evaluating a Joint with Full ROM and Functional Loss Due to Pain** | ***Situation***: Evaluation of a knee condition with normal initial ROM and additional functional loss indicated on *DeLuca* and *Mitchell* assessments.   * Examination reveals normal ROM for extension of the knee, but pain on motion is present. * In applying the *DeLuca* repetitive use test, the examiner determines that after repetitive use extension of the knee is additionally limited, and the post-test ROM is to 10 degrees due to pain. * The examiner provides a *Mitchell* assessment that during flare-ups the extension of the knee would be additionally limited to 15 degrees due to pain.   ***Result***: Assign one 20-percent disability evaluation under [38 CFR 4.71a, DC 5261](http://www.ecfr.gov/cgi-bin/text-idx?SID=2dd5087eef182bbdf97785fdbb1c3381&node=se38.1.4_171a&rgn=div8) for limited extension of the knee.  ***Explanation***: 15-degree limitation of extension, expressed in the *Mitchell* opinion, is the most advantageous assessment of functional loss for extension of the knee in this scenario. Therefore, the knee will be evaluated based on extension limited to 15 degrees, resulting in a 20-percent evaluation under [38 CFR 4.71a, DC 5261](http://www.ecfr.gov/cgi-bin/text-idx?SID=2dd5087eef182bbdf97785fdbb1c3381&node=se38.1.4_171a&rgn=div8).  ***Reference***: For more information on the *Deluca* and *Mitchell* cases, see M21-1, Part III, Subpart iv, 4.A.1.h. |

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| **k. Example of Evaluating a Joint With LOM and Functional Loss Due to Pain** | ***Situation***: Evaluation of a knee condition with limited initial ROM and additional functional loss indicated on *DeLuca* and *Mitchell* assessments.   * Flexion of the knee is limited to 70 degrees with pain on motion during initial examination. * In applying the *DeLuca* repetitive use test, the examiner determines that after repetitive use flexion of the knee is additionally limited, and the post-test ROM is 50 degrees as a result of pain with repetitive use. * The examiner provides a *Mitchell* assessment that during flare-ups the estimated ROM for flexion of the knee would be 30 degrees due to pain.   ***Result***: Assign one 20-percent disability evaluation under [38 CFR 4.71a, DC 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=2dd5087eef182bbdf97785fdbb1c3381&node=se38.1.4_171a&rgn=div8) for limited flexion of the knee.  ***Explanation***: Flexion of the knee would be assessed at 30 degrees, as the ROM estimated in the *Mitchell* assessment is the most advantageous representation of the Veteran’s limitation of flexion.  ***Reference***: For more information on the *Deluca* and *Mitchell* cases, see M21-1, Part III, Subpart iv, 4.A.1.h. |

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| l. Inappropriate Situations for Using Functional Loss to Evaluate Musculoskeletal Conditions | Functional loss as discussed in [38 CFR 4.40](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_140&rgn=div8), [38 CFR 4.45](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_145&rgn=div8), and [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_159&rgn=div8) is not used to evaluate musculoskeletal conditions that do not involve ROM findings.  ***Example***: An evaluation under [38 CFR 4.71a, DC 5257](http://www.ecfr.gov/cgi-bin/text-idx?SID=2dd5087eef182bbdf97785fdbb1c3381&node=se38.1.4_171a&rgn=div8) for lateral knee instability does not involve ROM findings. Therefore, the functional loss provisions are inapplicable.  A finding of crepitus/joint crepitation alone is not sufficient to assign a compensable evaluation for a joint under [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_159&rgn=div8).  The regulation alludes to crepitus (a clinical sign of a crackling or grating feeling or sound in a joint) as indicative of a point of contact that is diseased but crepitus is not synonymous with painful motion, which is required for the application of [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_159&rgn=div8).  ***Reference***: For additional information on the historical application of [38 CFR 4.40](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_140&rgn=div8), and [38 CFR 4.45](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_145&rgn=div8) to evaluations for intervertebral disc syndrome **(**IVDS), refer to [VAOPGCPREC 36-1997](http://vbaw.vba.va.gov/bl/21/advisory/PRECOP/97op/Prc36_97.doc). |

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| **m. Example of Evaluating Joints with Arthritis by X-Ray Evidence Only with Other Joint(s) Affected by Non-arthritic Condition** | ***Example***:Veteran is rated 10 percent for bilateral arthritis of the elbows confirmed by x-ray evidence, without limited or painful motion or incapacitating exacerbations. Veteran subsequently files a claim for service connection (SC) for chondromalacia of the right knee and is awarded a 20-percent evaluation based on VA examination, which revealed limitation of flexion of the right knee to 30 degrees.  ***Analysis***: A 10-percent evaluation for bilateral arthritis of the elbows and a separate 20-percent evaluation for right knee chondromalacia is justified. In this case, the rating does not violate Note (1) under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), because the knee condition is not an arthritic condition.  ***Reference***: For additional information on ratings not permissible under Note (1) under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=fa97f8a169e2599f5b20e5743ae50517&mc=true&node=se38.1.4_171a&rgn=div8), see M21-1, Part III, Subpart iv, 4.A.8.d. |

**2. Evaluating Musculoskeletal Disabilities of the Upper Extremities**

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| Introduction | This topic contains information on evaluating musculoskeletal disabilities of the upper extremities, including   * considering separate evaluations for disabilities of the shoulder and arm * example of separate evaluations for disabilities of the shoulder and arm * assigning separate evaluations for disabilities of the elbow, forearm, and wrist * example of separate evaluations for multiple disabilities of the elbow, forearm, and wrist * considering impairment of supination and pronation of the forearm * identifying digits of the hand, and * rating Dupuytren’s contracture of the hand. |

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| Change Date | February 1, 2016 |

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| **a. Considering Separate Evaluations for Disabilities of the Shoulder and Arm** | Separate evaluations may be given for disabilities of the shoulder and arm under [38 CFR 4.71a DCs 5201, 5202, or 5203](http://www.ecfr.gov/cgi-bin/text-idx?SID=06267d0544c9650e626f1fe90192edac&node=se38.1.4_171a&rgn=div8) if the manifestations represent separate and distinct symptomatology that are neither duplicative nor overlapping.  ***Reference***: For additional information concerning separate and distinct symptomatology, refer to   * [38 CFR 4.14](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_114&rgn=div8), and * [*Esteban v. Brown*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bme), 6 Vet.App. 259 (1994). |

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| **b. Example of Separate Evaluations for Disabilities of the Shoulder and Arm** | ***Situation***: A Veteran was involved in an automobile accident that resulted in multiple injuries to the upper extremities. The Veteran sustained the following injuries   * a humeral fracture resulting in restriction of arm motion at shoulder level, and * a clavicular fracture resulting in malunion of the clavicle.   ***Result***:   * assign a 20-percent evaluation for the impairment of the humerus under [38 CFR 4.71a, DC 5202-5201](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8), and * assign a separate 10-percent evaluation for malunion of the clavicle under [38 CFR 4.71a, DC 5203](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8).   ***Notes***:   * The hyphenated evaluation DC is assigned under [38 CFR 4.71a, DC 5202-5201](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8) because the humerus impairment affects ROM. * The separate evaluation for the clavicle disability is warranted because this disability does not affect ROM.   ***Exception***: Multiple evaluations cannot be assigned under [38 CFR 4.71a, DC 5201](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8) for limited flexion and abduction of the shoulder.  ***Reference***: For additional information on evaluating shoulder conditions, see [*Yonek v. Shinseki*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmy)*,* 22 F.3d 1355 (Fed. Cir. 2013). |

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| **c. Assigning Separate Evaluations for Disabilities of the Elbow, Forearm, and Wrist** | Impairments of the elbow, forearm, and wrist will be assigned separate disability evaluations. The motions of these joints are all viewed as clinically separate and distinct. Assign separate evaluations for impairment under the following DCs.   * elbow flexion under [38 CFR 4.71a, DC 5206](http://www.ecfr.gov/cgi-bin/text-idx?SID=e946814d91c13a689fba4efddae34bc3&mc=true&node=se38.1.4_171a&rgn=div8) * elbow extension under [38 CFR 4.71a, DC 5207](http://www.ecfr.gov/cgi-bin/text-idx?SID=e946814d91c13a689fba4efddae34bc3&mc=true&node=se38.1.4_171a&rgn=div8) * forearm supination and pronation under [38 CFR 4.71a, DC 5213](http://www.ecfr.gov/cgi-bin/text-idx?SID=e946814d91c13a689fba4efddae34bc3&mc=true&node=se38.1.4_171a&rgn=div8), and * wrist flexion or ankylosis under [38 CFR 4.71a, DC 5214](http://www.ecfr.gov/cgi-bin/text-idx?SID=e946814d91c13a689fba4efddae34bc3&mc=true&node=se38.1.4_171a&rgn=div8) or [38 CFR 4.71a, DC 5215](http://www.ecfr.gov/cgi-bin/text-idx?SID=e946814d91c13a689fba4efddae34bc3&mc=true&node=se38.1.4_171a&rgn=div8).   ***Reference***: For additional information on assigning separate evaluations for elbow motion, see M21-1, Part III, Subpart iv. 4.A.1.a. |

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| **d. Example of Separate Evaluations for Disabilities of the Elbow, Forearm, and Wrist** | ***Situation***: A Veteran sustained multiple injuries to the right upper extremity in a vehicle rollover accident. The following impairments are due to the service-connected (SC) injuries   * elbow flexion limited to 90 degrees * elbow extension limited to 45 degrees * full ROM on supination and pronation with painful supination, and * full ROM of the wrist with pain on dorsiflexion.   ***Result***: Assign the following disability evaluations   * 20 percent for limited elbow flexion under [38 CFR 4.71a, DC 5206](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8) * 10 percent for limited elbow extension under [38 CFR 4.71a, DC 5207](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8) * 10 percent for painful forearm supination under [38 CFR 4.71a, DC 5213](http://www.ecfr.gov/cgi-bin/text-idx?SID=2dd5087eef182bbdf97785fdbb1c3381&node=se38.1.4_171a&rgn=div8), and * 10 percent for painful wrist motion under [38 CFR 4.71a, DC 5215](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8).   ***Explanation***:   * Compensable LOM of elbow flexion and extension is present. Separate evaluations are warranted for elbow flexion and extension. * Motion of the forearm is separate and distinct from elbow motion. Therefore, a separate evaluation is warranted for painful supination. * Motion of the wrist is separate and distinct from forearm motion. Therefore, a separate evaluation is warranted for painful motion of the wrist.   ***Note***: If elbow flexion is limited to 100 degrees and elbow extension is limited to 45 degrees, assign a single 20-percent disability evaluation under [38 CFR 4.71a, DC 5208](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8).  ***References***: For more information on   * separate evaluations for motion of a single joint, see * [VAOPGCPREC 9-2004](http://www.va.gov/ogc/docs/2004/PREC92004.doc), and * M21-1, Part III, Subpart iv, 4.A.1.a * separate evaluations for the elbow, forearm, and wrist, see M21-1, Part III, Subpart iv, 4.A.2.c * evaluating painful motion of a joint, see * [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_159&rgn=div8), and * M21-1, Part III, Subpart iv, 4.A.1.c, and * considering impairment of supination and pronation of the forearm, see M21-1, Part III, Subpart iv, 4.A.2.e. |

