

following the initial infection of active osteomyelitis without subsequent reactivation, that two or more episodes following the initial infection are required to assign a 10-percent rating, and that the 10- or 20-percent rating will be assigned only once to cover disability at all sites of previously active infection with a future ending date for the 20-percent rating. These notes are so complex that they have become not only a source of confusion, they are also inconsistently interpreted and applied. We propose to remove both notes and substitute two new notes, with similar information, but in clearer language. Note (1) would direct the rater, subject to the provisions of § 4.68, to combine an evaluation for inactive or chronic osteomyelitis under diagnostic code 5000 with an evaluation for chronic residuals, such as limitation of motion, ankylosis, *etc.*, and for pain (under § 4.59) when appropriate, under the appropriate diagnostic code. Note (2) would direct the rater to evaluate, after removal or resection of the infected bone, under the diagnostic code most appropriate for evaluating the residuals, such as amputation, shortening, limitation of motion, *etc.*, but not under the criteria for diagnostic code 5000. Removing the ambiguities and providing instructions for rating in more succinct and clearer language would promote consistency of ratings.

### Arthritis

Rheumatoid arthritis, diagnostic code 5002, is currently evaluated either as an active process or on the basis of chronic residuals. For active arthritis, a 100-percent evaluation is assigned if there are constitutional manifestations and active joint involvement, and the condition is totally incapacitating. A 60-percent evaluation is assigned when the criteria for a 100-percent evaluation are not met, but there are weight loss and anemia productive of severe impairment of health, or severely incapacitating exacerbations occurring four or more times a year, or a lesser number over prolonged periods. A 40-percent evaluation is assigned for symptom combinations productive of definite impairment of health objectively supported by examination findings or if there are incapacitating exacerbations occurring three or more times a year. A 20-percent evaluation is assigned if there are one or two exacerbations a year in a well-established diagnosis. Alternatively, chronic residuals, such as limitation of motion or ankylosis, favorable or unfavorable, are rated under the appropriate diagnostic codes for the specific joints involved. When the limitation of motion of the specific

joints is noncompensable, 10 percent is assigned for each major joint or group of minor joints with limitation of motion, and these are combined. A note states that ratings for the active process will not be combined with the residual ratings for limitation of motion or ankylosis.

The consultants suggested minor changes under diagnostic code 5002, such as listing specific constitutional manifestations that might occur. However, because the current criteria contain language that is subjective and undefined, such as “severe” and “definite” impairment of health, “severely incapacitating” and “incapacitating” exacerbations, we propose to replace them with more objective criteria that are in accord with the consultants’ recommendations. We propose that a 100-percent evaluation be assigned based on constant or near-constant debilitating signs and symptoms due to a combination of inflammatory synovitis (pain, swelling, tenderness, warmth, and morning stiffness in and around joints) and destruction of multiple joints, plus extra-articular (other than joint) manifestations. These are findings that represent the most severe, advanced form of rheumatoid arthritis. We propose that evaluations other than 100 percent be based on the frequency and total duration of incapacitating exacerbations or flares of rheumatoid arthritis. The 60-percent evaluation would require incapacitating exacerbations or flares with a total duration of at least six weeks during the past 12-month period due either to inflammatory synovitis and destruction of multiple joints, or to a combination of joint problems and extra-articular manifestations. The 40-percent evaluation would require exacerbations or flares with a total duration of at least 4 weeks, but less than 6 weeks, during the past 12-month period due to inflammatory synovitis, weakness, and fatigue. The 20-percent evaluation would require incapacitating exacerbations or flares with a total duration of at least 2 weeks but less than 6 weeks during the past 12-month period due to inflammatory synovitis, weakness, and fatigue. The 10-percent evaluation would require incapacitating exacerbations or flares with a total duration of at least 1 week but less than 2 weeks during the past 12-month period due to inflammatory synovitis, weakness, and fatigue. These criteria are similar to those in the current schedule and to those recommended by the consultants, and are also consistent with the evaluation levels we have provided

for other conditions characterized by incapacitating episodes, such as hepatitis C, diagnostic code 7354, in the digestive portion of the rating schedule.

We propose to add four notes under diagnostic code 5002 to further assist evaluation. Note (1) would direct that rheumatoid arthritis be evaluated based either on the evaluation criteria under diagnostic code 5002 or on the combined evaluation of chronic residuals of affected joints, whichever method results in a higher evaluation. This is similar to instructions in a current note.

Note (2) would direct that when evaluating based on chronic joint residuals, each affected major joint or group of minor joints will be evaluated on findings such as limitation of motion, ankylosis, joint instability, *etc.*, under the appropriate diagnostic code, and each will be combined with an evaluation for pain under § 4.59 when appropriate. We propose to remove the current provision requiring that 10 percent be assigned for each major joint or group of minor joints with limitation of motion that is less than 10-percent disabling, because painful motion would be assessed under the provisions of § 4.59, and limitation of motion otherwise will be evaluated at the same level as limitation of motion due to other conditions. This would promote both internal consistency in the rating schedule and consistency in rating veterans with similar degrees of disability due to different conditions. Proposed note (3) would direct raters to separately evaluate extra-articular manifestations of rheumatoid arthritis, such as pulmonary fibrosis; pleural inflammation; weakness or atrophy of muscles; emaciation; anemia; vasculitis (of skin or systemic); neuropathy, such as peripheral nerve neuropathy, entrapment neuropathy, and cervical myelopathy; pericarditis; Sjogren’s syndrome (dry eyes and mouth); and eye complications (such as scleritis and episcleritis), under the appropriate diagnostic code, unless they have been used to support an evaluation at 60 or 100 percent under diagnostic code 5002. This will assure that all disabling manifestations of rheumatoid arthritis are appropriately evaluated, while also avoiding evaluating the same disability twice (see proposed § 4.14, “Avoiding overlapping of evaluations”). The current schedule does not provide directions for evaluating extra-articular manifestations.

Proposed note (4) would define an incapacitating exacerbation or flare as one requiring bedrest or wheelchair use and treatment by a health care provider. This is similar to the definition of