Also, this rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

*E. Unfunded Mandates Reform Act*

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

*F. Environment*

We have analyzed this rule under Department of Homeland Security Directive 023–01, Rev. 1, associated implementing instructions, and Environmental Planning COMDTINST 5090.1 (series), which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves a safety zone lasting 1.5 hours that will prohibit entry within a 1 square mile area of the Neuse River on December 5, 2020, from 4 p.m. to 5:30 p.m. It is categorically excluded from further review under paragraph L60(a) of Appendix A, Table 1 of DHS Instruction Manual 023–01–001–01, Rev. 1. A Record of Environmental Consideration supporting this determination is available in the docket. For instructions on locating the docket, see the **ADDRESSES** section of this preamble.

*G. Protest Activities*

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to call or email the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

**List of Subjects in 33 CFR Part 165**

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

## PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

**Authority:** 46 U.S.C. 70034, 70051; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.T05–0645 to read as follows:

**§ 165.T05–0645 Safety Zone; Neuse River, Airshow, New Bern, NC.**

(a) *Location.* The following area is a safety zone: All navigable waters of the Neuse River in New Bern, North Carolina, inside an area starting from approximate positions: Latitude 35°06′32″ N, longitude 077°01′54″ W, then north to latitude 35°06′55″ N, longitude 077°02′04″ W, then east to latitude 35°07′06″ N, longitude 077°01′27″ W, then southeast to latitude 35°06′49″ N, longitude 077°01′12″ W, then south to latitude 35°06′08″ N, longitude 077°01′18″ W, then west to latitude 35°06′02″ N, longitude 077°01′57″ W, then north to the point of origin, for a total area of approximately 1 mile square.

(b) *Definitions.* As used in this section—

*Captain of the Port (COTP)* means the Commander, Sector North Carolina.

*Designated representative* means a Coast Guard Patrol Commander, including a Coast Guard commissioned, warrant, or petty officer designated by the Captain of the Port North Carolina (COTP) for the enforcement of the safety zone.

(c) *Regulations.* (1) The general regulations governing safety zones in § 165.23 apply to the area described in paragraph (a) of this section.

(2) Entry into or remaining in this safety zone is prohibited unless authorized by the COTP North Carolina or the COTP North Carolina's designated representative. Unless permission to remain in the zone has been granted by the COTP North Carolina or the COTP North Carolina's designated representative, a vessel within this safety zone must immediately depart the zone when this section becomes effective.

(3) The Captain of the Port, North Carolina can be reached through the Coast Guard Sector North Carolina Command Duty Officer, Wilmington, North Carolina, at telephone number 910–343–3882.

(4) The Coast Guard and designated security vessels enforcing the safety zone can be contacted on VHF–FM marine band radio channel 13 (165.65 MHz) and channel 16 (156.8 MHz).

(d) *Enforcement.* The U.S. Coast Guard may be assisted in the patrol and enforcement of the safety zone by Federal, State, and local agencies.

(e) *Enforcement period.* This regulation will be enforced from 4 p.m. through 5:30 p.m. on December 5, 2020.

Dated: November 17, 2020.

**Matthew J. Baer,**

*Captain, U. S. Coast Guard, Captain of the Port North Carolina.*

[FR Doc. 2020–25688 Filed 11–27–20; 8:45 am]

**BILLING CODE 9110–04–P**

## DEPARTMENT OF VETERANS AFFAIRS

### 38 CFR Part 4

**RIN 2900–AP88**

## Schedule for Rating Disabilities: Musculoskeletal System and Muscle Injuries

**AGENCY:** Department of Veterans Affairs.

**ACTION:** Final rule.

**SUMMARY:** This document amends the Department of Veterans Affairs (VA) Schedule for Rating Disabilities (''VASRD'' or ''rating schedule'') by revising the portion of the rating schedule that addresses the musculoskeletal system. The purpose of this revision is to ensure that this portion of the rating schedule uses current medical terminology and provides detailed and updated criteria for the evaluation of musculoskeletal disabilities.

**DATES:** This rule is effective February 7, 2021.

**FOR FURTHER INFORMATION CONTACT:** Gary Reynolds, M.D., Regulations Staff (211C), Compensation Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, (202) 461–9700. (This is not a toll-free number.)

**SUPPLEMENTARY INFORMATION:** The National Defense Authorization Act of 2004, secs. 1501–07, Public Law 108–136, Stat. 1392, established the Veterans' Disability Benefits Commission (the ''Commission''). Section 1502 of Public Law 108–136 mandated the Commission to study

ways to improve the disability compensation system for military veterans. The Commission consulted with the Institute of Medicine (IOM) (now named the National Academy of Medicine) to review the medical aspects of current policies. In 2007, the IOM released its report titled ''A 21st Century System for Evaluating Veterans for Disability Benefits.'' (Micahel McGeary et al. eds. 2007).

The IOM report noted that the VA Rating Schedule for Disabilities was inadequate in areas because it contained obsolete information and did not sufficiently integrate current and accepted diagnostic procedures as well as the lack of current knowledge of the relationships between conditions and comorbidities. Following the release of the IOM report, VA created a musculoskeletal system workgroup to: (1) Improve and update the process that VA uses to assign levels of disability after it grants service connection; (2) improve the fairness in adjudicating disability benefits for service-connected veterans; and (3) invite public participation.

VA began rulemaking to remove obsolete diagnostic codes, modernize the names of selected diagnostic codes, revise descriptions and criteria, and add new diagnostic codes. VA published a proposed rule to revise the regulations involving the musculoskeletal system within VASRD on August 1, 2017 (82 FR 35719). Specifically, VA proposed to rename conditions to reflect current medicine, remove obsolete conditions, clarify ambiguities, and add conditions that previously did not have diagnostic codes. Interested persons were invited to submit comments on or before October 2, 2017. VA received comments from the National Organization of Veterans' Advocates, American Association of Nurse Practitioners, Paralyzed Veterans of America, and nine individuals. VA has made limited changes based on these comments, as discussed below.

