

the case of spine disabilities, it would be rare for pain not to be present. Pain is often the primary factor limiting motion, for example, and is almost always present when there is muscle spasm. Therefore, the evaluation criteria provided are meant to encompass and take into account the presence of pain, stiffness, or aching, which are generally present when there is a disability of the spine.

The prior schedule directed that a vertebral fracture that did not meet the criteria for a 60-percent or higher evaluation would be evaluated on the basis of limited motion or muscle spasm, with 10 percent added for demonstrable vertebral body deformity. Since the term "demonstrable deformity" was not defined, however, this provision was applied inconsistently. We proposed that a 10-percent evaluation be assigned for a vertebral body fracture with loss of 50 percent or more of the height. One commenter felt that this requirement was too stringent.

As we reported in the preamble to the proposed regulation, a recent medical textbook on disability evaluation states that vertebral fractures with loss of height of the vertebral body of 50-percent or less ordinarily do not require surgery, heal uneventfully, and are compatible with the resumption of normal activities after healing ("Disability Evaluation," 292–3 (Stephen L. Demeter, M.D., Gunnar B.J. Anderson, M.D., Ph.D., and George M. Smith, M.D., 1996)). Furthermore, should a vertebral body fracture with less than 50 percent loss of height prove to be disabling, it may be evaluated based on any specific disabling residuals that are present, such as pain or limitation of motion. In our judgment, the requirement that there be a loss of 50 percent or more of the height of a fractured vertebral body in order to assign a 10-percent evaluation based on deformity alone has a sound medical basis and will promote consistency, and we have made no change based on this comment.

One commenter felt that it is confusing and illogical to list the evaluation criteria for diagnostic codes 5235 to 5242 after diagnostic code 5243. In response, we have moved the General Rating Formula for Diseases and Injuries of the Spine to the beginning of the Spine subsection. For further clarity, we have added the title "Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes" to the set of evaluation criteria under diagnostic code 5243 and explained that intervertebral disc syndrome may be evaluated under either rating formula,

depending on which is more beneficial to the veteran. All other spine diseases and injuries will be evaluated under the General Rating Formula for Diseases and Injuries of the Spine.

We proposed that the language under diagnostic code 5243 be: "Evaluate intervertebral disc syndrome (preoperatively or postoperatively) either on the total duration of incapacitating episodes over the past 12 months or by combining under § 4.25 evaluations under the General Rating Formula for Diseases and Injuries of the Spine along with evaluations for all other disabilities, whichever method results in the higher evaluation." A commenter felt that the proposed language was confusing and suggested that we revise it.

We agree that the language could be clearer and have revised it to read: "Evaluate intervertebral disc syndrome (preoperatively or postoperatively) either under the General Rating Formula for Diseases and Injuries of the Spine or under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes, whichever method results in the higher evaluation when all disabilities are combined under § 4.25."

One commenter felt that painful motion, even if the range of motion is normal, should be one of the criteria for a 10-percent evaluation because usually any limitation of motion is due to pain, and we usually give 10 percent for pain on motion, under §§ 4.45 (The joints) and 4.59 (Painful motion).

As discussed above, we developed evaluation criteria that are meant to take pain and other symptoms into account. Therefore, an evaluation based on pain alone would not be appropriate, unless there is specific nerve root pain, for example, that could be evaluated under the neurologic sections of the rating schedule.

The same commenter said there is no need for criteria for a zero-percent evaluation, since § 4.31 (Zero percent evaluations) states that a zero percent evaluation can be assigned in any case when the requirements for a compensable evaluation are not met. On further consideration, and in view of other changes we have made in the General Rating Formula, we agree and have removed the zero-percent criteria.

The commenter also suggested that we add diagnostic codes for piriformis syndrome, mechanical back pain due to poor posture, and neck strain to the rating schedule.

Piriformis syndrome, often called pseudosciatica, is characterized by sciatica-like pain. It is regarded as a pain syndrome or a functional

syndrome because there is no demonstrable pathology to account for the symptoms. It is a controversial diagnosis because there is no agreement on how to diagnose it, and there is no way to confirm the diagnosis by testing. We have not added this to the rating schedule because its diagnosis is controversial and uncertain.

Section 4.40 indicates that functional loss of the musculoskeletal system may be due to pain when it is supported by adequate pathology. The diagnosis of mechanical back pain is a broad general diagnosis that does not identify an underlying pathologic process to account for the pain. Most mechanical back pain (70%) is due to lumbar strain or sprain, with 10% due to degenerative changes in discs and facets, 4% due to herniated discs, 4% due to osteoporotic compression fractures, and 3% due to spinal stenosis. (<http://www.emedicine.com/pmr/topic73.htm>). Examiners should be asked to identify the underlying pathologic process causing back pain, and evaluations can then be made under the appropriate diagnostic codes for spine disabilities that are listed in the rating schedule.

We agree that neck strain is a common disability in veterans and have therefore revised the title of diagnostic code 5237 to "Lumbosacral or cervical strain". We have also revised the heading of the General Rating Formula for Diseases and Injuries of the Spine accordingly.

One commenter suggested we add a note explaining when to use diagnostic code 5320 (for muscle injury of Group XX muscles (spinal muscles)) rather than 5237 (lumbosacral or cervical strain).

In our judgment, such a note is unnecessary. Diagnostic code 5320 is primarily used for evaluating muscle injuries due to wounds caused by gunshots or other missiles, as § 4.56 (Evaluation of muscle disabilities) indicates. Lumbosacral and cervical strain do not stem from wounds but mainly from work or recreational injuries that involve sudden twisting, overuse, improper lifting, etc., sometimes superimposed on mechanical problems such as obesity, postural defects, or anatomical defects (<http://users.rowan.edu>, The Merck Manual (17th edition 1999, page 504), <http://www.bonetumour.org/book>, <http://www.emedicine.com/sports/topic69.htm>). Muscle strains are, therefore, most appropriately evaluated under diagnostic code 5237 (lumbosacral and cervical strain).

VA appreciates the comments submitted in response to the proposed rule. Based on the rationale stated in the proposed rule and in this document, the