

would encompass those with limited motion of a degree that does not meet the criteria for either favorable or unfavorable. We also do not propose to adopt the higher levels suggested, as the consultants did not specify why they believe this condition is more disabling than it is currently evaluated.

We propose to change the title of diagnostic code 5201 from "Arm, limitation of motion of" to "Limitation of active abduction of shoulder" to indicate that the criteria under this code are limited to the evaluation of active abduction of the shoulder rather than limitation of arm motion in general. The consultants suggested no other change. We propose no change other than to objectively specify in degrees the movements currently designated by reference to side and shoulder positions, that is, by changing "Midway between side and shoulder" to "to between 26 degrees and 89 degrees from side" and changing "At shoulder level" to "to shoulder level (90 degrees)". This more objective measurement of the disability will promote more consistent evaluations.

Diagnostic code 5202 is currently called "Humerus, other impairment of." For the sake of clarity, we propose to change the title to "Residuals of fracture of humerus and residuals of dislocation of glenohumeral (shoulder) joint," because these are the specific conditions covered under this diagnostic code. In the current evaluation criteria, the term "flail shoulder" is a parenthetical expression after loss of head of humerus. However, we propose to delete the reference to flail shoulder joint because this is a neurological condition due to paralysis of shoulder motion from such things as brachial plexus or other nerve injuries or poliomyelitis, and is properly evaluated under the neurological section of the rating schedule. The level of evaluation for the paralysis would depend on the extent of loss of function. The term "false flail joint" is currently a parenthetical expression after nonunion of a fracture of the humerus. That term is rarely used medically, and we propose to delete it and replace it with "nonunion of head of humerus with motion at fracture site" because that phrase describes the disability in correct and commonly used medical terms. The current criteria include evaluation percentages of 80 and 70 (for dominant and nondominant side) for loss of head of humerus (flail shoulder), 60 and 50 for nonunion of humeral head (false flail joint), and 50 and 40 for fibrous union of humeral head. We propose to reduce the rating for loss of the head from 80 and 70 to 60 and 50 percent because the

consultants stated that this impairment is more amenable to treatment under modern medical techniques. We propose to retain the same evaluation percentages for nonunion and fibrous union.

This diagnostic code (5202) also contains criteria for evaluating recurrent dislocation at the scapulohumeral (glenohumeral) joint, providing 30 and 20 percent for frequent episodes and guarding of all arm movements and 20 and 20 percent for infrequent episodes and guarding of movement only at shoulder level. We propose to change the subtitle to "Recurrent dislocation of glenohumeral (shoulder) joint," which is the more common, current term, and to retain the percentage evaluations for frequent and infrequent episodes. We do, however, plan to specify what is meant by frequent (every 2 months or more frequently) and infrequent (less often than every 2 months, but at least once per year) episodes and to add a 10-percent level for evaluation when there has been at least one recurrence. We propose to add guarding of external rotation to the evaluation of infrequent dislocations under this code because this is a clearer description of the disability. These criteria are more clearly defined and will promote consistency.

Diagnostic code 5202 also includes evaluation criteria for malunion of the humerus, with evaluations of 30 and 20 percent for "marked" and 20 and 20 percent for "moderate." The consultants indicated that malunion is disabling only if it is symptomatic or there is functional impairment. We therefore propose to follow their recommendation and provide an evaluation level of 30 and 20 percent if the malunion is symptomatic and there is more than 45 degrees of angulation in the anterior-posterior plane or varus-valgus plane and a level of 20 percent if the malunion is symptomatic and there is 30 to 45 degrees of angulation in the anterior-posterior plane or varus-valgus plane. These criteria are less subjective and better define the degree of deformity and indicate that symptoms are required. These changes would promote consistency of evaluations.

Current diagnostic code 5203, "Clavicle or scapula, impairment of," provides evaluations of 20 and 20 percent (for dominant and nondominant sides) for dislocation, 20 and 20 percent for nonunion with loose movement, 10 and 10 percent for nonunion without loose movement, and 10 and 10 percent for malunion. The consultants said that the impairments from these conditions are less than current criteria would indicate, and suggested a 10-percent

evaluation for any of the following: acromioclavicular separation with chronic pain, sternoclavicular separation with chronic pain, and nonunion of the clavicle and scapula with chronic pain. Because their suggested criteria were no more objective than the current criteria, we consulted with the VHA Orthopedic Committee, who suggested the following more objective criteria, which we propose to adopt: For resection of the end of the clavicle; nonunion of the clavicle or scapula; or malunion of the clavicle or scapula with skin breakdown, skin irritation, or thoracic outlet syndrome, 20 and 10 percent; for dislocation of the acromioclavicular joint with pain and osteoarthritis; or painful sternoclavicular anterior dislocation, 10 and 10 percent; for malunion of the clavicle or scapula zero and zero percent unless skin breakdown, skin irritation or thoracic outlet syndrome is present. The thoracic outlet is an area behind each clavicle where an artery, a vein, and nerves cross over the first rib. Upper extremity symptoms, known as the thoracic outlet syndrome, can develop on one or both sides when the nerves or blood vessels in this area are compressed by any of several causes, including an abnormal position or shape of the clavicle after an injury. The symptoms may include pain, numbness, tingling, weakness, and aching of an arm or hand, and there also may be swelling and enlarged veins.

Untreated sternoclavicular posterior dislocations will be evaluated separately, on the basis of complications, such as from pressure on blood vessels or trachea. We propose to add a note stating that these criteria encompass pain, so an evaluation under diagnostic code 5203 is not to be combined with an evaluation for pain (under § 4.59). We propose to add a second note to explain what is meant by a thoracic outlet syndrome and to indicate that it can be separately evaluated if not used to support an evaluation under diagnostic code 5203. These objective criteria are more clearly related to the likely functional impairment of these various conditions, based on orthopedic experience.

We propose to add a new diagnostic code, 5204, for "Rotator cuff dysfunction and impingement syndrome," two common shoulder disabilities that warrant a separate diagnostic code because they may currently be rated under a variety of existing codes and therefore may not be rated consistently. The rotator cuff is a group of 4 muscles (the subscapularis, supraspinatus, infraspinatus, and teres minor, all originating from the scapula)