**General Terminology Changes**

Two separate comments recommending specific terminology changes were received.

One commenter suggested incorporating terminology used by claimants or seen in service treatment records into the VASRD regulations. The commenter stated that field medics do not always incorporate medical terminology or use treatises when entering information in a servicemember's medical record. The commenter also noted that individual claimants may not have sufficient medical training to utilize specific technical terminology when claiming a given disability. A stated intent of the current update to the rating schedule, as stated in the preamble to the proposed rule, is to employ current medical terminology in order to clarify and standardize the disability criteria. Accordingly, VA relies on medical standards and treatises when updating terminology.

As to the effect of technical terminology in part 4 on a veteran attempting to claim disability, there is none. Claimants are not required to possess medical knowledge or expertise when describing a claimed condition; they are simply required to describe their disability and/or symptoms as they experience and observe them. *Brokowski* v. *Shinseki,* 23 Vet. App. 79, 86–87 (2009). Moreover, VA reviews medical records with the understanding that different examiners, at different times, will not describe the same disability in the same language; it is the responsibility of the rating specialist to interpret reports of examination in the light of the whole recorded history, reconciling the various reports into a consistent picture so that the current rating may accurately reflect the elements of disability present. 38 CFR 4.2. Accordingly, VA reviews the entire evidentiary record in light of the disability claimed, circumstances of military service, and all other applicable records to create a cohesive picture of the disability in question; it is not the responsibility of the claimant or a military medical provider to employ terminology that necessarily matches the VASRD. Thus, VA makes no changes related to this comment.

Another commenter suggested use of the phrases ''greater than or equal to'' and ''less than or equal to'' rather than ''limited to XX degrees or more'' or ''limited to XX degrees or less'' for criteria based on numerical range of motion measurements. While this comment was taken into consideration, VA notes the phrases ''limited to XX degrees or more'' or ''limited to XX degrees or less'' are consistent with medically-accepted language used in the VASRD for range of motion measurement and elsewhere, and are well-understood and applied by VA claims processors efficiently and accurately. Accordingly, VA makes no changes based on this comment.

**Musculoskeletal Diagnostic Codes**

*I. Diagnostic Codes (DCs) 5002–5009*

One commenter asked if there was a DC for infectious arthritis. While there is not a standalone DC for infectious arthritis, infectious arthritis may be evaluated under DCs 5004 through 5009, depending on the infection associated with the arthritic findings. VA makes no change based on this comment.

Another commenter requested that VA use the same non-exhaustive list of conditions listed in proposed DC 5002's Note (1) for other selected DCs (5054, 5055, and 5250–5255). The list of conditions in DC 5002 is being provided to further explain the change from this DC contemplating a specific condition to contemplating a category of conditions. The other DCs suggested by the commenter are unlike proposed DC 5002 because they employ criteria based on a specific procedure (DCs 5054 & 5055) or defined range of motion measurement (DCs 5250–5255). VA makes no changes based on this comment.

Lastly, a commenter expressed concern that the directive to ''assign the higher evaluation'' under DC 5002 could result in situations where an active disease process results in a lower evaluation than if the residuals of the disease itself were evaluated. The directive in proposed Note (3) for DC 5002 specifically addresses this concern. As indicated in the preamble to the proposed rule, the purpose of Note (3) is to prevent ratings for both residuals and active disease process at the same time; instead, the Note requires claims processors to assign the evaluation more advantageous to the claimant: An evaluation for active disease process OR an evaluation for the residual effects of the disease (including combined and/or bilateral factors, where applicable). Accordingly, VA makes no change based on this comment.

*II. DCs 5010–5024*

One commenter suggested that arthritis ratings under DC 5010 resulting from separate traumas should not receive a combined evaluation under 38 CFR 4.25. VA makes no changes based on this comment, as the evaluations under the VASRD are based on the average impairment in earnings due to disabilities resulting from military service; the specific incidents or causes during military service are generally immaterial to a rating. As a practical matter, attempting to categorize functional impairment by specific traumatic instances would prove ineffective and often impossible, as specific instances of trauma are not necessarily captured in the treatment record for an individual.

One commenter asked how DC 5011 would help evaluate a case of facial fractures, hearing loss, a collapsed sinus, eye injury and so forth. VA notes

that DC 5011 does not provide specific evaluation criteria; rather, it serves as a standalone diagnostic code to track instances of decompression illness (also known as generalized barotrauma or the bends). As noted in the preamble to the proposed rule, residual manifestations of decompression illness often involve other body systems; the proposed evaluation criteria specifically directs claims processors to evaluate residuals under the appropriate body system. Accordingly, specific residual injuries will be evaluated under the most appropriate diagnostic code in the VASRD, in accordance with the findings and disability present. VA makes no changes based on this comment.

Another commenter questioned what effect the changes to DCs 5010, 5013 and 5014 would have on determinations under 38 CFR 3.309. 38 CFR 3.309 identifies diseases subject to presumptive service connection where certain circumstances of military service are otherwise met. This section pertains to establishing service connection; it does not involve the evaluation of any specified disability. The current rulemaking has no impact on the provisions of section 3.309 and therefore VA makes no changes based on this comment.

Another commenter recommended using the phrase ''medically-directed therapy'' as opposed to ''prescribed therapeutic procedure'' in the Note to DC 5012. While this comment was taken into consideration, VA's selected term has a specific meaning and indicates a prescribed course of treatment, as determined by a qualified medical professional, as evidence of the severity of the disability and disease, in the professional opinion of the provider. ''Medically-directed'' does not have the same meaning as ''prescribed'' and its use here would leave open for interpretation therapies that are either suggested at a lower level of necessity or directed by someone who is not licensed/qualified to prescribe treatment for malignancies. VA makes no changes based on this comment.