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| e. Considering Impairment of Supination and Pronation of the Forearm | When preparing rating decisions involving impairment of supination and pronation of the forearm, consider the following facts:   * Full pronation is the position of the hand flat on a table. * Full supination is the position of the hand palm up. * When examining limitation of pronation, the * arc is from full supination to full pronation, and * middle of the arc is the position of the hand, palm vertical to the table.   Assign the lowest, 20-percent evaluation when pronation cannot be accomplished through more than the first three-quarters of the arc from full supination.  Do *not* assign a compensable evaluation for both limitation of pronation and limitation of supination of the same extremity.  ***Reference***: For more information on painful motion, see   * [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_159&rgn=div8), and * M21-1, Part III, Subpart iv, 4.A.1.c. |

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| **f. Identifying Digits of the Hand** | Follow the guidelines listed below to accurately specify the injured digits of the hand.   * The digits of the hand are identified as * thumb * index * long * ring, or * little. * Do not use numerical designations for either the fingers or the joints of the fingers. * Each digit, except the thumb, includes three phalanges * the proximal phalanx (closest to the wrist) * the middle phalanx, and * the distal phalanx (closest to the tip of the finger). * The joint between the proximal and middle phalanges is called the ***proximal interphalangeal*** (PIP) joint. * The joint between the middle and distal phalanges is called the ***distal interphalangeal*** (DIP) joint. * The thumb has only two phalanges, the proximal phalanx and the distal phalanx. Therefore, each thumb has only a single joint, called the ***interphalangeal*** (IP) joint. * The joints connecting the phalanges in the hands to the metacarpals are the ***metacarpophalangeal*** (MCP) joints. * Designate either right or left for the digits of the hand.   ***Note***: If the location of the injury is unclear, obtain x-rays to clarify the exact point of injury.  ***Reference***: For more information on determining dominant handedness, refer to [38 CFR 4.69](http://www.ecfr.gov/cgi-bin/text-idx?SID=0d5268726d8c1566de1c1953d5a9c573&node=se38.1.4_169&rgn=div8). |

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| g. Rating Dupuytren’s Contracture of the Hand | The rating schedule for disabilities does not specifically list Dupuytren’s contracture as a disease entity; therefore, assign an evaluation on the basis of limitation of finger movement. |

#### 3. Evaluating Musculoskeletal Disabilities of the Spine and Lower Extremities

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| Introduction | This topic contains information on evaluating musculoskeletal disabilities of the spine and lower extremities, including   * evaluating manifestations of spine diseases and injuries * definition of incapacitating episode of IVDS * example of evaluating IVDS * evaluating ankylosing spondylitis * evaluating noncompensable knee conditions * separate evaluations for knee instability and LOM * separate evaluations – LOM and meniscus disabilities * separate evaluations, knee instability and meniscus disabilities * separate evaluations – genu recurvatum * evaluating shin splint * defining moderate and marked LOM of the ankle * considering ankle instability * evaluating plantar fasciitis, and * identifying the digits of the foot. |

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| a. Evaluating Manifestations of Spine Diseases and Injuries | Evaluate diseases and injuries of the spine based on the criteria listed in the [38 CFR 4.71a](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8), General Rating Formula for Diseases and Injuries of the Spine (General Rating Formula). Under this criteria, evaluate conditions based on chronic orthopedic manifestations (for example, painful muscle spasm or LOM) and any associated neurological manifestations (for example, footdrop, muscle atrophy, or sensory loss) by assigning separate evaluations for the orthopedic and neurological manifestations.  Evaluate IVDS under [38 CFR 4.71a, DC 5243](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8), either based on the General Rating Formula or the Formula for Rating IVDS Based on Incapacitating Episodes (Incapacitating Episode Formula), whichever formula results in the higher evaluation when all disabilities are combined under [38 CFR 4.25](http://www.ecfr.gov/cgi-bin/text-idx?SID=40fc1e088ec92f168f9d24242bd432e7&mc=true&node=se38.1.4_125&rgn=div8).  Variations of diagnostic terminology exist for IVDS. When used in the clinical setting, the following terminology is consistent with the general designation of IVDS:   * slipped or herniated disc * ruptured disc * prolapsed disc * bulging or protruded disc * degenerative disc disease * sciatica * discogenic pain syndrome * herniated nucleus pulposus, and * pinched nerve.   ***Notes***:   * When an SC thoracolumbar disability is present and objective neurological abnormalities or radiculopathy are diagnosed but the medical evidence does not identify a specific nerve root, rate the lower extremity radiculopathy under the sciatic nerve, [38 CFR 4.124a, DC 8520](http://www.ecfr.gov/cgi-bin/text-idx?SID=b563d2caeb25864bc9eba141a3d9f64e&node=se38.1.4_1124a&rgn=div8). * If an evaluation is assigned based on incapacitating episodes, a separate evaluation may not be assigned for LOM, radiculopathy, or any other associated objective neurological abnormality as it would constitute pyramiding. * Apply the previous provisions of [38 CFR 3.157 (b)](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part3/3_157.htm) (prior to March 24, 2015) when determining the effective date for neurological abnormalities of the spine that are identified by requisite records prior to March 24, 2015.   ***Example***: Veteran has been SC for degenerative disc disease (DDD) since 2012. Upon review of a claim for increase received on June 2, 2015, it is noted in VA medical records that the Veteran received treatment for bladder impairment secondary to DDD on July 7, 2014. Because the VA medical records constitute a claim for increase under rules in effect prior to March 24, 2015, it is permissible to apply previous rules from [38 CFR 3.157 (b)](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part3/3_157.htm) in adjudicating the bladder impairment issue.  ***References***: For more information on   * assigning disability evaluations for * peripheral nerve disabilities to include radiculopathy, see M21-1, Part III, Subpart iv, 4.G.4, and * progressive spinal muscular atrophy, see M21-1, Part III, Subpart iv, G.4.1.c, and * the historic application of [38 CFR 4.71a, DC 5285](http://www.gpo.gov/fdsys/pkg/CFR-2003-title38-vol1/pdf/CFR-2003-title38-vol1-part4.pdf), for demonstrable deformity of a vertebral body, refer to [VAOPGCPREC 03-2006](http://vbaw.vba.va.gov/bl/21/advisory/PRECOP/06op/pc0306.doc). |

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| **b. Definition: Incapacitating Episode of IVDS** | By definition, an incapacitating episode of IVDS requires bedrest prescribed by a physician.  In order to evaluate IVDS based on incapacitating episodes, there must be evidence the associated symptoms required bedrest as prescribed by a physician. The medical evidence of prescribed bedrest must be   * of record in the claims folder, ***or*** * reviewed and described by an examiner completing a Disability Benefits Questionnaire (DBQ).   ***Note***: If the records do not adequately document prescribed bedrest, use the General Rating Formula to evaluate IVDS and advise the Veteran to submit medical evidence documenting the periods of incapacitating episodes requiring bedrest prescribed by a physician. |

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| **c. Example of Evaluating IVDS** | ***Situation***: A Veteran’s IVDS is being evaluated.   * LOM warrants a 20-percent evaluation based under the general rating formula * mild radiculopathy of the left lower extremity warrants a 10-percent evaluation as a neurological complication, and * medical evidence shows incapacitating episodes requiring bedrest prescribed by a physician of four weeks duration over the past 12 months which would result in a 40-percent evaluation based on the incapacitating episode formula.   ***Result***: Assign a 40-percent evaluation based on incapacitating episodes.  ***Explanation***:   * Evaluating IVDS using incapacitating episodes results in the highest evaluation. * Since incapacitating episodes are used to evaluate IVDS, the associated LOM and neurological signs and symptoms will not be assigned a separate evaluation.   ***References***: For additional information on   * evaluating spinal conditions, see M21-1, Part III, Subpart iv, 4.A.3.a, and * determining whether evidence is sufficient to evaluate based on incapacitating episodes of IVDS, see M21-1, Part III, Subpart iv, 4.A.3.b. |

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| **d. Evaluating Ankylosing Spondylitis** | Ankylosing spondylitis may be evaluated as an active disease process or based upon LOM of the spine.  The following table describes appropriate action for evaluating ankylosing spondylitis. |

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| **If ankylosing spondylitis is...** | **Then ...** |
| an active process | evaluate under [38 CFR 4.71a, DC 5009](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8) (using the criteria in [38 CFR 4.71a, DC 5002](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8)). |
| inactive | * evaluate under [38 CFR 4.71a, DC 5240](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8) based on chronic residuals affecting the spine, and * separately evaluate other affected joints or body systems under the appropriate DC. |

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| **e. Evaluating Noncompensable Knee Conditions** | Evaluate a noncompensable knee condition by analogy to [38 CFR 4.71a, DC 5257](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8) if   * there is no associated arthritis * the schedular criteria for a noncompensable evaluation under [38 CFR 4.71a, DC 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8) or [DC 5261](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8) are not met, *and* * the condition cannot be appropriately evaluated under [38 CFR 4.71a, DC 5258, 5259, 5262, or 5263](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8).   ***References***: For more information on   * using analogous DCs, see [38 CFR 4.20](http://www.ecfr.gov/cgi-bin/text-idx?SID=a25f6b8117934a9ebee262b5ec0a0a60&mc=true&node=se38.1.4_120&rgn=div8), and * when to assign a zero-percent evaluation, see [38 CFR 4.31](http://www.ecfr.gov/cgi-bin/text-idx?SID=7cfdb4f1b10584057cd96f9f5c031c61&mc=true&node=se38.1.4_131&rgn=div8). |

