

addresses the issue of service connection rather than evaluation. In addition, the determination of whether arthritis in a particular joint is secondary to another condition often requires a medical opinion. Since this material is not a guide to evaluation, and therefore is not appropriate in the rating schedule, and in addition is more of a medical than an adjudicatory decision, we propose to delete this section.

Current § 4.59, "Painful motion," states that painful motion is an important factor of disability and that the intent of the schedule is to recognize painful motion with joint or periarticular pathology as productive of disability. It states that painful, unstable, or malaligned joints are entitled to at least the minimum compensable rating for the joint, and indicates how joints should be tested. However, the instructions for evaluating pain are ambiguous and subject to individual interpretation, for example, in that they direct the examiner to note facial expression, wincing, etc., on pressure or manipulation. Furthermore, the current rating schedule does not always follow these guidelines. For example, a zero-percent evaluation is assigned for lumbosacral strain (under diagnostic code 5295) when there are slight subjective symptoms (which would almost always include pain); for degenerative arthritis (under diagnostic code 5003) when there is limitation of motion due to pain unless there is objective confirmation; and for a fracture of the humerus (under diagnostic code 5202) when there is malunion that is less than moderate. The instructions also fail to provide a way for raters to assign higher evaluations for extreme pain, which can be totally disabling in some cases. We propose to delete the current information in this section because it does not provide clear and objective instructions to raters on how to assess pain nor does it indicate how pain due to musculoskeletal conditions other than joint disability should be assessed. This follows the recommendation of the consultants, who felt that the additional disability resulting from pain may not be adequately considered in the current schedule and that we may wish to include more information on the evaluation of pain. They did not make specific recommendations about how to do this. Based in part on consultation with a committee of orthopedic surgeons from the Veterans Health Administration (the VHA Orthopedic Committee), we propose to change the name of this section to "Evaluation of

pain in musculoskeletal conditions" in order to clarify the scope of the section and propose a specific set of criteria to be used for the evaluation of pain in these conditions. We propose that when the evaluation criteria for a condition listed in § 4.71a do not take pain into account, but pain is present, that raters combine an evaluation based on the criteria under the particular diagnostic code with an evaluation for pain under § 4.59. A single (combined) evaluation for the condition would then be assigned under the appropriate diagnostic code for the condition.

We propose to provide a wide range of evaluations for pain in § 4.59, with 100-, 30-, 20-, 10-, and zero-percent evaluation levels. The evaluation criteria are based on a combination of the degree of the subjective complaint of pain, which is largely unmeasurable, and associated correlative clinical or laboratory findings that are more objective. We propose that a 100-percent evaluation for pain be assigned when there is complaint of pain that globally interferes with and severely limits daily activities, as long as the requirements for a 30-percent evaluation for pain are met, and a psychiatric evaluation has excluded other processes to account for the pain. We propose that a 30-percent evaluation for pain be assigned when there is complaint of pain at rest, with pain on minimal palpation or on attempted range of motion on physical examination, plus X-ray or other imaging abnormalities, plus abnormal findings on a vascular or neurologic special study. We propose that a 20-percent evaluation for pain be assigned when there is complaint of pain on any use, with pain on palpation and through at least one-half of the range of motion on physical examination, plus X-ray or other imaging abnormalities. We propose that a 10-percent evaluation for pain be assigned when there is complaint of pain on performing some daily activities, with pain on motion (through any part of the range of motion) on physical examination, plus X-ray or other imaging abnormalities. We propose that a zero-percent evaluation for pain be assigned when there is complaint of mild or transient pain on performing some daily activities, with correlative finding(s) on physical examination (for example, pain on palpation or pain on stressing the joint), but without X-ray or other imaging abnormalities. Establishing these criteria for pain evaluation would assure that pain is taken into consideration in all cases where it is present, either under the criteria in § 4.59 or in the criteria under the

diagnostic code specific to the condition (if pain is part of those criteria). By linking the complaints of pain with objective findings, it will promote the consistent evaluation of pain. It would also provide a 100-percent level of evaluation for pain that severely limits all daily activities, an effect that is not addressed in the current rating schedule.

We also propose to add two notes to § 4.59. The first would direct that a rater not combine a 100-percent evaluation under this section with any other evaluation for the same condition. The second would state that the provisions of § 4.68, "Limitation of combined evaluation of musculoskeletal and neurologic disabilities of an extremity," will apply to the evaluation of conditions evaluated wholly or partly under § 4.59, except for a 100-percent evaluation, that is, this will allow assignment of a 100-percent evaluation based on pain even if it would exceed the limits of an evaluation under the provisions of § 4.68 (Limitation of combined evaluation of musculoskeletal and associated neurologic disabilities of an extremity).

This set of criteria would replace all the current material in § 4.59, which we propose to delete.

Current § 4.61, "Examination," discusses the need for a thorough examination of all major joints, including the need to examine Haygarth's and Heberdon's nodes, in order to properly evaluate a claimant's disability due to arthritis. However, the presence or absence of these nodes has no bearing on evaluation. Furthermore, the term "Haygarth's nodes," which means a swelling of joints related to rheumatoid arthritis, is no longer in common medical use. The examiner determines the type of arthritis that is present based on many factors, such as which joints are affected, the history, laboratory and imaging studies, physical findings, etc. Guidance for examiners in providing information sufficient to allow raters to evaluate joint disease is contained in disability examination worksheets. Since the material in this section is not pertinent to the evaluation of arthritis, is outdated, and is similar to material in §§ 4.1 and 4.2, we propose to delete it.

Current § 4.62, "Circulatory disturbances," reminds the rater not to overlook circulatory disturbances, especially of the lower extremity following injury to the popliteal space, and to rate them generally as phlebitis. Medical records should make it clear when a vascular injury is associated with a lower extremity injury. Evaluation will depend on the findings