

than 10 degrees of angulation in the varus-valgus plane or more than 15 degrees of angulation in the anterior-posterior plane. We also propose to add two notes. The first directs that a fracture of the femoral head or subcapital area with excision of less than 25 percent of the weightbearing portion be evaluated as aseptic necrosis under diagnostic code 5265. The second defines malunion of an intertrochanteric fracture as having a varus deformity, shortening, or rotation. These criteria are based on modern medical treatment and focus on the femoral impairment. Currently, additional disability of the knee or hip resulting from a femoral fracture is evaluated at 10, 20, or 30 percent, depending on whether the impairment is mild, moderate, or marked. These criteria are subjective and therefore difficult to apply consistently, and any hip or knee impairment can be separately rated as a secondary condition to the femoral shaft fracture. Therefore it is unnecessary to take into consideration impairment of the hip or knee in evaluating femoral shaft fracture, and we propose to remove those criteria.

Knee and Lower Leg

Ankylosis of the knee, diagnostic code 5256, is currently evaluated at 60 percent if the ankylosis is extremely unfavorable, in flexion at an angle of 45 degrees or more; at 50 percent if the ankylosis is in flexion between 20 and 45 degrees; at 40 percent if the ankylosis is in flexion between 10 and 20 degrees; and at 30 percent if the ankylosis is at a favorable angle in full extension, or flexion between zero and 10 degrees. We propose to revise the criteria to avoid the overlap of the required degrees of flexion in the current criteria by making the required flexion be more than 45 degrees for 60 percent; between 21 and 45 degrees for 50 percent; between 11 and 20 degrees for 40 percent; and in full extension, or in flexion between zero and 10 degrees for 30 percent.

Diagnostic code 5257 is currently titled "Knee, other impairment of," but the criteria are based only on the extent of recurrent subluxation or lateral instability. Thirty percent is assigned if the condition is "severe," 20 percent if it is "moderate," and 10 percent if it is "slight." We propose to change the title to "Knee instability" because this more precisely describes the content. The consultants recommended that evaluations be based on whether the instability is correctable by bracing and the extent to which it interferes with activities of daily living and athletic activities, such as running and jumping.

We propose to follow this recommendation, providing a 30-percent evaluation if there is documented instability that is not correctable by bracing and that interferes with activities of daily living; a 20-percent evaluation if there is documented instability that is correctable with bracing, but that interferes at times with activities of daily living and that prevents activities such as running and jumping; and a 10-percent evaluation if there is documented instability that is correctable by bracing and that does not interfere with activities of daily living, but at times may interfere with activities such as running and jumping. We also propose to add a note directing that an evaluation under diagnostic code 5257 may be combined with an evaluation for pain (under § 4.59) when appropriate. The proposed criteria are more objective than the current criteria, a change that will promote consistent evaluations.

Diagnostic code 5258 is currently titled "Cartilage, semilunar, dislocated, with frequent episodes of 'locking,' pain, and effusion into the joint". It provides a single evaluation level of 20 percent. The consultants suggested we change the title of diagnostic code 5258 to "Meniscus, tear with episodes of give way, locking and/or swelling". They suggested a single evaluation level of 10 percent, because they felt the impairment is not as great as in the original schedule. Diagnostic code 5259 is currently titled "Cartilage, semilunar, removal of, symptomatic," with a single evaluation level of 10 percent. The consultants suggested changing the condition to "Patellofemoral subluxation or dislocation" and to base evaluation on the frequency of episodes.

We propose to follow their suggestion in part by combining meniscus injuries, pre- or post-operatively, under diagnostic code 5258 and by changing the title to "Injury of meniscus (semilunar cartilage) of knee (pre- or post-operatively)," which is both a more current medical term and more reflective of the content. We also propose to provide a 20-percent evaluation for meniscus injury with episodes of giving way, locking, or joint effusion that interfere at times with activities of daily living and prevent activities such as running and jumping, and a 10-percent evaluation for meniscus injury with episodes of giving way, locking, or joint effusion that do not interfere with activities of daily living, but that at times interfere with activities such as running and jumping. We propose that evaluation alternatively be based on instability, degenerative arthritis, *etc.*, depending on the specific

findings, under the appropriate diagnostic code, because these are possible effects of meniscus injury or surgery. We also propose to add a note directing that an evaluation under diagnostic code 5258 be combined with an evaluation for pain (under § 4.59) when appropriate. Diagnostic code 5259 would be unnecessary under this reorganization, and we propose to remove it.

Diagnostic codes 5260 and 5261 currently pertain to limitation of flexion of the leg and limitation of extension of the leg, respectively. Because the terms extension and flexion are functions of the knee joint, we propose to change the word "leg" to "knee" in the titles of diagnostic codes 5260 and 5261. We propose to retitle diagnostic code 5260 "Limitation of flexion of knee." Flexion of the knee limited to 15 degrees is currently evaluated at 30 percent, flexion limited to 30 degrees is evaluated at 20 percent, flexion limited to 45 degrees is evaluated at 10 percent, and flexion limited to 60 degrees is evaluated at zero percent. The consultants pointed out that 30, 60, and 90 degrees are the important angles of measurement and are better measures of impairment than those in the current schedule. The VHA Orthopedic Committee agreed. We therefore propose to provide a 30-percent evaluation if flexion is limited to 30 degrees, a 20-percent evaluation if it is limited to 60 degrees, and a 10-percent evaluation if it is limited to 90 degrees.

Under diagnostic code 5261, currently "Leg, limitation of extension of," which we propose to retitle "Limitation of extension of knee," current evaluations are 50 percent if extension is limited to 45 degrees, 40 percent if it is limited to 30 degrees, 30 percent if it is limited to 20 degrees, 20 percent if it is limited to 15 degrees, 10 percent if it is limited to 10 degrees, and zero percent if it is limited to 5 degrees. The consultants pointed out that the three relevant ranges of measurement for limitation of extension are lack of extension of 5 to 15 degrees, lack of extension of 15 to 30 degrees, and lack of extension of 30 degrees or more. We therefore propose to provide evaluation levels of 50 percent if extension is limited to more than minus 30 degrees (lacks more than 30 degrees of full extension), 30 percent if extension is limited to between minus 16 and 30 degrees (lacks 16 to 30 degrees of full extension), and 10 percent if extension is limited to between minus 5 and 15 degrees (lacks 5 to 15 degrees of full extension). Reducing the number of levels of evaluation for limitation of flexion and extension to three will help simplify the