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| f. Separate Evaluations for Knee Instability and LOM | A separate evaluation for knee instability may be assigned in addition to any evaluation(s) assigned based on limitation of knee motion. OGC has issued Precedent Opinions that an evaluation under [38 CFR 4.71a, DC 5257](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8), does not pyramid with evaluations based on LOM.  [38 CFR 4.71a, DC 5257](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8) refers to subluxation or lateral instability, but Veterans Benefits Administration (VBA) policy is that evaluations based on posterior or anterior instability are also permitted and do not pyramid with evaluations based on LOM.  ***Exception***: Do not rate instability separately from a total knee replacement.   * The 30-percent and 100-percent evaluations under [38 CFR 4.71a, DC 5055](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8), are minimum and maximum evaluations and, as such, encompass all identifiable residuals post knee replacement – including LOM, instability, and functional impairment. * The 60-percent and intermediate evaluations by their plain text provide the exclusive methods by which residuals can be evaluated at 40 or 50 percent and contemplate instability. * Post arthroplasty, there may be instability with weakness (giving way) and pain. * Note that the only way to obtain an evaluation in excess of 30 percent under [38 CFR 4.71a, DC 5262](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8) (one of the specified bases for an intermediate evaluation under [38 CFR 4.71a, DC 5055](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8)) is if there is nonunion with loose motion and need for a brace. This clearly suggests instability is incorporated in the intermediate criteria.   ***Important***: The rating activity must pay close attention to the combined evaluation of the knee disability prior to replacement surgery and to follow all required due process and protected evaluation procedures.  ***References***: For more information on   * pyramiding and separating individual decisions in a rating decision, see M21-1, Part III, Subpart iv, 6.C.5.d * separate evaluation of knee instability, see * [VAOPGCPREC 23-97](http://www.va.gov/ogc/docs/1997/Prc23-97.doc), and * [VAOPGCPREC 9-98](http://www.va.gov/ogc/docs/1998/prc09-98.doc), and * due process issues pertinent to knee replacements including * change of DC for a protected disability evaluation, see * [38 CFR 3.951](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=70df8a154d2bdffaab9f94956057a637&ty=HTML&h=L&r=SECTION&n=se38.1.3_1951) * M21-1, Part III, Subpart iv, 8.C.1.k, and * M21-1, Part IV, Subpart ii, 2.J.5, and * reduction procedures that would apply prior to assignment of a post-surgical minimum evaluation lower than the running award rate, see * [38 CFR 3.105(e)](http://www.ecfr.gov/cgi-bin/text-idx?SID=22d729945030468d25e7ca3d00baa10b&mc=true&node=se38.1.3_1105&rgn=div8) * M21-1, Part III, Subpart iv, 8.D.1. * M21-1, Part IV, Subpart ii, 3.A.3, and * M21-1, Part IV, Subpart ii, 2.J. |

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| g. Separate Evaluations – LOM and Meniscus Disabilities | Do not assign separate evaluations for   * a meniscus disability * [38 CFR 4.71a, DC 5258](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8) (dislocated semilunar cartilage), or * [38 CFR 4.71a, DC 5259](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8) (symptomatic removal of semilunar cartilage), ***and*** * LOM of the same knee * [38 CFR 4.71a, DC 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8), (limitation of flexion) or * [38 CFR 4.71a, DC 5261](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8), (limitation of extension).   ***Explanation***: LOM of the knee is contemplated by the meniscus DCs.   * Although [38 CFR 4.71a, DC 5258](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8), refers to “dislocated” cartilage and “locking” of the knee the rating criteria contemplate LOM of the knee through functional impairment with use (namely pain and effusion). * [38 CFR 4.71a, DC 5259](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8), provides for a compensable evaluation for a “symptomatic” knee post removal of the cartilage. [VAOPGCPREC 9-98](http://www.va.gov/ogc/docs/1998/prc09-98.doc) states “DC 5259 requires consideration of [38 CFR 4.40](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_140&rgn=div8) and [38 CFR 4.45](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=7d5d768c5632ab587b80f605fcd5dfb9&mc=true&r=SECTION&n=se38.1.4_145) because removal of semilunar cartilage may result in complications producing loss of motion.” |

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| h. Separate Evaluations, Knee Instability and Meniscus Disabilities | Do not assign separate evaluations for   * subluxation or lateral instability under [38 CFR 4.71a, DC 5257](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8), and * a meniscus disability * [38 CFR 4.71a, DC 5258](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8), or * [38 CFR 4.71a, DC 5259](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8)   ***Explanation***: The criteria for both of those codes contemplate instability.   * Dislocation and locking under [38 CFR 4.71a, DC 5258](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8) is consistent with instability. * The broad terminology of "symptomatic" under [38 CFR 4.71a, DC 5259](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8) also contemplates instability. * Medical EPSS notes that instability is common symptomatology associated with both of these disabilities. |

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| i. Separate Evaluations – Genu Recurvatum | When evaluating genu recurvatum, which involves hyperextension of the knee beyond 0 degrees of extension, under [38 CFR 4.71a, DC 5263](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8)   * do *not also* evaluate separately under [38 CFR 4.71a, DC 5261](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8), but * *do* evaluate separately under other evaluations *if* manifestations that are not overlapping, such as limitation of flexion under [38 CFR 4.71a, DC 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8), are attributed to genu recurvatum, and * do *not* evaluate separately under [38 CFR 4.71a, DC 5257](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8); however, if instability is manifested from genu recurvatum at the “moderate” or “severe” level, evaluate under [38 CFR 4.71a, DC 5263-5257](http://www.ecfr.gov/cgi-bin/text-idx?SID=0bd8cbf4ebf7f012b8415b710ea821da&mc=true&node=se38.1.4_171a&rgn=div8). |

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| **j. Evaluating Shin Splints** | Evaluate shin splints analogously with [38 CFR 4.71a, DC 5262](http://www.ecfr.gov/cgi-bin/text-idx?SID=e8fdbb668d97e82f2406bf2c4a1bc49f&node=se38.1.4_171a&rgn=div8). The table below explains the process and necessary considerations for evaluating shin splints. |

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| **Step** | **Action** |
| 1 | Is a chronic disability present?   * If *yes*, go to Step 2. * If *no*, deny SC. |
| 2 | * Determine whether the shin splint disability affects the right, left, or bilateral extremity(ies). * Go to Step 3. |
| 3 | * Determine whether shin splints affect the knee or the ankle. * Go to Step 4. |
| 4 | Has SC been established for a knee or ankle joint condition affecting the same joint as the shin splints?   * If *yes* * grant SC for the shin splints * assign a single evaluation for the symptoms of the shin splint condition with the symptoms caused by the other SC knee or ankle joint condition, and * evaluate the predominant symptoms under the most favorable DC(s) for that joint. * If the shin splints are the predominant disability, go to Step 5. * If the other SC disability of the knee or ankle joint is the predominant disability, evaluate under the criteria for the other SC disability and go to Step 6. * If *no* * award SC for the shin splints under [38 CFR 4.71a, DC 5299-5262](http://www.ecfr.gov/cgi-bin/text-idx?SID=e8fdbb668d97e82f2406bf2c4a1bc49f&node=se38.1.4_171a&rgn=div8), and * go to Step 5.   ***Note***: For all awards of SC for shin splints, in the DIAGNOSIS field in the Veterans Benefits Management System-- Rating **(**VBMS-R) indicate   * which side (right or left) is affected, and * whether there is knee or ankle involvement.   ***Example***: *shin splints, right lower extremity, with ankle impairment*. |
| 5 | * Access the Musculoskeletal - Other calculator within VBMS-R * Choose SHIN SPLINTS from diagnosis drop down. * Go to Step 6. |
| 6 | * Utilize information from the DBQ and/or other medical evidence of record to determine whether the associated knee or ankle symptoms are mild, moderate, or severe, and * choose the corresponding level of symptoms. |

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| k. Defining Moderate and Marked LOM of the Ankle | The following criteria are for application when evaluating LOM of the ankle under [38 CFR 4.71a, DC 5271](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8)   * Moderate limitation of ankle motion is present when there is * less than 15 degrees dorsiflexion, or * less than 30 degrees plantar flexion. * Marked LOM is demonstrated when there is * less than five degrees dorsiflexion, or * less than 10 degrees plantar flexion. |

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| **l. Considering Ankle Instability** | Do not assign separate evaluations for LOM and instability of the ankle.  DCs for the ankle, including [38 CFR 4.71a, DC 5271](http://www.ecfr.gov/cgi-bin/text-idx?SID=2375abdd93d9ea77dbeab85b13dc534b&node=se38.1.4_171a&rgn=div8) and [38 CFR 4.71a, DC 5262](http://www.ecfr.gov/cgi-bin/text-idx?SID=2375abdd93d9ea77dbeab85b13dc534b&node=se38.1.4_171a&rgn=div8), include broad language that does not explicitly include consideration of any particular ankle symptomatology. |

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| **m. Evaluating Plantar Fasciitis** | Evaluate plantar fasciitis analogous to pes planus, [38 CFR 4.71a, DC 5276](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0ba792d9e43f57d3adb80c97fde7df9&node=se38.1.4_171a&rgn=div8).  The most common symptom seen with plantar fasciitis is heel pain. The following considerations apply when evaluating the heel pain   * [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=2ec7350adee36049b3011df9cfd38f55&node=se38.1.4_159&rgn=div8) is not applicable because the heel is not a joint. * Heel pain is consistent with the criteria for a moderate disability under [38 CFR 4.71a, DC 5276](http://www.ecfr.gov/cgi-bin/text-idx?SID=2ec7350adee36049b3011df9cfd38f55&node=se38.1.4_171a&rgn=div8) based on pain on manipulation and use of the feet. * Moderate disability under [38 CFR 4.71a, DC 5276](http://www.ecfr.gov/cgi-bin/text-idx?SID=2ec7350adee36049b3011df9cfd38f55&node=se38.1.4_171a&rgn=div8) warrants assignment of a 10-percent evaluation for heel pain without application of [38 CFR 4.59](http://www.ecfr.gov/cgi-bin/text-idx?SID=2ec7350adee36049b3011df9cfd38f55&node=se38.1.4_159&rgn=div8).   ***Note***: When SC is established for pes planus and plantar fasciitis, evaluate the symptoms of both conditions together under [38 CFR 4.71a, DC 5276](http://www.ecfr.gov/cgi-bin/text-idx?SID=2ec7350adee36049b3011df9cfd38f55&node=se38.1.4_171a&rgn=div8). |

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| **n. Identifying the Digits of the Foot** | Follow the guidelines listed below to accurately specify the injured digits of the foot   * Refer to the digits of the foot as * first or great toe * second * third * fourth, or * fifth. * Each digit, except the great toe, includes three phalanges * the proximal phalanx (closest to the ankle) * the middle phalanx, and * the distal phalanx (closest to the tip of the toe). * The joint between the proximal and middle phalanges is called the ***proximal interphalangeal*** (PIP) joint. * The joint between the middle and distal phalanges is called the ***distal interphalangeal*** (DIP) joint. * The great toes each have only two phalanges, the proximal phalanx and the distal phalanx. Therefore, each great toe has only a single joint, called the ***interphalangeal*** (IP) joint. * The joints connecting the phalanges in the feet to the metatarsals are the ***metatarsophalangeal*** (MTP) joints. * Designate either right or left for the digits of the foot.   ***Note***: If the location of the injury is unclear, obtain x-rays to clarify the exact point of injury. |

#### 4. Congenital Musculoskeletal Conditions

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| Introduction | This topic contains information on congenital conditions, including   * recognizing variations in musculoskeletal development and appearance, and * considering notable congenital or developmental defects. |

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| Change Date | December 13, 2005 |

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| a. Recognizing Variations in Musculoskeletal Development and Appearance | Individuals vary greatly in their musculoskeletal development and appearance. Functional variations are often seen and can be attributed to   * the type of individual, and * his/her inherited or congenital variations from the normal. |