One commenter suggested adding a Note to DC 5014 indicating that, if medical evidence does not specifically indicate or state there are no residuals, there is insufficient evidence to apply the provisions of DC 5014. VA appreciates this comment but notes that 38 CFR 4.2 specifically instructs claims processors to return examinations as inadequate for evaluation purposes if the examination report does not contain sufficient detail or if a diagnosis is not supported by the findings on examination. Accordingly, the suggested Note would be duplicative of current regulations and VA makes no change.

Also, a commenter suggested adding notes to indicate where hydrarthrosis, synovitis, and periostitis could be evaluated since VA proposed removing specific DCs for these conditions. As noted in the preamble to the proposed rule, hydrarthrosis and synovitis are signs of underlying conditions that are already captured within the evaluation criteria of other DCs. Likewise, periostitis is a non-specific inflammatory process caused by underlying conditions that can be rated in accordance with the primary diagnosis. VA sees no need to limit these signs to specific DCs; they will be evaluated with an underlying diagnosis. VA makes no changes based on this comment.

Finally, on further review, the sentence following DC 5024 is more aptly described as a Note to DCs 5013 through 5024. As such, the final rule recharacterizes it as a Note and removes as unnecessary the proposed limitation that gout only be evaluated under DC 5003.

*III. DCs 5051–5056 (Introductory Notes)*

One commenter requested clarification as to why joint resurfacing and total joint replacement qualify for 100 percent disability compensation during the convalescent period, but partial joint replacement does not. VA recognizes that partial joint replacement (more accurately referred to as subtotal joint replacement) may result in disability in a manner similar to joint resurfacing and/or total joint replacement. However, VA currently lacks sufficient data to determine that partial joint replacement warrants a temporary post-surgical rating in lieu of a rating based on the effects of the underlying disability. To that end, VA will consider adding criteria specific to subtotal joint replacement in a future rulemaking, once sufficient evidence is received and reviewed to provide adequate evaluation criteria.

One commenter asked if revision procedures were eligible for the same compensation as the original procedures. While this comment was asked about hip replacement, it could be applied to all of the prosthetic replacement DCs. If the original complete prosthetic component is replaced, or, in addition to replacement of the original component, additional components are installed, then the revision procedure should be evaluated in the same manner as the initial procedure. In other words, if the revision fully replaces the original total prosthetic joint replacement, VA treats the complete revision procedure in the same manner as the initial total joint replacement. To that end, in this final rule, VA has recharacterized the proposed note at the beginning of the ''Prosthetic Implants and Resurfacing'' subsection as Note (1) and added a Note (2) that directs claim processors to only evaluate revision procedures in the same manner as the original procedure if the revision completely replaces the original components.

For organization and clarity, VA has also moved three other notes to the beginning of the ''Prosthetic Implants and Resurfacing'' subsection and added a clarifying instruction. Specifically, the note immediately following DC 5111 has been moved to the beginning of the subsection and redesignated as Note (3). DC 5053's note and DC 5056's Note (1), which were identical, have been moved and redesignated as Note (4). An instruction that clarifies when the 100 percent evaluation period begins and ends for DCs 5054 and 5055 is provided as Note (5). And Note (2) under DC 5056 has been moved and redesignated as Note (6).

*IV. DCs 5054 and 5055*

Multiple comments were received for DCs 5054 and 5055. Generalized objections included two commenters who shared their personal histories involving revision procedures/surgeries on their hips as the underlying basis for their objections. Two commenters also expressed reservations with the reduction in the convalescent period for these DCs because of non-sedentary or physically demanding occupations, as well as additional service-connected disabilities that potentially complicate the evaluation. In regard to using personal experiences to justify any objection to the proposed changes, VA notes that 38 U.S.C. 1155 (the statute that governs implementation of the ratings schedule) provides that ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civilian occupations. Accordingly, VA formulates the VASRD based on average impairments in civil occupations, not isolated personal experiences or the demands of specific occupations. In addition, the reduction in convalescent periods is based on average recovery times, as noted in the proposed rulemaking and sources cited therein. There are provisions to address exceptional individual circumstances on a case-by-case basis that fall outside the scope of this rulemaking. No changes are made based on those comments.

Another commenter disputed the study cited in the preamble to the proposed rule. The commenter used a quotation from the authors characterizing the methodological quality as moderate to low and comparisons of rates and speeds of return to work being hampered by large variations in patient selection and measurement methods. VA disagrees that the limitations identified by the commenter should invalidate the justification to reduce the convalescent period from 12 months to 4 months for hip and knee replacements. There are multiple studies within the medical literature which demonstrate sufficient functional recovery well short of 12 months. The study cited in the proposed rule focused upon a specific outcome (return to work without restriction), rather than completion of the associated rehabilitation program. VA convalescence rates are awarded at the 100 percent level—which, in accordance with the criteria throughout 38 CFR part 4, equates to a complete inability to work. Following the convalescent period, VA assigns a non-convalescent evaluation based on residual functional impairment, the purpose of which is to assess residual disability and compensate for average earnings loss based on said residual disability.

One commenter proposed that a reduction in benefits for these DCs occur only after mandatory examination. Post-convalescence reductions for these conditions occur without a mandatory examination, due to the common nature of these medical procedures as well as the expected outcome and residuals, as supported by medical evidence cited in the preamble to the proposed rule. As stated in 38 CFR 4.1, the percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations. VA acknowledges that there may be individual circumstances which require additional consideration due to worse-than-expected residuals or the factual need for additional convalescence. In these circumstances, a claimant may submit a claim with pertinent treatment records to support an increased evaluation for residuals or additional convalescence, all without requiring a mandatory examination. VA makes no changes based on this comment.

