

standardized description of joint measurements.

Current Plate III, showing bones of the hand, and current Plate IV, showing bones of the foot, are incomplete and outdated, so we propose to remove them and replace them with updated Plates III and IV.

We propose to add one additional plate to the musculoskeletal section of the rating schedule to illustrate range of motion of the cervical and dorsolumbar (thoracolumbar) spine (Plate V). This will be included with the separate regulation that would revise the portions of the musculoskeletal system that address disabilities of the spine.

In the current rating schedule, next to the percentage evaluations following diagnostic codes 5054, 5104 through 5130, 5160 through 5167, 5250, and 5275, superscripts are included directing that entitlement to special monthly compensation be considered. We are replacing the numbered superscript with asterisks that will refer to a single footnote containing similar information that will follow diagnostic code 5275, at the end of the area of the schedule that addresses shortening of the lower extremity, which is the last area of the musculoskeletal system in which special monthly compensation might be applicable. We propose to add a note at the beginning of § 4.71a, preceding the coded evaluations of disabilities, instructing raters to refer to § 3.350 whenever they rate an injury that has resulted in anatomical loss or loss of use of a limb. We believe that this will adequately notify the rater to ensure that there is a complete review for special monthly compensation. There is a footnote at diagnostic codes 5126 through 5130 indicating that entitlement to special monthly compensation is established if there is amputation of the thumb and any three fingers of a hand, since this is equivalent to the loss of use of one hand. This is not explicitly stated in § 3.350, which is the regulation that addresses special monthly compensation (SMC). However, it is not appropriate in part 4, because it addresses SMC rather than the evaluation of disabilities, and we therefore propose to remove this rule from part 4 and add it to 38 CFR 3.350.

Current table II, "Ratings for multiple losses of extremities with dictator's rating code and 38 CFR citation," was prepared for use by raters when dictating a rating decision for transcription, but the codes are out of date. The updated codes, which are not regulatory, are located in Appendix A of VA's Adjudication Procedures Manual, M21-1. The codes are not needed for

disability evaluation, and we therefore propose to delete Table II.

Osteomyelitis

The current evaluation criteria for osteomyelitis, diagnostic code 5000, provide ratings of 100 percent for osteomyelitis of the pelvis, vertebrae, or extending into major joints, or with multiple localization or with long history of intractability and debility, anemia, amyloid liver changes, or other continuous constitutional symptoms; 60 percent for frequent episodes, with constitutional symptoms; 30 percent if there is definite involucrum or sequestrum, with or without discharging sinus; 20 percent if there is a discharging sinus or other evidence of active infection within the past 5 years; and 10 percent if the infection is inactive, following repeated episodes, without evidence of active infection in past 5 years. There are also two complex notes under this diagnostic code.

The current evaluation criteria are complex and difficult to apply consistently, and do not reflect the effectiveness of modern treatment techniques, such as aggressive antibiotic therapy and microsurgery. Although the consultants suggested no major changes to the current criteria, we propose substantial revisions for the sake of clarity, ease of use, and consistency of evaluations. We propose to restructure the criteria based on which bone or bones are affected, whether the infection is active or inactive, whether or not there are debilitating complications (such as anemia, septicemia, or amyloidosis), and the number of recurrences, if any, within the past 5 years.

We propose to provide a 100-percent evaluation for chronic intractable osteomyelitis of any site when it is associated with debilitating complications such as anemia and amyloidosis. These criteria better define when chronic osteomyelitis is so disabling that it warrants a 100-percent evaluation. We also propose to evaluate osteomyelitis of the spine, pelvis, shoulder, elbow, wrist, hip, knee or ankle, or of two or more non-contiguous bones, when active or acute, with constitutional signs and symptoms, such as fever, fatigue, malaise, debility, and septicemia, at 100 percent. We propose to evaluate osteomyelitis at one of these sites that is inactive or chronic at 60 percent, if there were two or more recurrent episodes of active infection (following the initial infection) within the past 5 years; at 30 percent if there was one recurrent episode of active infection (following the initial infection) within the past 5 years; and at zero

percent if there were no recurrent episodes of active infection within the past 5 years.

We propose to evaluate osteomyelitis that does not involve the spine, pelvis, shoulder, elbow, wrist, hip, knee or ankle, does not involve two or more non-contiguous bones, and does not involve only a finger or toe, at 40 percent if osteomyelitis is active or acute; at 30 percent if the infection is inactive or chronic, with two or more recurrent episodes of active infection (following the initial infection) within the past 5 years; at 20 percent if the infection is inactive or chronic and there was one recurrent episode of active infection (following the initial infection) within the past 5 years; and at zero percent if there were no recurrent episodes of active infection within the past 5 years.

We propose to evaluate osteomyelitis of a single finger or toe at 10 percent when the infection is active or acute, at 10 percent when the infection is inactive and chronic, with two or more recurrent episodes of active infection (following the initial infection) within the past 5 years, and at zero percent when the infection is inactive or chronic, with one or no recurrent episodes of active infection (following the initial infection) within the past 5 years. These evaluations would be assigned even when they exceed the evaluation for amputation of a finger or toe, as is the case in the current schedule. The proposed criteria, although similar in scope to the current criteria, are clearer, less complex, and more objective and would promote more consistent evaluations. The proposed criteria are also more in keeping with disability due to osteomyelitis under modern medical treatment.

We also propose to revise the notes under diagnostic code 5000. The current first note states that a rating of 10 percent, as an exception to the amputation rule, is to be assigned in any case of active osteomyelitis where the amputation rating for the affected part is no percent. It goes on to say that this 10-percent rating and the other partial ratings of 30 percent or less are to be combined with ratings for ankylosis, limited motion, nonunion or malunion, shortening, *etc.*, subject, of course, to the amputation rule, and that the 60-percent rating, as it is based on constitutional symptoms, is not subject to the amputation rule. Finally, it states that a rating for osteomyelitis will not be applied following cure by removal or radical resection of the affected bone.

The second note states that the 20-percent rating on the basis of activity within the past 5 years is not assignable