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| b. Considering Notable Congenital or Developmental Defects | Give careful attention to congenital or developmental defects such as   * absence of parts * subluxation (partial dislocation of a joint) * deformity or exostosis (bony overgrowth) of parts, and/or * accessory or supernumerary (in excess of the normal number) parts.   Note congenital defects of the spine, especially   * spondylolysis * spina bifida * unstable or exaggerated lumbosacral joints or angle, or * incomplete sacralization.   ***Notes***:   * Do not automatically classify spondylolisthesis as a congenital condition, although it is commonly associated with a congenital defect. * Do not overlook congenital diastasis of the rectus abdominus, hernia of the diaphragm, and the various myotonias.   ***Reference***: For more information on congenital or developmental defects, see [38 CFR 4.9](http://www.ecfr.gov/cgi-bin/text-idx?SID=2c0fdf993dcb4d21745677a20d577163&mc=true&node=se38.1.4_19&rgn=div8). |

#### 5. RA

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| Introduction | This topic contains information about RA, including   * characteristics of RA * periods of flares and remissions of RA * clinical signs of RA * radiologic changes found in RA * disability factors associated with RA, and * points to consider in rating decisions involving joints affected by RA. |

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| Change Date | May 11, 2015 |

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| a. Characteristics of RA | The following are characteristics of rheumatoid arthritis (RA), also diagnosed as atrophic or infectious arthritis, or arthritis deformans   * the onset * occurs before middle age, and * may be acute, with a febrile attack, and * the symptoms include a usually laterally symmetrical limitation of movement * first affecting PIP and MCP joints * next causing atrophy of muscles, deformities, contractures, subluxations, and * finally causing fibrous or bony ankylosis (abnormal adhesion of the bones of the joint).   ***Important***: Marie-Strumpell disease, also called rheumatoid spondylitis or ankylosing spondylitis, is *not* the same disease as RA. RA and Marie-Strumpell disease have separate and distinct clinical manifestations and progress differently.  ***Reference***: For more information on evaluating ankylosing spondylitis, see M21-1, Part III, Subpart iv, 4.A.3.d. |

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| b. Periods of Flares and Remissions of RA | The symptoms of RA come and go, depending on the degree of tissue inflammation. When body tissues are inflamed, the disease is active. When tissue inflammation subsides, the disease is inactive (in remission).  Remissions can occur spontaneously or with treatment, and can last weeks, months, or years. During remissions, symptoms of the disease disappear, and patients generally feel well. When the disease becomes active again (relapse), symptoms return.  ***Note***: The return of disease activity and symptoms is called a flare. The course of RA varies from patient to patient, and periods of flares and remissions are typical. |

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| c. Clinical Signs of RA | The table below contains information about the clinical signs of RA. |

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| Stage of Disease | Symptoms |
| Initial | * periarticular and articular swelling, often free fluid, with proliferation of the synovial membrane, and * atrophy of the muscles.   ***Note***: Atrophy is increased to wasting if the disease is unchecked. |
| Late | * deformities and contractures * subluxations, or * fibrous or bony ankylosis. |

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| d. Radiologic Changes Found in RA | The table below contains information about the radiologic changes found in RA. |

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| Stage of Disease | Radiologic Changes |
| Early | * slight diminished density of bone shadow, and * increased density of articular soft parts without bony or cartilaginous changes of articular ends.   ***Note***: RA and some other types of infectious arthritis do not require x-ray evidence of bone changes to substantiate the diagnosis, since x-rays do not always show their existence. |
| Late | * diminished density of bone shadow * loss of bone substance or articular ends, and * subluxation or ankylosis. |

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| e. Disability Factors Associated With RA | Give special attention to the following disability factors associated with RA in addition to, or in advance of, demonstrable x-ray changes:   * muscle spasms * periarticular and articular soft tissue changes, such as * synovial hypertrophy * flexion contracture deformities * joint effusion, and * destruction of articular cartilage, and * constitutional changes such as * emaciation * dryness of the eyes and mouth (Sjogren’s syndrome) * pulmonary complications, such as inflammation of the lining of the lungs or lung tissue * anemia * enlargement of the spleen * muscular and bone atrophy * skin complications, such as nodules around the elbows or fingers * gastrointestinal symptoms * circulatory changes * imbalance in water metabolism, or dehydration * vascular changes * cardiac involvement, including pericarditis * dry joints * low renal function * postural deformities, and * low-grade edema of the extremities.   ***Reference***: For more information on the features of RA, see <http://www.niams.nih.gov/Health_Info/Rheumatic_Disease/default.asp>. |

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| f. Points to Consider in Rating Decisions Involving Joints Affected by RA | In the DIAGNOSIS field of the rating decision, state which joints are affected by RA as evidenced by any of the following findings   * synovial hypertrophy or joint effusion * severe postural changes; scoliosis; flexion contracture deformities * ankylosis or LOM of joint due to bony changes, and/or * destruction of articular cartilage. |

#### 6. Degenerative Arthritis

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| Introduction | This topic contains information about degenerative arthritis, including   * characteristics of degenerative arthritis * diagnostic symptoms of degenerative arthritis * radiologic changes found in degenerative arthritis * symptoms of degenerative arthritis of the spine and pelvic joints, and * points to consider in the rating decision for degenerative and traumatic arthritis. |

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| Change Date | January 11, 2016 |

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| a. Characteristics of Degenerative Arthritis | The following are characteristics of degenerative arthritis, also diagnosed as osteoarthritis or hypertrophic arthritis.   * The onset generally occurs after the age of 45. * It has no relation to infection. * It is asymmetrical (more pronounced on one side of the body than the other). * There is limitation of movement in the late stages only. |

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| b. Diagnostic Symptoms of Degenerative Arthritis | Diagnostic symptoms of degenerative arthritis include   * the presence of Heberden’s nodes or calcific deposits in the terminal joints of the fingers with deformity * ankylosis, in rare cases * hyperostosis and irregular, notched articular surfaces of the joints * destruction of cartilage * bone eburnation, and * the formation of osteophytes.   ***Note***: The flexion contracture deformities and severe constitutional symptoms described under RA do not usually occur in degenerative arthritis. |

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| c. Radiologic Changes Found in Degenerative Arthritis | The table below contains information about the radiologic changes found in degenerative arthritis. |

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| Stage | Radiologic Changes |
| Early | delicate spicules of calcium at the articular margins without   * diminished density of bone shadow, and * increased density of articular of parts. |
| Late | * ridging of articular margins * hyperostosis * irregular, notched articular surfaces, and * ankylosis only in the spine. |

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| d. Symptoms of Degenerative Arthritis of the Spine and Pelvic Joints | Degenerative arthritis of the spine and pelvic joints is characterized clinically by the same general characteristics as arthritis of the major joints except that   * limitation of spine motion occurs early * chest expansion and costovertebral articulations are not usually affected * referred pain is commonly called “*intercostal neuralgia”* and “*sciatica*,” and * localized ankylosis may occur if spurs on bodies of vertebrae impinge. |

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| e. Points to Consider in the Rating Decision for Degenerative and Traumatic Arthritis | Degenerative and traumatic arthritis require x-ray evidence of bone changes to substantiate the diagnosis.  ***Note***: In evaluating arthritis of the spine, the principles for extending SC to joints affected by the subsequent development of degenerative arthritis (as contemplated under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=78d55d2ed5cf55f4d2955d08de7f2b52&mc=true&node=se38.1.4_171a&rgn=div8)), is not dependent on the choice of DC.  ***Example***: Veteran is SC for degenerative arthritis of the spine under [38 CFR 4.71a, DC 5242](http://www.ecfr.gov/cgi-bin/text-idx?SID=78d55d2ed5cf55f4d2955d08de7f2b52&mc=true&node=se38.1.4_171a&rgn=div8) and subsequently develops degenerative arthritis in the right elbow, with no intercurrent cause noted. In this case, the principles of extending SC to joints, as contemplated in [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=78d55d2ed5cf55f4d2955d08de7f2b52&mc=true&node=se38.1.4_171a&rgn=div8), also apply even though the Veteran is rated under [38 CFR 4.71a, DC 5242](http://www.ecfr.gov/cgi-bin/text-idx?SID=78d55d2ed5cf55f4d2955d08de7f2b52&mc=true&node=se38.1.4_171a&rgn=div8). Thus, SC for arthritis of the right elbow may be established.    ***Reference***: For more information on considering x-ray evidence when evaluating arthritis and non-specific joint pain, see   * [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=78d55d2ed5cf55f4d2955d08de7f2b52&mc=true&node=se38.1.4_171a&rgn=div8), and * M21-1, Part III, Subpart iv, 3.D.4.g. |

#### 7. LOM in Arthritis Cases

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| Introduction | This topic contains information on LOM due to arthritis, including   * joint conditions compensable under other DCs * joint conditions not compensable under other DCs * reference for rating decisions involving LOM * arthritis previously rated as a single disability * using DCs 5013 through 5024 in rating decisions, and * considering the effects of a change of diagnosis in arthritis cases. |

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| Change Date | January 11, 2016 |

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| a. Joint Conditions Compensable Under Other DCs | For a joint or group of joints affected by degenerative arthritis, use the DC which justifies the assigned evaluation.  ***Example***: When the requirements for compensable LOM of a joint are met under a DC other than [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8), hyphenate that DC in the conclusion with a preceding “5003*-*.” Then list the appropriate DC, such as [38 CFR 4.71a, DC 5261](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8), limited extension of the knee, 10 percent, creating the DC “5003-5261.”  ***Exception***: If other joints affected by arthritis are compensably evaluated in the same rating decision, use only the DC appropriate to these particular joints which supports the assigned evaluation and omit the modifying “5003.” |

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| b. Joint Conditions Not Compensable Under Other DCs | Whenever LOM due to arthritis is noncompensable under codes appropriate to a particular joint, assign 10 percent under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8) for each major joint or group of minor joints affected by limited or painful motion as prescribed under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8).  If there is no limited or painful motion, but there is x-ray evidence of degenerative arthritis, assign under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8) either a 10-percent evaluation or a 20-percent evaluation for occasional incapacitating exacerbations, based on the involvement of two or more major joints or two or more groups of minor joints.  ***Important***: Do *not* combine under [38 CFR 4.25](http://www.ecfr.gov/cgi-bin/text-idx?SID=40fc1e088ec92f168f9d24242bd432e7&mc=true&node=se38.1.4_125&rgn=div8) a 10- or 20-percent evaluation that is based solely on x-ray findings with evaluations that are based on limited or painful motion. See example in M21-1, Part III, Subpart iv, 4.A.8.d. |

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| c. Reference: Rating Decisions Involving LOM | For more information on rating decisions involving LOM, see M21-1, Part III, Subpart iv, 4.A.7. |