Another commenter proposed to extend the convalescent period whenever a revision procedure is performed. While a revision procedure may require additional time in the hospital following the procedure, this time typically amounts to a few days. Additionally, while the recovery may be potentially slower following a revision, VA is currently unaware of published medical literature which quantifies this recovery in a manner sufficient to identify a unique and/or extended period of convalescence for purposes of the VASRD. Should such evidence exist at a future date, VA will review it and consider revisions to the criteria as necessary. At this time, however, VA makes no changes based on this comment.

One commenter disagreed with the proposed reduction in the convalescent period because (1) there was little to no public support for such a reduction and (2) the studies used to support the reduction were not specific to veterans. The language in 38 U.S.C. 1155 specifically contemplates a schedule of ratings based on the average impairment in earnings from civil occupations, with revisions from time to time in accordance with experience. If a particular disability's effect on earnings capacity measurably changes (usually through a combination of improved medical management and job market changes), VA complies with its statutory authority by revising the criteria contained in the VASRD to ensure evaluations are consistent with available data. VA is unaware of any study pertinent to the disabilities at issue that quantifies a different impact of a specific disability or disabilities on the general population comparative to the veteran population. Should such information become available, VA will review it along with all other available scientific, medical, and economic data available to ensure the VASRD provides the most accurate and adequate evaluations. At this time, however, VA makes no revisions based on these comments.

One commenter offered an alternative schema to VA's proposal for DC 5054. This commenter recommended a separate DC be created for hip resurfacing. The commenter provided multiple sources to justify a minimum evaluation within the criteria for this alternative schema (citing multiple sources which compared resurfacing to prosthetic replacement). The commenter also criticized VA's proposed revision for DC 5054, asserting it was contradictory to government and industry standards. The commenter asserted that the purpose and advantage of hip resurfacing is bone preservation, not improved range of motion or activity. Finally, the commenter stated that VA should evaluate resurfacing and total arthroplasty under separate DCs.

VA makes no changes based on these comments for several reasons. First, VA disagrees with the statement that a minimum evaluation for hip resurfacing post convalescence similar to total arthroplasty is required. As noted in the preamble to the proposed rule, joint resurfacing preserves more of the original anatomy of the joint, leading to greater functional potential, and ultimately less occupational disability or impairment in earnings capacity compared to a total arthroplasty. Also, the sources cited by the commenter refer to the hip resurfacing procedure itself, the unique complications associated with resurfacing, and how it compares to total arthroplasty. While relevant in individual cases, potential complications in and of themselves do not consistently predict either residual occupational disability or average impairment in earnings capacity in a manner consistent with VA's authority to maintain and revise the VASRD. Additionally, as stated previously in response to similar comments, should individual complications arise, VA has the means to address these unique situations on a case-by-case basis either through additional convalescence or increased evaluations. With regard to the comment that VA's proposed revision is contrary to government and industry standards, VA notes that the commenter did not provide resources which establish either government or industry standards for the evaluation of resurfacing or residual disability in light of occupational impairment or earnings loss, and VA is unaware of an official government or industry standard upon which to base any changes to the proposed rule.

However, to further clarify VA's intent to provide a minimum evaluation following only total joint replacement, VA has added language to the Note following final DCs 5054 and 5055 clarifying that the minimum evaluation does not apply to resurfacing. Regarding the comment that range of motion as a residual for hip resurfacing would not be addressed under other DCs, VA notes that the (proposed and now final) rule directs the rater to use DCs 5250 through 5255 to evaluate such residuals. DCs 5251, 5252, and 5253 address decreased range of motion of the hip joint as a potential residual. Additionally, VA notes that the commenter's reference to ''bone preservation'' is consistent with VA's explanation in the preamble of the proposed rule (noting that resurfacing ''preserves more of the original anatomy''). In any event, the intent of the VASRD is to assess and evaluate

residual disability and occupational impairment. Currently, VA is unaware of medical or economic data to support an evaluation for hip resurfacing based on the quantity of bone preserved. Additionally, VA notes that a single DC for both resurfacing and prosthetic component replacement is more appropriate than having separate DCs, as the symptoms leading up to and resulting from both procedures are similar and predictable (loss of weight bearing capability, muscle strength/endurance, and range of motion due to complications such as component loosening, infection, etc.).

*V. DCs 5120–5173*

One commenter stated that the rating for disarticulation of the shoulder in DC 5120 may conflict with the rules for rating the shoulder muscles and ankylosed joints. VA notes that a disarticulation at the shoulder joint removes all the joints along with their associated muscles of the upper extremity. Thus, there would be no muscles or joints remaining, and therefore no evaluation based on ankylosis of the joint could be assigned.

Another commenter asked why VA removed prompts from certain DCs directing claims processors to consider eligibility for special monthly compensation (SMC). The removal of the prompts from DCs in the proposed rule was an unintentional error. Accordingly, VA has re-inserted the prompts to consider SMC for all applicable DCs.

One commenter questioned both the need and the basis for the proposed changes to DC 5170. The commenter disagreed with VA's proposed criteria modification to include different amputation degrees within one DC and argued that at least two different DCs was a more appropriate approach. As noted in the preamble to the proposed rule, VA is adding this terminology to incorporate a residual which causes a similar disability to the one captured by current DC 5170. Furthermore, the amputation levels captured in the (proposed and now final) DC cause similar effects on occupational disability and impairment of earnings capacity. By grouping conditions and injuries with similar functional impairment together, VA provides accurate and adequate evaluations that reflect actual functional impairment while also providing more efficient and timely delivery of benefits.

*VI. DCs 5235–5243*

One commenter requested that VA include more medical diagnoses synonymous with intervertebral disc syndrome (IVDS) and arthritis because, in the commenter's view, claims processors are inconsistent with acknowledging other similar conditions/diagnoses that are not specifically labeled as IVDS, arthritis, or degenerative joint disease (DJD). VA's original intent was to classify disability associated with IVDS under DC 5243 and all other intervertebral disc disabilities under DC 5242. To clarify that issue, VA has added such an instruction to final DC 5243.

