

and their tendons that surround the glenohumeral (shoulder) joint. These structures stabilize the shoulder joint and allow the arm to rotate ("Essentials of Musculoskeletal Care" 114 (Robert K. Snider, M.D., ed., 1999)). The rotator cuff may become symptomatic as a result of bursitis, tendinitis, or a tear or sprain affecting structures in the area. Both repetitive activity and acute injury can lead to rotator cuff damage. The major symptoms are pain, weakness, and loss of motion. Rotator cuff dysfunction is often associated with impingement syndrome, which is a condition in which the acromion or coracoid process of the scapula, the coracoacromial ligament, and the acromioclavicular joint press on the underlying bursa, biceps, tendon, and rotator cuff (Snider, 108). Impingement may lead to rotator cuff damage. Pain, weakness, and loss of function are possible outcomes of impingement syndrome. Because the effects of rotator cuff dysfunction and impingement syndrome are similar, and they often occur together, they can be rated under the same set of criteria. The consultants suggested adding impingement syndrome to the schedule with a single evaluation level of 10 percent for either side, based on the presence of the diagnosis and a positive impingement sign (a clinical test of arm movement that indicates the impingement syndrome is present). We propose to follow their suggestion for a 10-percent evaluation but to add an evaluation level of 20 and 20 percent for those with limitation of motion of internal rotation, external rotation, flexion, and abduction, since this limitation of motion would be more disabling than the presence of a positive impingement sign alone would warrant. Furthermore, since limitation of abduction alone may be rated under diagnostic code 5201 (limitation of active abduction of shoulder) at higher levels, we propose to add a note directing that evaluation be made under diagnostic code 5201 if a higher evaluation could be assigned based on limitation of abduction, but this evaluation may not be combined with an evaluation under diagnostic code 5204. We also propose to add a note directing the rater to combine an evaluation based on the criteria under diagnostic code 5204 with an evaluation for pain under § 4.59 when appropriate, since pain may be the predominant symptom. These criteria would take into account the usual manifestations of these conditions in an objective way, and also take into account any pain that is present under a standardized method of evaluation.

### Elbow and Forearm

Current diagnostic code 5205, "Elbow, ankylosis of," has evaluation levels of 60 and 50, 50 and 40, and 40 and 30 percent, based on whether the ankylosis is unfavorable, at an angle of less than 50 degrees or with complete loss of supination or pronation; intermediate, at an angle of more than 90 degrees or between 70 degrees and 50 degrees; or favorable, at an angle between 90 degrees and 70 degrees. The consultants recommended that all degrees of elbow ankylosis be rated at 80 percent because elbow ankylosis is very disabling regardless of position and it is impossible to distinguish between levels of disability. The VHA Orthopedic Committee also felt that the current criteria for unfavorable ankylosis would be equivalent to an above elbow amputation and agreed that a rating of 80 (for dominant) and 70 (for non-dominant) percent for unfavorable elbow ankylosis, at an angle of less than 50 degrees, or with complete loss of supination or pronation, is appropriate. They also felt that the intermediate and favorable ankylosis evaluations should be elevated, but not to the level that is equivalent to an amputation above the elbow. We therefore propose to retain the same criteria for elbow ankylosis, with editorial changes, but to elevate the evaluations for each level to 80 and 70 percent for unfavorable, 60 and 50 percent for intermediate, and 50 and 40 percent for favorable ankylosis. These evaluation levels are more consistent with the extent of disability these degrees of ankylosis produce, based on orthopedic experience and judgment.

Diagnostic codes 5206, 5207, and 5208 currently refer to limitation of flexion and extension of the forearm. Because extension and flexion are actually functions of the elbow joint, we propose to change the word "forearm" to "elbow" in the headings of diagnostic codes 5206, 5207, and 5208. We propose to retain the same criteria except for two nonsubstantive changes under diagnostic code 5207 that we are making because of language that has been a source of confusion. We propose to change the phrase "extension limited to X degrees" to "extension is limited to minus X degrees (lacks X degrees of full extension)" because full extension is zero degrees, and if less than full extension is possible, a negative number is required, since the range of extension is zero to minus 145 degrees. For example, if there is 110 degrees of limitation of extension (or, extension is limited by 110 degrees), it means that only minus 35 degrees of full extension is possible or that extension is limited

to minus 35 degrees. For the sake of clarity, we propose to revise this language, using zero degrees as the reference point for full extension, as Plate I indicates is correct. Also currently, a 10-percent evaluation is provided both for limitation of extension to 60 degrees and for limitation of extension to 45 degrees. We propose to revise the criteria for a 10-percent level of evaluation to encompass both, by proposing a 10-percent evaluation if extension is limited to between minus 45 and minus 74 degrees (extension lacks at least 45 but less than 75 degrees of full extension). This eliminates the need for two sets of criteria for the 10-percent evaluation level. Similarly, for diagnostic code 5208, we propose to change the current language of the title (and evaluation criteria) from "Forearm, flexion limited to 100 degrees and extension to 45 degrees" to "Flexion of elbow is limited to 100 degrees, and extension is limited to minus 45 degrees (lacks 45 degrees of full extension).

Diagnostic code 5209, "Elbow, other impairment of," calls for evaluations of 60 and 50 percent for a flail joint, and of 20 and 20 percent for joint fracture, with marked cubitus varus or cubitus valgus deformity or with ununited fracture of head of radius. The consultants recommended no changes. However, we propose to remove the criterion of "flail joint" from this section, since it refers to complete paralysis at the elbow, a neurologic condition that would be more appropriately evaluated under § 4.124a in the neurologic portion of the rating schedule. The specific diagnostic code and evaluation would depend on the exact findings. Complete paralysis of the shoulder and elbow due to upper radicular (fifth and sixth cervical nerves) impairment would warrant a 70- or 60-percent evaluation (for dominant and non-dominant side, respectively). If only the middle radicular cervical nerve group is impaired, the evaluation for complete paralysis of adduction, abduction, and rotation of arm, plus flexion of elbow and extension of wrist would also warrant a 70- or 60-percent evaluation. It is unlikely that elbow movements alone would be completely paralyzed in a given situation because the same nerves that innervate the muscles about the elbow innervate muscles that affect the movement of other parts of the arm. The VHA Orthopedic Committee stated that the normal position of the elbow is 10–15 degrees of valgus and that any degree of cubitus varus (*i.e.*, any degree of varus greater than zero degrees) will greatly