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| d. Arthritis Previously Rated as a Single Disability | The rating activity may encounter cases for which arthritis of multiple joints is rated as a single disability.  Use the information in the table below to process cases for which arthritis was previously evaluated as a single disability but the criteria for assignment of separate evaluations for affected joints was met at the time of the prior decision. |

|  |  |
| --- | --- |
| If … | Then … |
| * the separate evaluation of the arthritic disability results in no change in the combined degree previously assigned, and * a rating decision is required | reevaluate using the current procedure with the same effective date as previously assigned. |
| reevaluating the arthritic joint separately results in an increased combined evaluation | apply [38 CFR 3.105(a)](http://www.ecfr.gov/cgi-bin/text-idx?SID=92932f5845e33fcc776900678bb1dec3&mc=true&node=se38.1.3_1105&rgn=div8) to retroactively increase the assigned evaluation. |
| reevaluating the arthritic joint separately results in a reduced combined evaluation | * request an examination, and * if still appropriate, propose reduction under [38 CFR 3.105(a)](http://www.ecfr.gov/cgi-bin/text-idx?SID=92932f5845e33fcc776900678bb1dec3&mc=true&node=se38.1.3_1105&rgn=div8) and [38 CFR 3.105(e)](http://www.ecfr.gov/cgi-bin/text-idx?SID=92932f5845e33fcc776900678bb1dec3&mc=true&node=se38.1.3_1105&rgn=div8).   ***Exception***: Do not apply [38 CFR 3.105(a)](http://www.ecfr.gov/cgi-bin/text-idx?SID=92932f5845e33fcc776900678bb1dec3&mc=true&node=se38.1.3_1105&rgn=div8) if the assigned percentage is protected under [38 CFR 3.951](http://www.ecfr.gov/cgi-bin/text-idx?SID=f468c4d563a96e488587dc5a693b1846&mc=true&node=se38.1.3_1951&rgn=div8).  ***Reference***: For more information on protected rating decisions, see M21-1, Part III, Subpart iv, 8.C. |

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| e. Using DCs 5013 Through 5024 in Rating Decisions | Use the table below to evaluate cases that use [38 CFR 4.71a, DCs 5013 through 5024](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8). |

|  |  |
| --- | --- |
| If the DC of the case is … | Then … |
| gout under [38 CFR 4.71a, DC 5017](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8) | evaluate the case as RA, [38 CFR 4.71a, 5002](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8). |
| * [38 CFR 4.71a, 5013 through 5016](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8), and * [38 CFR 4.71a, DC 5018 through 5024](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8) | evaluate the case according to the criteria for limited motion or painful motion under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8), degenerative arthritis.  ***Note***: The provisions under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8), regarding a compensable minimum evaluation of 10 percent for limited or painful motion apply to these DCs and no others.  ***Reference***: For more information on evaluations of 10 and 20 percent based on x-ray findings, see [38 CFR 4.71a, DC 5003, Note (2)](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8). |

|  |  |
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| f. Considering the Effects of a Change in Diagnosis in Arthritis Cases | A change of diagnosis among the various types of arthritis, particularly if joint disease has been recognized as SC for several years, has no significant bearing on the question of SC.  ***Note***: In older individuals, the effects of more than one type of joint disease may coexist.  ***Reference***: For information on evaluating RA, see [38 CFR 4.71a, DC 5002](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8). |

**8. Examples of Rating Decisions for LOM in Arthritis Cases**

|  |  |
| --- | --- |
| Introduction | This exhibit contains four examples of rating decisions for LOM in arthritis cases including   * example of degenerative arthritis with separately compensable joints affected * example of degenerative arthritis evaluated based on x-ray evidence only * example of noncompensable degenerative arthritis of a single joint, and * example of degenerative arthritis evaluated based on x-ray evidence only and another compensable evaluation. |

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| a. Example of Degenerative Arthritis With Separately Compensable Joints Affected | ***Situation***: The Veteran has residuals of degenerative arthritis with limitation of abduction of the right shoulder (major) to 90 degrees and limitation of flexion of the right knee to 45 degrees. |

|  |  |
| --- | --- |
| *Coded Conclusion*: |  |
| 1. SC (VE INC) |  |
| 5003-5201 | Degenerative arthritis, right shoulder (dominant) |
| 20% from 12-14-03 |  |
|  |  |
| 5260 | Degenerative arthritis, right knee |
| 10% from 12-14-03 |  |
|  |  |
| COMB | 30% from 12-14-03 |

|  |
| --- |
| ***Rationale***: The shoulder and knee separately meet compensable requirements under [38 CFR 4.71a, DCs 5201](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8) and [38 CFR 4.71a, DC 5260](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8), respectively. |

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| --- | --- |
| b. Example of Degenerative Arthritis Evaluated Based on X-Ray Evidence Only | ***Situation***: The Veteran has x-ray evidence of degenerative arthritis of both knees without   * limited or painful motion of any of the affected joints, or * incapacitating episodes. |

|  |  |
| --- | --- |
| *Coded Conclusion*: |  |
| 1. SC (PTE INC) |  |
| 5003 | Degenerative arthritis of the knees, x-ray evidence |
| 10% from 12-30-01 |  |

|  |
| --- |
| ***Rationale***: There is no limited or painful motion in either joint, but there is x-ray evidence of arthritis in more than one joint to warrant a 10-percent evaluation under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8). |

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| c. Example of Noncompensable Degenerative Arthritis of a Single Joint | ***Situation***: The Veteran has x-ray evidence of degenerative arthritis of the right knee without limited or painful motion. |

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| *Coded Conclusion*: |  |
| 1. SC (PTE INC) |  |
| 5003 | Degenerative arthritis, right knee, x-ray evidence only |
| 0% from 12-30-01 |  |

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| --- |
| ***Rationale***: There is no limited or painful motion in the right knee or x-ray evidence of arthritis in more than one joint to warrant a compensable evaluation under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8). |

|  |  |
| --- | --- |
| **d. Example of Degenerative Arthritis Evaluated Based on X-Ray Evidence Only and Another Compensable Evaluation** | ***Situation***: The Veteran has x-ray evidence of degenerative arthritis of both knees without limited or painful motion or incapacitating exacerbations. The Veteran also has residuals of degenerative arthritis with limitation of abduction of the right shoulder (major) to 90 degrees. |

|  |  |
| --- | --- |
| *Coded Conclusion*: |  |
| 1. SC (VE INC) |  |
| 5003-5201 | Degenerative arthritis, right shoulder (dominant) |
| 20% from 12-14-03 |  |
|  |  |
| 5260 | Degenerative arthritis, right knee |
| 0% from 12-14-03 |  |
|  |  |
| 5260 | Degenerative arthritis, left knee |
| 0% from 12-14-03 |  |
|  |  |
| COMB | 20% from 12-14-03 |

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| --- |
| ***Rationale***: Since the shoulder condition meets compensable requirements under [38 CFR 4.71a, DCs 5201](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8), each knee condition must be evaluated under separate DCs. Based on Note (1) under [38 CFR 4.71a, DC 5003](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8), ratings of arthritis based on x-ray findings only (without limited or painful motion or incapacitating exacerbations) ***cannot*** be combined with ratings of arthritis based on limitation of motion. |

#### 9. Osteomyelitis

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| --- | --- |
| Introduction | This topic contains information about osteomyelitis, including   * requiring constitutional symptoms for assignment of a 100-percent or 60-percent evaluation under DC 5000 * historical evaluations for osteomyelitis * assigning historical evaluations for osteomyelitis * the reasons to discontinue a historical evaluation for osteomyelitis * assigning a 10-percent evaluation for active osteomyelitis, and * application of the amputation rule to evaluations for osteomyelitis. |

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| Change Date | May 11, 2015 |

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| a. Requiring Constitutional Symptoms for Assignment of a 100-Percent or 60-Percent Evaluation Under DC 5000 | Constitutional symptoms are a prerequisite to the assignment of either the 100-percent or 60-percent evaluations under [38 CFR 4.71a, DC 5000](http://www.ecfr.gov/cgi-bin/text-idx?SID=13bcad22732de2e24d3da7cad62932d5&node=se38.1.4_171a&rgn=div8).  Since both the 60- and 100-percent evaluations are based on constitutional symptoms, neither is subject to the amputation rule.  ***Reference***: For more information on the amputation rule, see [38 CFR 4.68](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_168&rgn=div8). |

|  |  |
| --- | --- |
| b. Historical Evaluations for Osteomyelitis | Both the 10-percent evaluation and that part of the 20-percent evaluation that is based on “other evidence of active infection within the last five years” are   * historical evaluations, and * based on recurrent episodes of osteomyelitis.   ***Note***: The 20-percent historical evaluation based on evidence of active infection within the past five years *must* be distinguished from the 20-percent evaluation authorized when there is a discharging sinus. |

|  |  |
| --- | --- |
| c. Assigning Historical Evaluations for Osteomyelitis | An initial episode of active osteomyelitis is *not* a basis for either of the historical evaluations.  Assign the historical evaluation as follows   * When the first *recurrent* episode of osteomyelitis is shown * assign a 20-percent historical evaluation, and * extend the evaluation for five years from the date of examination showing the osteomyelitis to be inactive. * Assign a closed evaluation at the expiration of the five-year extension. * Assign the 10-percent historical evaluation only if there have been two or more recurrences of active osteomyelitis following the initial infection. |

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| d. Reasons to Discontinue a Historical Evaluation for Osteomyelitis | Do *not* discontinue the historical evaluation, even if treatment includes saucerization, sequestrectomy, or guttering, because the osteomyelitis is not considered cured.  ***Exception***: If there has been removal or radical resection of the affected bone   * consider osteomyelitis cured, and * discontinue the historical evaluation. |

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| e. Assigning a 10-Percent Evaluation for Active Osteomyelitis | When the evaluation for amputation of an extremity or body part affected by osteomyelitis would be 0 percent, assign a 10-percent evaluation if there is active osteomyelitis.  ***References***: For more information on   * applying the amputation rule to evaluations for active osteomyelitis, see M21-1, Part III, Subpart iv, 4.A.9.f, and * evaluating osteomyelitis, see [38 CFR 4.71a, DC 5000](http://www.ecfr.gov/cgi-bin/text-idx?SID=b311fb502bb95064c304abc01770f498&node=se38.1.4_171a&rgn=div8). |

|  |  |
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| **f. Application of the Amputation Rule to Evaluations for Osteomyelitis** | Use the following table to determine how the amputation rule affects evaluations assigned for osteomyelitis. |

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| --- | --- |
| **If the osteomyelitis evaluation is...** | **Then the amputation rule...** |
| 10 percent based on active osteomyelitis of a body part where the amputation evaluation would normally be 0percent | does not apply. |
| * 10 percent based on active osteomyelitis of a body part where the amputation evaluation would normally be 0percent, or * 30 percent or less under [38 CFR 4.71a, DC 5000](http://www.ecfr.gov/cgi-bin/text-idx?SID=b311fb502bb95064c304abc01770f498&node=se38.1.4_171a&rgn=div8), *and* * the 10-percent evaluation is combined with evaluations for * ankylosis * limited motion * nonunion or malunion * shortening, or * other musculoskeletal impairment | applies to the combined evaluation. |
| 60 percent based on constitutional symptoms of osteomyelitis, per 38 [CFR 4.71a, DC 5000](http://www.ecfr.gov/cgi-bin/text-idx?SID=b311fb502bb95064c304abc01770f498&node=se38.1.4_171a&rgn=div8) | does not apply since the 60-percent evaluation is based on constitutional symptoms. |

|  |
| --- |
| ***Reference***: For more information on the amputation rule, see   * [38 CFR 4.68](http://www.ecfr.gov/cgi-bin/text-idx?SID=20e6c35d263fcb18012ae2dfcf3e5d46&node=se38.1.4_168&rgn=div8), and * M21-1 Part III, Subpart iv, 4.A.12.d. |