*VII. DC 5244*

For newly proposed DC 5244, two commenters had questions, and one commenter offered to provide training assistance to claims processors learning how to evaluate this newly proposed DC. The issue of training is beyond the scope of this rulemaking and therefore VA does not respond. One commenter stated that using the term ''paraplegia'' was problematic because it lumped a number of disabilities together and because paraplegia has a legal meaning. Specifically, the commenter questioned if paraplegia under DC 5244 also applies to paraplegia caused by amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS) and whether anal and bladder sphincter control impairment is necessary for assigning paraplegia under this DC, as is required to qualify for SMC under 38 CFR 3.350(e)(2), which is titled *Paraplegia.* The other commenter asked if incomplete paralysis is compensable. First, VA intended DC 5244 to rate paralysis resulting from trauma, as indicated in the title. It is separate and distinct from paralysis caused by either ALS or MS, which are neurological diseases and are rated using the appropriate neurological DC hyphenated with DC 5110 (loss of use of both feet). Second, although paraplegia is the title of § 3.350(e)(2), that provision provides requirements for SMC; paraplegia awarded under DC 5244 does not require impairment of anal and bladder sphincter control. Third, with regard to the comment on incomplete versus complete paralysis, VA has provided a note in this final rule that, if traumatic paralysis does not cause loss of use of both hands or both feet, it is incomplete paralysis and must be rated using the appropriate diagnostic code (*e.g.,* 38 CFR 4.124a, Diseases of the Peripheral Nerves).

*VIII. DCs 5255 and 5257*

One commenter concurred with the proposed changes to DC 5255. VA thanks the commenter for the input. Other commenters (1) asked if patellofemoral pain syndrome (PFPS) was included in DC 5255; (2) asked what would happen to DCs 5258 and 5259, given the proposed changes to DC 5257; and (3) recommended that claims processors be provided additional guidance for evaluating malunion under DC 5255. First, PFPS is a symptom that may result from patellar instability, but is a less appropriate fit for DC 5255, which contains criteria requiring fractures or malunions. Second, VA intends no changes to DCs 5258 or 5259, as they involve different components of the knee; accordingly, the changes to DC 5257 have no impact on DCs 5258 and 5259. Lastly, VA will provide non-regulatory guidance and training to claims processors for evaluating malunion under DC 5255.

Four additional commenters had concerns with and suggested alternatives to the proposed criteria of DC 5257. The first commenter expressed concern that the term ''physician prescribed'' excludes nurse practitioners, though such prescriptions are well within their scope of practice. VA agrees, and has substituted ''medical provider'' in place of ''physician'' to indicate that such instructions are intended to include qualified medical providers such as nurse practicioners.

The second commenter argued that (1) there is subjectivity with measuring translation; and (2) operative intervention should not be the basis for distinguishing a 30 percent evaluation from a 20 percent evaluation. After review, VA agrees that using translation can add an unintended amount of subjectivity to the evaluation criteria. To that end, VA has revised the proposed criteria to remove the reference to translation, and, instead, will use the elements of ligament status, instability, and need for assistive devices/bracing. A 10 percent evaluation will be granted if a sprained, incompletely torn ligament, or completely torn ligament (whether repaired, unrepaired, or failed repair) causes persistent instability but does not require a prescription for either bracing or an assistive device for ambulation. A 20 percent evaluation will be granted under one of two circumstances: (a) In the presence of a sprained, incompletely torn ligament, or repaired completely torn ligament that causes persistent instability and a medical provider prescribes a brace and/or assistive device; or, (b) in the presence of an unrepaired completely torn ligament or completely torn ligament with failed repair that causes persistent instability and requires a prescription for either a brace or an assistive device for ambulation. A 30 percent evaluation will be granted for an unrepaired completely torn ligament or completely torn ligament with failed

repair that requires a prescription for both a brace and an assistive device for ambulation. As to the original comment, this final rule considers both operative intervention and prescriptions as a basis for distinguishing the 30 percent and 20 percent evaluations. As a result of these changes, proposed Note (1), providing measurements of joint translation, has been withdrawn.

The third commenter felt that VA gave no explanation for the new criteria, that the criteria should include assistive devices and/or bracing whether prescribed by a provider or not, and that the criteria requiring both an assistive device and bracing was too restrictive. In the preamble to the proposed rule, VA provided a full explanation for the evaluation criteria for knee instability, citing multiple peer-reviewed medical sources which further support the criteria used. Regarding the requirement for provider-prescribed bracing, braces and other assistive devices are commonly and readily available for purchase without prescription; the use of such devices, without a prescription, does not always demonstrate the presence of a knee disability impairing earning capacity. A qualified medical professional's prescription, however, provides objective evidence of the instability. Accordingly, for purposes of assessing the severity of knee instability, this (proposed and final) rule considers bracing in its evaluation criteria only when the brace or assistive device is prescribed by a provider. Moreover, to the extent the commenter believes that requiring bracing *and* an assistive device is too restrictive, this final rule provides a 20% rating where only one of the two has been prescribed.

The fourth commenter asserted that the proposed changes to DC 5257 (1) will result in compensation that is either completely detached from functional loss or not commensurate with the functional loss being evaluated; (2) completely ignore functional loss and misplace emphasis on physical abnormalities and recommended treatment; and (3) did not consider knee instability caused by conditions other than ligament damage.

