

preexisted service, may or may not have been congenital, and, if preexisting service, may or may not have undergone aggravation during service. Making all of those determinations is part of the rating process that decides whether the condition should be service-connected, but they are not inherent to evaluation. We also propose to add the term "pes planus" to the title, since this is the medical term for flatfoot. The current criteria provide an evaluation of 50 percent if bilateral and 30 percent if unilateral for the pronounced condition, with marked pronation, extreme tenderness of the plantar surfaces of the feet, marked inward displacement and severe spasm of the tendo achillis on manipulation, not improved by orthopedic shoes or appliances. It provides an evaluation of 30 percent if bilateral and 20 percent if unilateral for the severe condition, with objective evidence of marked deformity (pronation, abduction, etc.), pain on manipulation and use accentuated, indication of swelling on use, characteristic callosities. It provides an evaluation of 10 percent for either the unilateral or bilateral condition if it is moderate, with weightbearing line over or medial to great toe, inward bowing of the tendo achillis, pain on manipulation and use of the feet. It also provides an evaluation of zero percent if mild, with symptoms relieved by built-up shoe or arch support.

The consultants suggested only three levels of disability with deletion of the "pronounced" category, which they said was not clearly differentiated from the "severe" category. Raters have also been confused by the criteria for the "severe" and "pronounced" levels. The consultants suggested new, more detailed and comprehensive criteria ranging from 40 percent (for the bilateral condition) to zero percent. We propose to adopt their criteria, with one exception. Instead of the single evaluation level of 10 percent for unilateral or bilateral flatfeet of moderate deformity that they suggested, we propose to evaluate each foot separately at every level, since it is clearly more disabling to have deformed feet bilaterally than unilaterally, and assigning the same evaluation whether only one foot or both feet are involved is not equitable. We propose to assign a 20-percent evaluation for deformity with, on weightbearing, significant eversion of the heel, flattened arch, collapse of the midfoot structures with the talar head displaced both medial and plantar, forefoot abduction; pain in the arch; not significantly relieved by the use of appliances, orthoses, or

orthopedic shoes. We propose a 10-percent evaluation for deformity with a perpendicular position to slight eversion of the heel, the presence of a slight arch on non-weightbearing which totally collapses on weightbearing; forefoot abduction; pain in the arch and legs; partially relieved by the use of appliances, orthoses, or orthopedic shoes. We propose a zero-percent evaluation if there is deformity but a normal arch on non-weightbearing, a perpendicular heel position; tenderness in the arch or muscles and tendons attaching to the midfoot; symptoms completely relieved by, or do not require, the use of appliances, orthoses, or orthopedic shoes. We propose to add a note directing that each foot be separately evaluated, with the evaluations to be combined. This would represent a change in procedure from the current criteria and is warranted because flatfoot may be either a unilateral or bilateral condition and is clearly more disabling if both feet are affected, even at the milder level. In addition, the feet may not be at the same level of severity, and these evaluations allow an individual assessment of each foot. We propose to add a second note, for the sake of clarity, directing raters not to combine an evaluation under this diagnostic code with an evaluation for pain under § 4.59 because pain is encompassed by these evaluation criteria.

Diagnostic code 5277 is currently titled "Weak foot, bilateral." This is a vague condition. The consultants suggested a change to "Compromised (or weak) foot, bilateral" because this is how the condition is described in current medical practice and suggested it be rated based on the underlying condition, with a minimum evaluation of 10 percent. They noted that it may include single or multiple conditions affecting function, including muscle atrophy, loss, weakness, and stiffness; bone atrophy or loss; joint stiffness; vascular compromise; or neurological compromise. We propose instead to delete this diagnostic code, as suggested by the VHA Orthopedic Committee, because there are specific rating criteria under other diagnostic codes for disabilities such as arthritis, neuropathy, and vascular disease that may affect the foot, and the existing and recommended criteria under 5277 are not necessary for evaluation.

Diagnostic code 5278 is currently titled "Claw foot (pes cavus), acquired," and we propose to update it to "Pes cavus (clawfoot)," removing "acquired," because the consultants pointed out that it is difficult to distinguish an acquired pes cavus from a congenital one. It is

currently evaluated at 50 percent if bilateral and 30 percent if unilateral if there is marked contraction of the plantar fascia with dropped forefoot, all toes hammertoes, very painful callosities, and marked varus deformity. It is evaluated at 30 percent if bilateral and 20 percent if unilateral if all toes tend to dorsiflexion, and there are limitation of dorsiflexion at ankle to right angle, shortened plantar fascia, and marked tenderness under metatarsal heads. It is evaluated at 10 percent whether bilateral or unilateral if the great toe is dorsiflexed, and there are some limitation of dorsiflexion at ankle and definite tenderness under metatarsal heads. If the condition is "slight," it is evaluated at zero percent. These criteria contain several subjective terms, for example, "marked," "definite," and "slight," that inject an element of subjectivity.

The consultants recommended three levels instead of four, with 40 percent the highest level, when bilateral, comparable to other lower extremity conditions. They also suggested that 10 percent be assigned for moderate pes cavus bilaterally, because the impairment is considerably less. We propose to revise the criteria, with each foot being separately evaluated, using the most objective of the criteria related to disability as a basis of evaluation, namely, whether appliances, orthoses, or orthopedic shoes are required and whether they relieve symptoms of pain and tenderness, and callosities, if present. These criteria represent a modification of the consultants' recommendations. We propose that a 20-percent evaluation be assigned if symptoms and callosities are not significantly relieved by appliances, orthoses, or orthopedic shoes; a 10-percent evaluation if symptoms and callosities are partially relieved by appliances, orthoses, or orthopedic shoes; and a zero-percent evaluation if symptoms are completely relieved by, or do not require, the use of appliances, orthoses, or orthopedic shoes. We propose to add two notes under this diagnostic code, the first directing that each foot be separately evaluated, with the evaluations to be combined. This would allow each foot to be separately evaluated, which will be of value when the condition differs in severity from one foot to the other. We propose to add a second note stating that in the absence of trauma or other specific cause of aggravation, pes cavus is to be considered a congenital or developmental abnormality.

Diagnostic code 5279 is currently titled "Metatarsalgia, anterior (Morton's disease), unilateral, or bilateral". There