#### 10. Examples of the Proper Rating Procedure for Osteomyelitis

|  |  |
| --- | --- |
| Introduction | This exhibit contains eight examples of the proper procedure for rating osteomyelitis, including   * example of evaluating osteomyelitis based on a history of a single active initial episode * example of evaluating an active initial episode of osteomyelitis * example of evaluating osteomyelitis following review exam for initial active episode * example of evaluating osteomyelitis with current discharging sinus * example of evaluating osteomyelitis with a historical evaluation following a single recurrence with scheduled reduction due to inactivity * example of evaluating a recurrence of osteomyelitis * example of evaluating osteomyelitis following second recurrence, and * example of evaluating osteomyelitis following curative resection of affected bone. |

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| a. Example of Evaluating Osteomyelitis Based on a History of a Single Active Initial Episode | ***Situation***: The Veteran was diagnosed with osteomyelitis in service with discharging sinus. At separation from service the osteomyelitis was inactive with no involucrum or sequestrum. There is no evidence of recurrence.  ***Result***: As there has been no recurrence of active osteomyelitis following the initial episode in service, the historical evaluation of 20 percent is not for application. The requirements for a 20-percent evaluation based on activity are not met either. |

|  |  |
| --- | --- |
| *Coded Conclusion:* |  |
| 1. SC (PTE INC) |  |
| 5000 | Osteomyelitis, right tibia |
| 0% from 12-2-93 |  |

|  |  |
| --- | --- |
| b. Example of Evaluating an Active Initial Episode of Osteomyelitis | ***Situation***: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.a, but the Veteran had a discharging sinus at the time of separation from service.  ***Result***: The Veteran meets the criteria for a 20-percent evaluation based on a discharging sinus. Schedule a future examination to ascertain the date of inactivity. |

|  |  |
| --- | --- |
| *Coded Conclusion*: |  |
| 1. SC (PTE INC) |  |
| 5000 | Osteomyelitis, right tibia, active |
| 20% from 12-2-93 |  |

|  |  |
| --- | --- |
| c. Example of Evaluating Osteomyelitis Following Review Exam for Initial Active Episode | ***Situation***: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.b. Subsequent review examination reveals the sinus tract was healed and there is no other evidence of active infection.  ***Result***: Since the Veteran has not had a recurrent episode of osteomyelitis since service, a historical evaluation of 20 percent is not for application. Take rating action under [38 CFR 3.105(e)](http://www.ecfr.gov/cgi-bin/text-idx?SID=a18de443791ac76fbe390708ba1a3421&mc=true&node=se38.1.3_1105&rgn=div8). |

|  |  |
| --- | --- |
| *Coded Conclusion*: |  |
| 1. SC (PTE INC) |  |
| 5000 | Osteomyelitis, right tibia, inactive |
| 20% from 12-2-93 |  |
| 0% from 3-1-95 |  |

|  |  |
| --- | --- |
| d. Example of Evaluating Osteomyelitis With Current Discharging Sinus | ***Situation***: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.b. The Veteran is hospitalized July 2l, 1996, with active osteomyelitis of the right tibia shown with discharging sinus. There is no involucrum, sequestrum, or constitutional symptom. Upon release from the hospital the discharging sinus is still present.  ***Result***: Assign the 20-percent evaluation based on evidence showing draining sinus from the proper effective date. Schedule a future examination to ascertain date of inactivity. |

|  |  |
| --- | --- |
| *Coded Conclusion*: |  |
| 1. SC (PTE INC) |  |
| 5000 | Osteomyelitis, right tibia, active |
| 0% from 3-1-95 |  |
| 20% from 7-21-96 |  |

|  |  |
| --- | --- |
| e. Example of Evaluating Osteomyelitis With a Historical Evaluation Following a Single Recurrence With Scheduled Reduction Due to Inactivity | ***Situation***: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.d. A routine future examination was conducted on July 8, 1997, showing the osteomyelitis to be inactive. There was no discharging sinus, no involucrum, sequestrum, or constitutional symptom. The most recent episode of active osteomyelitis (July 21, 1996) constitutes the first “recurrent” episode of active osteomyelitis.  ***Result***: Continue the previously assigned 20-percent evaluation, which was awarded on the basis of discharging sinus as a historical evaluation for five years from the examination showing inactivity. |

|  |  |
| --- | --- |
| *Coded Conclusion*: |  |
| 1. SC (PTE INC) |  |
| 5000 | Osteomyelitis, right tibia, inactive |
| 20% from 7-21-96 |  |
| 0% from 7-8-02 |  |

|  |  |
| --- | --- |
| f. Example of Evaluating a Recurrence of Osteomyelitis | ***Situation***: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.e. In October 1999, the Veteran was again found to have active osteomyelitis with a discharging sinus, without involucrum, sequestrum, or constitutional symptoms.  ***Result***: Continue the 20-percent evaluation. Reevaluation is necessary to remove the future reduction to 0 percent, and to schedule a future examination to establish the date of inactivity. |

|  |  |
| --- | --- |
| *Coded Conclusion*: |  |
| 1. SC (PTE INC) |  |
| 5000 | Osteomyelitis, right tibia, active |
| 20% from 7-21-96 |  |

|  |  |
| --- | --- |
| g. Example of Evaluating Osteomyelitis Following Second Recurrence | ***Situation***: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.f. A review examination was conducted on April 8, 2000. The examination showed the discharging sinus was inactive, and there was no other evidence of active osteomyelitis. The most recent episode of osteomyelitis (October 1999) constitutes the second "recurrent" episode of active osteomyelitis.  ***Result***: The historical evaluations of 20 and 10 percent both apply. |

|  |  |
| --- | --- |
| *Coded Conclusion*: |  |
| 1. SC (PTE INC) |  |
| 5000 | Osteomyelitis, right tibia, inactive |
| 20% from 7-21-96 |  |
| 10% from 4-8-05 |  |

|  |  |
| --- | --- |
| h. Example of Evaluating Osteomyelitis Following Curative Resection of Affected Bone | ***Situation***: Same facts as example shown in M21-1, Part III, Subpart iv, 4.A.10.g. The Veteran was hospitalized June 10, 2002, with a recurrent episode of active osteomyelitis. A radical resection of the right tibia was performed and at hospital discharge (June 21, 2002), the osteomyelitis was shown to be cured.  ***Result***: Assign a temporary total evaluation of 100 percent under [38 CFR 4.30](http://www.ecfr.gov/cgi-bin/text-idx?SID=feb9a860a5cbd56b3cd419692f67becf&mc=true&node=se38.1.4_130&rgn=div8) with a 1-month period of convalescence. Following application of [38 CFR 3.105(e)](http://www.ecfr.gov/cgi-bin/text-idx?SID=a18de443791ac76fbe390708ba1a3421&mc=true&node=se38.1.3_1105&rgn=div8), reduce the evaluation for osteomyelitis to zero percent as an evaluation for osteomyelitis will not be applied following cure by removal or radical resection of the affected bone. |

|  |  |
| --- | --- |
| *Coded Conclusion*: |  |
| 1. SC (PTE INC) |  |
| 5000 | Osteomyelitis, right tibia, P.O. |
| 20% from 7-21-96 |  |
| 100% from 6-10-02 (Par. 30) |  |
| 20% from 8-1-02 |  |
| 0% from 10-1-02 |  |

#### 11. Muscle Injuries

|  |  |
| --- | --- |
| Introduction | This topic contains information about rating muscle injuries, including   * types of muscle injuries * standard muscle strength grading system for examinations * identification of muscle groups (MGs) in examination reports * general criteria for muscle evaluations * fractures associated with gunshot wound (GSW) and shell fragment wounds (SFW) * determining whether 38 CFR 4.55 applies to muscle injuries * applying 38 CFR 4.55 to muscle injuries * evaluating joint manifestations and muscle damage acting on the same joint * evaluating damage to multiple muscles within the same MG * considering peripheral nerve involvement in muscle injuries * evaluating muscle injuries with peripheral nerve conditions of different etiology * evaluating scars associated with muscle injuries, and * applying the amputation rule to muscle injuries. |

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| Change Date | May 11, 2015 |

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| **a. Types of Muscle Injuries** | A missile that penetrates the body results in two problems   * it destroys muscle tissue in its direct path by crushing it, then * the temporary cavitation forces stretch the tissues adjacent to the missile track and result in additional injury or destruction.   Muscles are much more severely disrupted if multiple penetrating projectiles strike in close proximity to each other. Examples of this type of injury are   * explosive device injuries * deforming or fragmenting rifle projectiles, or * any rifle projectile that strikes bone.   For additional information regarding types of injuries, the effects of explosions and projectiles, and symptoms and complications, refer to the following table. |

|  |  |  |
| --- | --- | --- |
| **Type of Injury** | **Initial Effects** | **Signs, Symptoms, and Complications** |
| gunshots | Entrance and exit wounds result. The amount of damage and relative size of entrance and exit wounds depends on many factors such as   * caliber of bullet * distance from victim * organs, bone, blood vessels, and other structures hit. | * Exit wounds are generally larger than entrance wounds, and * bullets are essentially sterile when they reach the body but carry particles into wound which could be sources of infection. |
| fragments from explosive devices | Most result in decreased tissue penetration compared to denser rifle bullets. | Multiple fragments in a localized area result in tissue disruption affecting a wide area. |
| tears and lacerations | Muscles that become isolated from nerve supply by lacerations will be non-functional. | * Torn muscle fibers heal with very dense scar tissue, but the nerve stimulation will not cross this barrier. * Parts of muscle isolated from the nerve will most likely remain non-contractile resulting in a strength deficit proportional to amount of muscle tissue disrupted. * Treatment for small tears is symptomatic. * Large tears/lacerations may require reconstruction. |
| through and through wound | Injuring instrument enters and exits the body. | Two wounds result   * entrance wound, and * exit wound. |

|  |
| --- |
| ***References***: For more information on   * muscle groups (MGs) and corresponding DCs, see [38 CFR 4.73](http://www.ecfr.gov/cgi-bin/text-idx?SID=016559808328edc689352a04140359bf&node=se38.1.4_173&rgn=div8) * anatomical regions of the body, see [38 CFR 4.55(b)](http://www.ecfr.gov/cgi-bin/text-idx?SID=016559808328edc689352a04140359bf&node=se38.1.4_155&rgn=div8), and * gunshot wounds (GSWs) with pleural cavity involvement, see [38 CFR 4.97, DC 6840-6845, Note (3)](http://www.ecfr.gov/cgi-bin/text-idx?SID=fac28fd48626614c9d2369ea61c7d14a&node=se38.1.4_197&rgn=div8). |