VA appreciates the comment, but disagrees with the commenter's first assertion. Per 38 U.S.C. 1155, the schedule and its ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations. VA compensates for functional loss that results in an impairment of earning capacity. The criteria for DC 5257, as indicated in the preamble to the proposed rule, incorporate both functional loss elements (assistive devices & bracing), as well as diagnostic elements (sprain, incomplete ligament tear, complete ligament tear). These criteria, which rely upon published sources reflecting current medical standards, serve as accurate proxies for functional loss of the magnitude that negatively impacts earnings. Furthermore, the proposed (and now final) criteria are easily observed and measured. Additionally, given the progressive manner of the criteria, VA provides compensation commensurate with the severity of the disability.

As to the commenter's second assertion that the proposed criteria base evaluations on recommended treatment, that is not the case. The proposed (and now final) criteria compensate for residual disability after specific treatment interventions are prescribed, not on the prescribed treatment itself, as well as observable and measurable factors to create a more complete assessment for evaluation purposes.

Third, with regards to the causes for knee instability other than ligament damage, VA intended the evaluation for patellar instability to be limited to the patellofemoral complex only. Thus, this final rule clarifies the proposed criteria and requires a diagnosed condition involving the patellofemoral complex for a patellar instability evaluation. A history of surgical repair (or the lack thereof) and the prescriptions for the instability dictate whether that evaluation will be 10, 20, or 30 percent (consistent with the format for recurrent subluxation evaluations).

Given this revision, VA has added a note (Note (1)) explaining that the patellofemoral complex consists of the quadriceps tendon, patella (knee cap), and patellar tendon. Proposed Note (2), despite technical edits, still provides that certain surgical procedures do not qualify as surgical repair under the patellar instability provisions of this DC.

In further response to the commenter's contention, we note that knee instability resulting from muscle failure can be evaluated under DC 5313 or DC 5314. Furthermore, with regards to knee instability and specific occupations, which the commenter also raised, compensation is based on the average of impairment in earning capacity for civil occupations, not the severity of disability encountered in selected occupations. Lastly, the language alternatively proposed by the commenter, which stems from a 2003 VA proposal, does not accommodate patellar instability, a shortcoming VA is unwilling to accept. VA notes that the 2003 proposal was withdrawn specifically to address concerns and issues with the rulemaking and to develop a new proposal at a later date. 69 FR 22757. Therefore, VA makes no revisions based on this commenter's input.

*IX. DC 5262*

Unrelated to any particular comment, VA has revised the language of DC 5262 in this final rule to provide clarity on the specific criteria distinguishing the 30, 20, and 10 percent ratings for shin splints. Moreover, VA has decided not to adopt a rule that would require imaging evidence for a compensable rating; as the preamble to the proposed rule noted, shin splints are typically diagnosed—and can be properly assessed—by history and physical examination. M. Winters et al., ''Medial tibial stress syndrome can be diagnosed reliably using history and physical examination,'' 52(19) Br. J. Sports Med.1267–72 (2018).

As to the comments, one commenter asked two questions: (1) Is there ever a scenario where shin splints and fractured tibia/fibula do not have overlapping symptoms, and (2) Is a distal fracture rated as an ankle disability and shin splints as a knee disability? Whether or not symptoms from shin splints and a certain fracture may or may not overlap is a medical question for medical examiners in individual cases. Therefore, VA will not speculate on the answer to the first question here. In regard to the second question, VA's intent is that a tibia/fibula malunion be rated as either an ankle or knee disability. Beyond malunion, however, uncomplicated tibia/fibula fractures should still be rated under DC 5262.

*X. DCs 5278–5285*

Three commenters provided input for the proposed changes to these codes. Besides the commenters who concurred, one commenter disagreed with the criteria for proposed DC 5285, contending that veterans who are not surgical candidates are punished by the proposed 20 and 30 percent criteria. To address those veterans who would potentially benefit from surgical intervention, but who are not surgical candidates, VA is adding a Note (2) to DC 5285 indicating that a veteran who is recommended surgical intervention for plantar fasciitis but is not a surgical candidate would be eligible for either the 20 or 30 percent evaluation levels. The Note proposed in the proposed rule is recharacterized as Note (1). VA has also revised the wording of DC 5285 for clarity.

**Muscle Injuries**

One commenter concurred with proposed DC 5330. VA thanks the commenter for the input.

**Miscellaneous Issues**

*I. General Support for Rulemaking*

Several commenters expressed support for particular revisions, as well as the rulemaking in general. Many of these comments, which were received from individuals as well as organizations in the veteran community, expressed appreciation for VA's action in updating the rating schedule for musculoskeletal disabilities. VA appreciates the time and effort expended by these commenters in reviewing the proposed rule and in submitting comments, as well as their support for this rulemaking.

*II. Public Access*

One commenter requested public access to the information developed by the musculoskeletal system workgroup. In the preamble to the proposed rule, VA explained that the workgroup, comprised of subject matter experts from VA, the Department of Defense, and medical academia, held two public forums in August 2010 and June 2012, discussing possible revisions to the musculoskeletal regulations. A transcript of this public forum and all related materials are on file and available for public inspection in the Office of Regulation Policy and Management. (Contact information for that office is noted in the **ADDRESSES** section of the proposed rule. 82 FR at 35719.)

VA emphasizes that the workgroup did not participate in the deliberative rulemaking process; the workgroup discussed the general topic of the VASRD body system and provided feedback on the areas that were subject to advances since the last major revision of the body system. To this end, where changes to the scientific and/or medical nature of a given condition were made in the proposed rule, VA cited the published, publicly available source for these changes. Not only did this provide the public with access to the source for a given proposed change, it also confirmed that VA relied upon peer-reviewed scientific and medical information to support a given change. While similar information may have been presented by a workgroup member, VA relied upon the published document(s) as the primary source for a change and included such sources in the administrative record for this rulemaking. VA did not propose scientific and/or medical changes to the VASRD in the absence of publicly available, peer-reviewed sources.

