

rating process and will be in accord with the consultants' recommendation about relevant ranges. These levels will also be clearer in reference to Plate II, which shows the range of motion of the knee as zero to 140 degrees (which includes both flexion and extension of the knee), and which therefore requires that less than full extension be expressed as a negative number.

Diagnostic code 5262, Tibia and fibula, impairment of, currently has evaluation criteria pertaining to residuals of fracture of the tibia or fibula. Evaluations are 40 percent if there is nonunion, with loose motion, requiring a brace, 30 percent if there is malunion with marked knee or ankle disability, 20 percent if there is malunion with moderate knee or ankle disability, and 10 percent if there is malunion with slight knee or ankle disability. The consultants suggested no change. However, we propose changes in order to eliminate the subjective terms "marked," "moderate," and "slight" and the indefinite term "ankle or knee disability." We propose to use evaluation criteria similar to those we are proposing for fractures of the femur. We propose a 40-percent evaluation if there is nonunion, with loose motion, requiring a brace; a 30-percent evaluation if there is an asymptomatic nonunion; a 20-percent evaluation if there is a symptomatic malunion with either more than 10 degrees of angulation in the varus-valgus plane or more than 15 degrees of angulation in the anterior-posterior plane; and a 10-percent evaluation if there is a symptomatic malunion with neither more than 10 degrees of angulation in the varus-valgus plane nor more than 15 degrees of angulation in the anterior-posterior plane. These would provide more objective criteria to promote consistent evaluations. We also propose to revise the title to "Nonunion or malunion of fracture of tibia or fibula," in order to better identify the content of this diagnostic code.

We propose to delete diagnostic code 5263, "Genu recurvatum," since the consultants said this diagnosis is no longer used. Some degree of genu recurvatum (which means backward curving or hyperextended knee) is normal in females, and when acquired, is a finding that occurs as part of other conditions, such as nerve paralysis or osteoarthritis, rather than being a primary diagnosis or disability. Its evaluation would be encompassed by the evaluation for the primary underlying condition.

Aseptic Necrosis of Femoral Head

We propose to add a new diagnostic code, 5265, for aseptic necrosis (or avascular necrosis or osteonecrosis) of the femoral head. The consultants recommended this addition and suggested criteria similar to those we propose, although they used subjective terms that we have replaced with more objective criteria. For example, they suggested a 100-percent evaluation for a "severe" level with "severe" pain requiring use of ambulatory support, a 50-percent evaluation for a "moderate" level with "moderate" pain aggravated by activity and requiring intermittent ambulatory support, a 10-percent level for a "mild" level with previous severe or moderate disease that has stabilized, without collapse of the femoral head (at least 2 years after onset) and minimal pain; and a zero-percent evaluation for a "minimal" level with previous severe or moderate disease that has stabilized (at least 2 years after onset) with minimal residual deformity. They felt that if there is mild or minimal aseptic necrosis, there should also be an assessment of limitation of motion, with the higher rating being given.

Aseptic necrosis (or avascular necrosis or osteonecrosis) of the hip is seen commonly if there has been interference of the blood supply to the head of the femur due to trauma, metabolic disease, vascular disease, etc., with resulting bone death of part or all of the femoral head. Eventually, the affected bone collapses. It is likely that it would currently be rated analogous to fracture of the femur (diagnostic code 5255), which has current evaluations ranging from 10 to 80 percent (and for which we propose to have evaluation levels of 30 to 60 percent, as described above). The proposed new criteria under diagnostic code 5255 are not appropriate for aseptic necrosis of the femur because a fracture of the femur is not always present, and the findings are not necessarily similar. Aseptic necrosis may be painless early but then cause progressive pain with weight bearing or even at rest. Eventually, a hip replacement may be needed because of bone destruction. We propose to base evaluations on whether ambulatory support is needed and whether the femoral head is collapsed, and to evaluate pain, when present, separately under § 4.59, rather than assessing pain on the subjective criteria of whether it is "mild," "moderate," or "severe". We propose to evaluate aseptic necrosis at 60 percent if there is collapse of the femoral head and constant ambulatory support is required; at 40 percent if there is collapse of the femoral head and

intermittent ambulatory support is required; and at 10 percent if there is evidence of aseptic necrosis without collapse of the femoral head. We do not propose to include a 100-percent evaluation as the consultants suggested because their evaluation levels included subjective complaints of pain, and we propose to add a note directing that an evaluation under diagnostic code 5265 will be combined with a separate evaluation for pain under § 4.59 when appropriate. We also propose to add a note indicating that the condition may be alternatively evaluated as limitation of motion of the hip combined with an evaluation for pain when appropriate, if that would result in a higher evaluation.

Other Knee Conditions

There are two relatively common areas of disability of the knee that are not addressed in the current schedule—fracture, subluxation, or dislocation of the patella and patellofemoral pain syndrome. The consultants recommended we add diagnostic codes for these conditions, and we propose to do so.

We propose to add diagnostic code 5266 as "Patellar fracture and instability." This would include subluxation and dislocation of the patella, residuals of patellectomy (removal of the patella), and patellar fracture. The consultants suggested two levels of evaluation for subluxation and dislocation of the patella, with 20 percent assigned for patellofemoral subluxation or dislocation that is "frequent," occurring more than once a month, and 10 percent for patellofemoral subluxation or dislocation that is "infrequent," occurring less than once a month. They also suggested a separate diagnostic code for patellar fracture, with a 30-percent evaluation for symptomatic nonunion and a 20-percent evaluation for patellectomy. We propose instead that all of these conditions be evaluated under a single diagnostic code with three levels of evaluation. We propose to evaluate subluxation (a partial dislocation in which the patella spontaneously goes back into normal position) based on different criteria from the more severely disabling dislocation (which requires manual replacement of the patella). We propose an evaluation of 30 percent if there is symptomatic nonunion of a fracture of the patella, or if there is patellectomy, or if there is recurrent patellar dislocation occurring six or more times during the past 12-month period. We propose a 20-percent evaluation if there is patellofemoral subluxation (partial or incomplete dislocation of the patella) occurring