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| **b. Standard Muscle Strength Grading System for Examinations** | Refer to the following table for information about how muscle strength is evaluated on an examination. |

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| **Numeric Grade** | **Corresponding Strength Assessment** | **Indications on Exam** |
| (0) | absent | no contraction felt |
| (1) | trace | muscle can be felt to tighten but no movement is produced |
| (2) | poor | muscle movement is produced against gravity but cannot overcome resistance |
| (3) | fair | muscle movement is produced against gravity but cannot overcome resistance |
| (4) | good | muscle movement is produced against resistance, however, less than normal resistance |
| (5) | normal | muscle movement can overcome a normal resistance |

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| **c. Identification of MG in Examination Reports** | The examination report must include information to adequately identify the MG affected by either   * specifically noting which MG is affected, or * noting which muscles are involved so that the name of the muscles may be used to identify the MG affected. |

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| **d. General Criteria for Muscle Evaluations** | Evaluation of muscle disabilities is the result of a multi-factorial consideration. However, there are hallmark traits that are suggestive of certain corresponding evaluations. Refer to the following table for additional information regarding these hallmark traits and the suggested corresponding disability evaluation. |

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| **If the evidence shows a history of...** | **Then consider evaluating the muscle injury as...** |
| open comminuted fracture *with*   * muscle damage, or * tendon damage | severe.  ***Note***: This level of impairment is specified by regulation at [38 CFR 4.56(a)](http://www.ecfr.gov/cgi-bin/text-idx?SID=58c48f445b6cd16d9747462b22ebb5f6&node=se38.1.4_156&rgn=div8). |
| through and through or deep penetrating wound by small high velocity missile or large low velocity missile *with*   * debridement * prolonged infection, or * sloughing of soft parts, and * intermuscular scarring | at least moderately severe. |
| through and through injury *with muscle damage* | no less than moderate.  ***Note***: This level of impairment is specified by regulation at [38 CFR 4.56(b)](http://www.ecfr.gov/cgi-bin/text-idx?SID=58c48f445b6cd16d9747462b22ebb5f6&node=se38.1.4_156&rgn=div8). |
| retained fragments in muscle tissue | at least moderate. |
| deep penetrating wound *without*   * explosive effect of high velocity missile, * residuals of debridement, or * prolonged infection | at least moderate. |

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| ***Important***: No single factor is controlling for the assignment of a disability evaluation for a muscle injury. The entire evidence picture must be taken into consideration.  ***Reference***: For more information on assigning disability evaluations for muscle injuries, see   * [*Troph v. Nicholson*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmt), 20 Vet.App. 317 (2006) * [*Robertson v. Brown*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmr), 5 Vet.App. 70 (1993) * [*Jones v. Principi*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmm), 18 Vet.App. 248 (2004),and * [38 CFR 4.7](http://www.ecfr.gov/cgi-bin/text-idx?SID=5ea21f80cfce18234b1d683343e5345d&mc=true&node=se38.1.4_17&rgn=div8). |

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| **e. Fractures Associated With GSW/SFW** | All fractures associated with a GSW and/or shell fragment wound (SFW) will be considered open because all of them involve an opening to the outside. Most GSW/SFW fractures are also comminuted due to the shattering nature of the injury. |

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| **f. Determining Whether 38 CFR 4.55 Applies to Muscle Injuries** | [38 CFR 4.55](http://www.ecfr.gov/cgi-bin/text-idx?SID=dfe9837fdb70e234eb6088450d0c7320&node=se38.1.4_155&rgn=div8) applies to certain combinations of muscle injuries and joint conditions. Consider the provisions of [38 CFR 4.55](http://www.ecfr.gov/cgi-bin/text-idx?SID=dfe9837fdb70e234eb6088450d0c7320&node=se38.1.4_155&rgn=div8) if   * there are multiple MGs involved * the MG acts on a joint or joints, and/or * there is peripheral nerve damage to the same body part affected by the muscle. |

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| **g. Applying 38 CFR 4.55 to Muscle Injuries** | If more than one MG is injured or affected or if the injured MG acts on a joint, conduct a preliminary review of the evidence to gather information needed to properly apply the provisions of [38 CFR 4.55](http://www.ecfr.gov/cgi-bin/text-idx?SID=dfe9837fdb70e234eb6088450d0c7320&node=se38.1.4_155&rgn=div8). The information needed will include   * whether the affected MGs are in the same or different anatomic regions * whether the MGs are acting on a single joint or multiple joints, and * whether the joint or joints is/are ankylosed.   After the preliminary review is complete, use the evidence gathered and apply the following table to determine how [38 CFR 4.55](http://www.ecfr.gov/cgi-bin/text-idx?SID=dfe9837fdb70e234eb6088450d0c7320&node=se38.1.4_155&rgn=div8) affects the evaluation of the muscle injury. |

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| **Step** | **Action** |
| 1 | Does the MG(s) act on an ankylosed joint?   * If *yes*, go to Step 2. * If *no*, go to Step 4 |
| 2 | For MG(s) that act on an ankylosed joint, is the joint an ankylosed knee *and* is MG XIII disabled?   * If *yes*, grant separate evaluations for the ankylosed knee and the MG XIII injury. For the MG XIII injury, assign the next lower level than that which would otherwise be assigned. Then go to Step 3. * If *no*, then is the ankylosed joint the shoulder *and* are MGs I and II *severely* disabled? * If *yes*, then assign a single evaluation for the muscle injury and the shoulder ankylosis under DC 5200. The evaluation will be at the level of unfavorable ankylosis. * If *no*, then no evaluation will be assigned for the muscle injury. The combined disability arising from the ankylosis and the muscle injury will be evaluated as ankylosis. |
| 3 | For the injury to MG XIII with an associated ankylosed knee, are there other MG injuries in the same anatomical region affecting the pelvic girdle and/or thigh?   * If *no*, then no additional change to the evaluation for the muscle injury is warranted. * If *yes*, do the affected MG injuries act on the ankylosed knee? * If *yes*, then no separate evaluation for the muscle injury to a MG other than MG XIII can be assigned, as indicated in Step 2. * If *no*, then for the MG XIII injury that acts on the knee and the injury to another MG of the pelvic girdle and thigh acting on a different joint, is the different joint ankylosed? * If *yes*, then no separate evaluation can be assigned for the other MG injury of the pelvic girdle and thigh, as indicated in Step 2. No further action is warranted. * If *no*, then assign a single evaluation for the MG XIII injury and the injury to the other MG of the pelvic girdle and thigh anatomical region by determining the most severely injured MG and increasing by one level. |
| 4 | * For muscle injury(ies) acting on unankylosed joint(s), is a single MG injury involved? * If *yes*, then grant a single evaluation for the muscle injury. * If *no*, then are the MG injuries in the same anatomical region? * If *yes*, go to Step 5. * If *no*, go to Step 6 |
| 5 | Do the MGs in the same anatomical region act on a single joint?   * If yes, are the MGs involved MG I and II acting on a shoulder joint? * If *yes*, then * assign separate disability evaluations for the MGs, but * the combined evaluation cannot exceed the evaluation for unfavorable ankylosis of the shoulder. * If *no*, then for the muscles in the same anatomical region acting on a single joint, * assign separate disability evaluations for the MGs, but * the combined evaluation must be less than the evaluation that would be normally assigned for unfavorable anklyosis of the joint involved. * If *no*, for the MGs in the same anatomical region acting on different joints, are the MG injuries compensable? * If *yes*, then assign a single disability evaluation for the affected MGs by * determining the evaluation for the most severely injured MG, and * increasing by one level and using as the combined evaluation. * If *no*, then assign a noncompensable evaluation for the combined MG injuries. |
| 6 | For MG injuries in different anatomical areas, is a single unankylosed joint affected?   * If *yes*, are MG I and II affected and acting upon the shoulder? * If *yes*, then * assign separate disability evaluations for the muscle injuries, but * the combined evaluation cannot exceed the evaluation for unfavorable ankylosis of the shoulder. * If *no*, for the MG injuries in different anatomical areas affecting a single unankylosed joint (not including MG I and II acting on the shoulder) * assign separate disability evaluations for the muscle injuries, but * the combined evaluation must be lower than the evaluation that would be assigned for unfavorable ankylosis of the affected joint. * If *no*, then for MG injuries in different anatomical areas acting on different unankylosed joints, assign separate disability evaluations for each MG injury. |

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| ***References***: For additional information on   * evaluating joint manifestations and muscle damage acting on the same joint, see M21-1, Part III, Subpart iv, 4.A.11.h, and * evaluating peripheral nerve involvement in muscle injuries, see M21-1 Part III, Subpart iv, 4.A.11.j. |

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| **h. Evaluating Joint Manifestations and Muscle Damage Acting on the Same Joint** | A separate evaluation for joint manifestations and muscle damage acting on the same joint are prohibited if both conditions result in the same symptoms.  Although LOM is not directly discussed in [38 CFR 4.56](http://www.ecfr.gov/cgi-bin/text-idx?SID=cbcf4a87e1bca06ca12cebf47eece30e&node=se38.1.4_156&rgn=div8http://www.ecfr.gov/cgi-bin/text-idx?SID=cbcf4a87e1bca06ca12cebf47eece30e&node=se38.1.4_156&rgn=div8), the DC provisions within [38 CFR 4.73](http://www.ecfr.gov/cgi-bin/text-idx?SID=cbcf4a87e1bca06ca12cebf47eece30e&node=se38.1.4_173&rgn=div8) describing the functions of various MGs are describing motion.   * The muscles move the joint. * If the joint manifestation is LOM, that manifestation is already compensated through the evaluation assigned by a muscle rating decision. * Evaluating the same symptoms under multiple DCs is prohibited by [38 CFR 4.14](http://www.ecfr.gov/cgi-bin/text-idx?SID=70df8a154d2bdffaab9f94956057a637&node=se38.1.4_114&rgn=div8).   ***Note***: Consider the degree of disability under the corresponding muscle DC and joint DC and assign the higher evaluation.  ***Exception***: Per [38 CFR 4.55(c)(1)](http://www.ecfr.gov/cgi-bin/text-idx?SID=cbc3aa622e44ec12918333696ffb3bff&node=se38.1.4_155&rgn=div8), if MG XIII is disabled and acts on an ankylosed knee, separate disability evaluations can be assigned for the muscle injury and the knee ankylosis. However, the evaluation for the MG injury will be rated at the next lower level than that which would have otherwise been assigned.  ***Reference***: For additional information concerning evaluating muscle injuries and joint conditions, see M21-1, Part III, Subpart iv, 4.A.11.f-g. |

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| **i. Evaluating Damage to Multiple Muscles Within the Same MG** | A separate evaluation cannot be assigned for each muscle within a single MG. Muscle damage to any of the muscles within the group must be included in a single evaluation assigned for the MG. |

