

50 percent if requiring use of one crutch or two canes only for ambulating long distances (500 feet or more), due to pain, instability, or weakness (muscle strength grade 3 to 4 out of 5), or if there is loss of 21 to 40 degrees of the full arc of motion; and at 40 percent if residuals require the use of one cane or brace for ambulation, due to pain, instability, or weakness, or if there is loss of 10 to 20 degrees of the full arc of motion. We propose to retain a 30-percent evaluation for residuals as a minimum following arthroplasty. We also propose to add two notes, the first stating that a full arc of motion of the knee after arthroplasty is a range of motion of 0 to 110 degrees, and the second directing raters not to combine an evaluation under these criteria with an evaluation for pain under § 4.59. Pain as a residual of arthroplasty is taken into account in these evaluation criteria.

Ankle replacement (diagnostic code 5056), is currently evaluated under the same criteria as other arthroplasties, with 40 percent assigned if there are chronic residuals consisting of severe painful motion or weakness in the affected extremity; rating by analogy to diagnostic codes 5270 or 5271 if there are intermediate degrees of residual weakness, pain or limitation of motion; and a minimum evaluation of 20 percent. We propose similar changes for this arthroplasty, removing the current subjective criteria and directing that evaluation be based on ankylosis (under diagnostic code 5270) or limitation of motion (under diagnostic code 5271), whichever results in a higher evaluation, combining this evaluation with an evaluation for pain under § 4.59 when appropriate. We propose to retain the 20 percent minimum evaluation level.

Anatomical Loss and Loss of Use of Hands and Feet

The current list of potential combinations of disabilities under diagnostic codes 5104 through 5111 is incomplete because it does not include "loss of use of one hand and anatomical loss of the other hand" or "loss of use of one foot and anatomical loss of the other foot." We propose to combine "Anatomical loss of both hands" (diagnostic code 5106) and "Loss of use of both hands" (diagnostic code 5109) into one code, diagnostic code 5106, titled "Anatomical loss or loss of use of one hand and anatomical loss or loss of use of the other hand." Similarly, we propose to combine "Anatomical loss of both feet" (diagnostic code 5107) and "Loss of use of both feet" (diagnostic code 5110) into one code, diagnostic code 5107, titled "Anatomical loss or

loss of use of one foot and anatomical loss or loss of use of the other foot." These changes will make diagnostic codes 5109 and 5110 redundant, and we propose to delete them. Finally, we propose to combine "Anatomical loss of one hand and loss of use of one foot" (diagnostic code 5104), "Anatomical loss of one foot and loss of use of one hand" (diagnostic code 5105), "Anatomical loss of one hand and one foot" (diagnostic code 5108), and "Loss of use of one hand and one foot" (diagnostic code 5111) into one code, diagnostic code 5104, titled "Anatomical loss or loss of use of one hand and anatomical loss or loss of use of one foot." Diagnostic codes 5105, 5108, and 5111 will then be redundant, and we propose to delete them.

Other Amputations

Diagnostic codes 5123, 5124, and 5125 currently pertain to amputation of the forearm. Under diagnostic codes 5123, "Forearm, amputation of, above insertion of pronator teres" and 5124, "Forearm, amputation of, below insertion of pronator teres," we propose to add the alternative titles of "short, below elbow amputation" and "long, below elbow amputation," respectively, since these are terms commonly used in medical practice to distinguish levels of amputation. The insertion of the pronator teres is located at the middle one-third of the lateral surface of the radius, and, for the sake of clarity, we also propose to add that definition to the titles of diagnostic codes 5123 and 5124. We propose to revise the current title of diagnostic code 5125 from "Hand, loss of use of" to "Wrist disarticulation," because a wrist disarticulation procedure results in anatomical loss of the hand.

Under the subheading "Multiple finger amputations," we propose to edit paragraphs (a) through (f) and rename them notes, numbered one through five, consistent with the way we have designated rating instructions throughout this section. We also propose to move the notes from their current position following the diagnostic codes for multiple finger amputations to the beginning of the applicable diagnostic codes, for clarity and ease of reference. The last of these paragraphs defines loss of use of the hand. This is a duplication of § 3.350 (a)(2), and we propose to delete it as unnecessary. We propose to change the term middle finger to long finger for disabilities resulting from finger amputations and ankylosis of the fingers because this is the current medical term for this finger.

We propose to retitle diagnostic code 5160, now titled "Disarticulation, with loss of extrinsic pelvic girdle muscles" under amputation of thigh, to "Disarticulation of hip, with loss of extrinsic pelvic girdle muscles" for the sake of clarity about the site of amputation.

We propose to make editorial changes in the language of diagnostic codes 5163, 5164, and 5165, regarding leg amputations and diagnostic codes 5172 and 5173, regarding amputation of toes, for clarity. No substantive change is intended.

Shoulder and Arm

Ankylosis of the shoulder is currently rated under diagnostic code 5200, which is titled "Scapulohumeral articulation, ankylosis of." Since the common term for the shoulder joint is the glenohumeral, rather than the scapulohumeral joint, we propose to change the heading of diagnostic code 5200 and other references to the joint accordingly. For the sake of clarity, we propose to change the word "piece" to "unit" when referring to the scapula and humerus in the evaluation criteria under diagnostic code 5200. The current criteria for ankylosis of the shoulder are 50 and 40 percent (dominant and nondominant sides) for unfavorable ankylosis with abduction limited to 25 degrees from side; 40 and 30 percent for intermediate ankylosis between favorable and unfavorable; and 30 and 20 percent for favorable ankylosis, with abduction to 60 degrees, can reach mouth and head.

The consultants suggested an 80-percent evaluation for unfavorable ankylosis, defined as abduction limited to 25 degrees from side, and a 40-percent evaluation for favorable ankylosis, defined as abduction of 60 degrees, can reach mouth and head. The consultants suggested removing the intermediate level because ankylosis is either favorable or unfavorable and suggested elevating the unfavorable ankylosis to 80 percent and the favorable to 40 percent based on the same criteria for favorable and unfavorable as the current criteria. We consulted further with the VHA Orthopedic Committee, however, and the Committee indicated that an intermediate level is possible. We therefore propose to retain evaluations of 40 and 30 percent for intermediate ankylosis, which we propose to define as ankylosis with abduction limited to between 26 and 59 degrees, and to retain evaluations of 50 and 40 percent for unfavorable ankylosis and 30 and 20 percent for favorable ankylosis, retaining the current criteria. This