Accordingly, references in the proposed rule to the workgroup serve as an explanatory background and introduction to the VASRD rewrite project; the changes made by this rulemaking are not a reflection of the workgroup or any workgroup member. All changes based on scientific and/or medical information are a reflection of cited, published materials which are available to the public. VA has made deliberative materials available (via citation in the rulemaking) and is providing access to materials from the public forum for public inspection at the Office of Regulation Policy and Management.

*III. Technical Corrections*

On review, the current rating schedule refers evaluations of inactive tuberculosis of the bones and joints (DC 5001) to 38 CFR 4.88b; however, § 4.88b was redesignated to § 4.88c in 1994. Therefore, the final rule simply corrects this reference.

In addition, the final rule revises the subheading for DCs 5051 to 5056 to ''Prosthetic Implants and Resurfacing,'' which the proposed rule noted in its regulatory text, but not in its preamble.

Also, DCs 5054 and 5055 have been reorganized to provide clarity to the applicability of the evaluation criteria. The 100 percent evaluation applies to both resurfacing and replacements. However, the 90, 70, 50, and 30 percent evaluations apply only to replacements. Therefore, the subheading referencing ''replacement'' in these DCs was relocated to the most appropriate location.

Lastly, VA made non-substantive edits to the parenthetical of DC 5242 and the proposed language for recurrent subluxation or instability under DC 5257.

*IV. Other Comments Unrelated to or Outside the Scope of This Rulemaking*

VA received comments dealing with issues not directly related to proposed amendments to the rating schedule for musculoskeletal disabilities. One commenter suggested adding specified conditions to the list of presumptive disabilities for Former Prisoners of War (FPOW). Similarly, one commenter expressed concern over the impact of this rulemaking on the provisions for presumptive service connection for FPOWs in 38 CFR 3.309. Another commenter noted that the changes would assist in providing necessary treatment for the listed disabilities.

VA does not respond to these comments because they are either unrelated to this rulemaking or beyond its scope.

**Regulatory Flexibility Act**

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This final rule will not affect any small entities. The impact of this rulemaking results in cost savings to the VA's compensation and pension appropriations. There are no small entities involved, associated have an affilitation with VA's compensation and pension appropriations. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

**Executive Orders 12866, 13563, and 13771**

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined that this rule is an economically significant regulatory action under Executive Order 12866.

VA's impact analysis can be found as a supporting document at *www.regulations.gov,* usually within 48 hours after the rulemaking document is published. Additionally, a copy of this rulemaking and its impact analysis are available on VA's website at *www.va.gov/orpm/,* by following the link for VA Regulations Published from FY 2004 Through Fiscal Year to Date. This rule is not subject to the requirements of E.O. 13771 because this rule results in no more than *de minimis* costs.

**Unfunded Mandates**

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any

one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

**Paperwork Reduction Act**

This final rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

**Catalog of Federal Domestic Assistance**

The Catalog of Federal Domestic Assistance program numbers and titles for this rule are 64.013, Veterans Prosthetic Appliances; 64.104, Pension for Non-Service-Connected Disability for Veterans; 64.109, Veterans Compensation for Service-Connected Disability; and 64.110, Veterans Dependency and Indemnity Compensation for Service-Connected Death.

**Congressional Review Act**

This regulatory action is a major rule under the Congressional Review Act, 5 U.S.C. 801–808, because it may result in an annual effect on the economy of $100 million or more. In accordance with 5 U.S.C. 801(a)(1), VA will submit to the Comptroller General and to Congress a copy of this regulatory action and VA's Regulatory Impact Analysis.

**List of Subjects in 38 CFR Part 4**

Disability benefits, Pensions, Veterans.

**Signing Authority**

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Pamela Powers, Chief of Staff, Department of Veterans Affairs, approved this document on April 1, 2020, for publication.

Dated: November 13, 2020.

**Jeffrey M. Martin,**

*Assistant Director, Office of Regulation Policy & Management, Office of the Secretary, Department of Veterans Affairs.*

For the reasons set out in the preamble, VA amends 38 CFR part 4, subpart B, as follows:

## PART 4—SCHEDULE FOR RATING DISABILITIES

### Subpart B—Disability Ratings

■ 1. The authority citation for part 4, subpart B continues to read as follows:

**Authority:** 38 U.S.C. 1155, unless otherwise noted.

■ 2. Amend § 4.71a by:

■ a. Revising diagnostic codes 5001, 5002, 5003, 5009–5015, 5018, 5020, 5022, 5023, 5024, 5054, 5055, 5120, 5160, 5170, 5201, 5202, 5242, 5243, 5255, 5257, 5262, and 5271;

■ b. Removing the notes following diagnostic codes 5053 and 5056 and the note at the end of the table entitled ''Prosthetic Implants and Resurfacing'';

■ c. Adding notes following diagnostic code 5024;

■ d. Revising the heading ''Prosthetic Implants'' to read ''Prosthetic Implants and Resurfacing'' and adding notes 1 through 6 to it; and

■ e. Adding the diagnostic code 5244 to the table entitled ''The Spine'' and the diagnostic code 5285 to the table entitled ''The Foot''.