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| **j. Considering Peripheral Nerve Involvement in Muscle Injuries** | When there is nerve damage associated with the muscle injury, use the following table to determine appropriate actions to take to evaluate the nerve damage and the muscle injury. |

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| **If ...** | **Then ...** |
| * the nerve damage is in the same body part as the muscle injury, *and* * the muscle injury and the nerve damage affect the same functions of the affected body part | assign a single evaluation for the combined impairment by determining whether the nerve code or the muscle code will result in a higher evaluation. Assign the higher evaluation.  ***Note***: If the muscle and nerve evaluations are equal, evaluate with the DC with the highest maximum evaluation available. |
| * the nerve damage is in the same body part as the muscle injury, *and* * the muscle injury and the nerve damage affect entirely different functions of the affected body part | assign separate evaluations for the nerve damage and the muscle injury. |

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| **k. Evaluating Muscle Injuries with Peripheral Nerve Conditions of Different Etiology** | The provisions of [38 CFR 4.55](http://www.ecfr.gov/cgi-bin/text-idx?SID=dfe9837fdb70e234eb6088450d0c7320&node=se38.1.4_155&rgn=div8) preclude the combining of a muscle injury evaluation with a peripheral nerve paralysis evaluation involving the same body part when the same functions are affected. A muscle injury and a peripheral nerve paralysis of the same body part, originating from separate etiologies, may not be rated separately.   * The exception to this rule is only when entirely different functions are affected. * Etiology of the disability is irrelevant in rendering a determination regarding combining evaluations for muscle injuries and peripheral nerve paralysis.   ***Example***: A Veteran is SC for GSW to the right leg MG XI at 10 percent. He develops SC diabetic peripheral neuropathy many years later. The peripheral neuropathy affects the external popliteal nerve. Since MG XI and the external popliteal nerve both control the same functions, dorsiflexion of the foot and extension of the toes, only a single disability evaluation can be assigned under either [38 CFR 4.73, DC 5311](http://www.ecfr.gov/cgi-bin/text-idx?SID=174c60495ce1e9c0d4884c37335612a8&node=se38.1.4_173&rgn=div8) or [38 CFR 4.73, DC 8521](http://www.ecfr.gov/cgi-bin/text-idx?SID=174c60495ce1e9c0d4884c37335612a8&node=se38.1.4_173&rgn=div8), whichever is more advantageous. |

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| **l. Evaluating Scars Associated With Muscle Injuries** | Use the following table to determine appropriate action to take when evaluating scars associated with muscle injuries. |

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| **If ...** | **Then ...** |
| there is scarring associated with the muscle injury | assign a separate evaluation for the scar, even if noncompensable. |
| there is painful or unstable scarring associated with the muscle injury | assign a separate compensable disability evaluation under [38 CFR 4.118, DC 7804](http://www.ecfr.gov/cgi-bin/text-idx?SID=8fa6724d3188ec09c13ff6af41f7cf4c&node=se38.1.4_1118&rgn=div8). |
| there is scarring that results in functional loss under [38 CFR 4.118, DC 7805](http://www.ecfr.gov/cgi-bin/text-idx?SID=8fa6724d3188ec09c13ff6af41f7cf4c&node=se38.1.4_1118&rgn=div8) that is compensable | do not assign a separate evaluation if the body part affected and the functional impairment resulting from the scar are the same as the part and function affected by the muscle injury. |

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| ***Reference***: For more information on assigning separate evaluations for the muscle injury and associated scarring, see   * [*Esteban v. Brown*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bme), 6 Vet.App. 259 (1994) * [*Jones v. Principi*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmj), 18 Vet.App. 248 (2004), and * [38 CFR 4.14](http://www.ecfr.gov/cgi-bin/text-idx?SID=79ee3fbf439e8c4e6ee385ec809fbab9&node=se38.1.4_114&rgn=div8). |

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| **m. Applying the Amputation Rule to Muscle Injuries** | The amputation rule applies to musculoskeletal conditions and any associated peripheral nerve injuries. Therefore, when assigning separate evaluations for the muscle injury, peripheral nerve injury directly related to that muscle injury must be considered in applying the amputation rule.  ***References***: For more information on   * the amputation rule, see [38 CFR 4.68](http://www.ecfr.gov/cgi-bin/text-idx?SID=3dcf139a08f4220f1b663624863f4c46&node=se38.1.4_168&rgn=div8), and * evaluating peripheral nerve disabilities associated with muscle injuries, see M21-1, Part III, Subpart iv, 4.A.11.j. |

#### 12. Miscellaneous Musculoskeletal Considerations

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| Introduction | This topic contains general guidance on evaluating musculoskeletal conditions, including   * SC for fractures * SC for osteopenia * evaluating fibromyalgia * applying the amputation rule, and * considering conflicting decisions regarding loss of use (LOU) of an extremity. |

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| Change Date | February 1, 2016 |

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| a. SC for Fractures | Decision makers must not automatically award SC for fracture or fracture residuals based on a mere service treatment record (STR) reference to a fracture.   * Where SC of a fracture or fracture residuals is *claimed*, SC will be established when sufficient evidence, such as x-rays, a surgical report, casting, or a physical evaluation board report, documents the fracture. * If SC of a fracture has not been claimed and objective evidence such as x-ray report documents an in-service fracture, invite a claim for SC for the fracture.   The following considerations apply when granting SC for a fracture:   * SC will be established for a healed fracture even without current residual limited motion or functional impairment of a joint. * Assign a DC consistent with the location of the fracture. The fracture will be rated as noncompensable in the absence of any disabling manifestations.   ***Reference***: For more information about unclaimed chronic disabilities found in STRs, see M21-1, Part IV, Subpart ii, 2.A.1.a and f. |

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| **b. SC for Osteopenia** | Osteopenia is clinically defined as mild bone density loss that is often associated with the normal aging process. Low bone density does not necessarily mean that an individual is losing bone, as this may be a normal variant.  Osteopenia is comparable to a laboratory finding which is not subject to SC compensation.  Use the following table to determine the appropriate action to take when SC for osteopenia has been granted. |

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| **If ...** | **Then ...** |
| SC for osteopenia was granted by rating decision dated *prior to* December 19, 2013 (the date on which guidance was issued to clarify the proper procedures for considering SC for osteopenia) | * do not sever SC, as it was properly established based on guidance available at the time the decision was made, * do not reduce the previously assigned evaluation unless the condition has improved, and * consider claims for increased evaluation and schedule examination as warranted based on the facts of the case.   ***Note***: Provisions of [38 CFR 3.951](http://www.ecfr.gov/cgi-bin/text-idx?SID=5d7de5e656ff0106cfa08aac437b09ea&node=se38.1.3_1951&rgn=div8) and [38 CFR 3.957](http://www.ecfr.gov/cgi-bin/text-idx?SID=6a17e9b586e8acade155c1b03f427778&node=se38.1.3_1957&rgn=div8) regarding protection of SC remain applicable. |
| SC for osteopenia was granted by rating decision dated *on or* *after* December 19, 2013 | propose to sever SC based on a finding of clear and unmistakable error (CUE). |

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| ***Note***: Osteoporosis, in contrast to osteopenia, is considered a disease entity characterized by severe bone loss that may interfere with mechanical support, structure, and function of the bone. SC for osteoporosis under [38 CFR 4.71a DC 5013](http://www.ecfr.gov/cgi-bin/text-idx?SID=bb3684f1b5f15390c87a9d0a6b45dffc&node=se38.1.4_171a&rgn=div8) is warranted when the requirements are otherwise met. |

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| **c. Evaluating Fibromyalgia** | The criteria for evaluation of fibromyalgia under [38 CFR 4.71a, DC 5025](http://www.ecfr.gov/cgi-bin/text-idx?SID=c91c526668ff77d740cdc2572fcd55e5&node=se38.1.4_171a&rgn=div8) does not exclude assignment of separate evaluations when disabilities are diagnosed secondary to fibromyalgia. This includes, but is not limited to, disability diagnoses for which symptoms are included in the evaluation criteria under [38 CFR 4.71a, DC 5025](http://www.ecfr.gov/cgi-bin/text-idx?SID=c91c526668ff77d740cdc2572fcd55e5&node=se38.1.4_171a&rgn=div8), such as   * depression * anxiety * headache, and * irritable bowel syndrome.   ***Notes***:   * If signs and symptoms are not sufficient to warrant a diagnosis of a separate condition, then they are evaluated with the musculoskeletal pain and tender points under [38 CFR 4.71a, DC 5025](http://www.ecfr.gov/cgi-bin/text-idx?SID=c91c526668ff77d740cdc2572fcd55e5&node=se38.1.4_171a&rgn=div8). * The same signs and symptoms cannot be used to assign separate evaluations under different DCs, per [38 CFR 4.14](http://www.ecfr.gov/cgi-bin/text-idx?SID=c91c526668ff77d740cdc2572fcd55e5&node=se38.1.4_114&rgn=div8).   ***Reference***: For more information on evaluating chronic pain syndrome (somatic symptom disorder), see M21-1, Part III, Subpart iv, 4.H.1.j. |

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| **d. Applying the Amputation Rule** | The combined evaluation for disabilities of an extremity shall not exceed the evaluation for the amputation at the elective level, were amputation to be performed. The amputation rule is included in the musculoskeletal section of the rating schedule and, consequently, applies only to musculoskeletal disabilities and not to disabilities affecting other body systems.  ***Exceptions***:   * Any peripheral nerve injury associated with the musculoskeletal injury will be considered when applying the amputation rule. * Actual amputation with associated painful neuroma will be evaluated at the next-higher site of elective reamputation.   ***Note***: The amputation rule does not apply to bilateral evaluations under DCs 5276 to 5279.  ***References***: For more information on the   * amputation rule, see * [38 CFR 4.68](http://www.ecfr.gov/cgi-bin/text-idx?SID=f69019960cbee531ea8c3733895b301c&mc=true&node=se38.1.4_168&rgn=div8), and * [*Moyer v. Derwinski*](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bmm), 2 Vet.App. 289 (1992) * application of the amputation rule to rating decisions for osteomyelitis, see M21-1, Part III, Subpart iv, 4.A.9.f * application of the amputation rule to rating decisions for muscle injuries, see M21-1, Part III, Subpart iv, 4.A.11.m, and * VBMS-R amputation rule instructions, see the [VBMS-R Job Aid](http://vbaw.vba.va.gov/VBMS/docs/VBMS_Job_Aid_Amputation_Rule_Job_Aid_082613_v_5_0.pdf). |

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| e. Considering Conflicting Decisions Regarding LOU of an Extremity | Forward the claims folder to the Director, Compensation Service (211B), for an advisory opinion under M21-1, Part III, Subpart vi, 1.A.2.a to resolve a conflict if   * the Insurance Center determines LOU of two extremities prior to rating consideration involving the same issue, and * the determination conflicts with the proposed rating decision.   ***Note***: This issue will generally be brought to the attention of the rating activity as a result of the type of personal injury, correspondence, or some indication in the claims folder that the insurance activity is involved. |