The revisions and additions read as follows:

**§ 4.71a Schedule of ratings—musculoskeletal system.**

ACUTE, SUBACUTE, OR CHRONIC DISEASES

| | Rating |
|---|---|
| * * * * * * * | |
| 5001 Bones and joints, tuberculosis of, active or inactive: | |
| Active | 100 |
| Inactive: See §§ 4.88c and 4.89. | |
| 5002 Multi-joint arthritis (except post-traumatic and gout), 2 or more joints, as an active process: | |
| With constitutional manifestations associated with active joint involvement, totally incapacitating | 100 |
| Less than criteria for 100% but with weight loss and anemia productive of severe impairment of health or severely incapacitating exacerbations occurring 4 or more times a year or a lesser number over prolonged periods | 60 |
| Symptom combinations productive of definite impairment of health objectively supported by examination findings or incapacitating exacerbations occurring 3 or more times a year | 40 |
| One or two exacerbations a year in a well-established diagnosis | 20 |
| **Note (1):** Examples of conditions rated using this diagnostic code include, but are not limited to, rheumatoid arthritis, psoriatic arthritis, and spondyloarthropathies. | |
| **Note (2):** For chronic residuals, rate under diagnostic code 5003. | |
| **Note (3):** The ratings for the active process will not be combined with the residual ratings for limitation of motion, ankylosis, or diagnostic code 5003. Instead, assign the higher evaluation. | |
| 5003 Degenerative arthritis, other than post-traumatic: | |
| * * * * * * * | |
| 5009 Other specified forms of arthropathy (excluding gout). | |
| **Note (1):** Other specified forms of arthropathy include, but are not limited to, Charcot neuropathic, hypertrophic, crystalline, and other autoimmune arthropathies. | |
| **Note (2):** With the types of arthritis, diagnostic codes 5004 through 5009, rate the acute phase under diagnostic code 5002; rate any chronic residuals under diagnostic code 5003. | |
| 5010 Post-traumatic arthritis: Rate as limitation of motion, dislocation, or other specified instability under the affected joint. If there are 2 or more joints affected, each rating shall be combined in accordance with § 4.25. | |
| 5011 Decompression illness: Rate manifestations under the appropriate diagnostic code within the affected body system, such as arthritis for musculoskeletal residuals; auditory system for vestibular residuals; respiratory system for pulmonary barotrauma residuals; and neurologic system for cerebrovascular accident residuals. | |
| 5012 Bones, neoplasm, malignant, primary or secondary | 100 |
| **Note:** The 100 percent rating will be continued for 1 year following the cessation of surgical, X-ray, antineoplastic chemotherapy or other prescribed therapeutic procedure. If there has been no local recurrence or metastases, rate based on residuals. | |
| 5013 Osteoporosis, residuals of. | |

ACUTE, SUBACUTE, OR CHRONIC DISEASES—Continued

| | Rating |
|---|---|
| 5014 Osteomalacia, residuals of. | |
| 5015 Bones, neoplasm, benign. | |
| * * * * * * * | |
| 5018 [Removed] | |
| * * * * * * * | |
| 5020 [Removed] | |
| 5022 [Removed] | |
| 5023 Heterotopic ossification. | |
| 5024 Tenosynovitis, tendinitis, tendinosis or tendinopathy. | |
| **Note to DCs 5013 through 5024:** Evaluate the diseases under diagnostic codes 5013 through 5024 as degenerative arthritis, based on limitation of motion of affected parts. | |
| * * * * * * * | |

PROSTHETIC IMPLANTS AND RESURFACING

| | Rating | |
|---|---|---|
| | Major | Minor |
| **Note (1):** When an evaluation is assigned for joint resurfacing or the prosthetic replacement of a joint under diagnostic codes 5051–5056, an additional rating under § 4.71a may not also be assigned for that joint, unless otherwise directed. | | |
| **Note (2):** Only evaluate a revision procedure in the same manner as the original procedure under diagnostic codes 5051–5056 if all the original components are replaced. | | |
| **Note (3):** The term ''prosthetic replacement'' in diagnostic codes 5051–5053 and 5055–5056 means a total replacement of the named joint. However, in DC 5054, ''prosthetic replacement'' means a total replacement of the head of the femur or of the acetabulum. | | |
| **Note (4):** The 100 percent rating for 1 year following implantation of prosthesis will commence after initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge. | | |
| **Note (5):** The 100 percent rating for 4 months following implantation of prosthesis or resurfacing under DCs 5054 and 5055 will commence after initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge. | | |
| **Note (6):** Special monthly compensation is assignable during the 100 percent rating period the earliest date permanent use of crutches is established. | | |
| * * * * * * * | | |
| 5054 Hip, resurfacing or replacement (prosthesis): | | |
| For 4 months following implantation of prosthesis or resurfacing | | 100 |
| Prosthetic replacement of the head of the femur or of the acetabulum: | | |
| Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches | | [1] 90 |
| Markedly severe residual weakness, pain or limitation of motion following implantation of prosthesis | | 70 |
| Moderately severe residuals of weakness, pain or limitation of motion | | 50 |
| Minimum evaluation, total replacement only | | 30 |
| **Note:** At the conclusion of the 100 percent evaluation period, evaluate resurfacing under diagnostic codes 5250 through 5255; there is no minimum evaluation for resurfacing. | | |
| 5055 Knee, resurfacing or replacement (prosthesis): | | |
| For 4 months following implantation of prosthesis or resurfacing | | 100 |
| Prosthetic replacement of knee joint: | | |
| With chronic residuals consisting of severe painful motion or weakness in the affected extremity | | 60 |
| With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5256, 5261, or 5262. | | |
| Minimum evaluation, total replacement only | | 30 |
| **Note:** At the conclusion of the 100 percent evaluation period, evaluate resurfacing under diagnostic codes 5256 through 5262; there is no minimum evaluation for resurfacing. | | |
| * * * * * * * | | |

AMPUTATIONS: UPPER EXTREMITY

| | Rating | |
|---|---|---|
| | Major | Minor |
| Arm, amputation of: | | |
| 5120 Complete amputation, upper extremity: | | |
| Forequarter amputation (involving complete removal of the humerus along with any portion of the scapula, clavicle, and/or ribs) | [1] 100 | [1] 100 |

AMPUTATIONS: UPPER EXTREMITY—Continued

| | Rating | |
|---|---|---|
| | Major | Minor |
| Disarticulation (involving complete removal of the humerus only) | [1] 90 | [1] 90 |
| * * * * * * * | | |

AMPUTATIONS: LOWER EXTREMITY

| | Rating |
|---|---|
| Thigh, amputation of: | |
| 5160 Complete amputation, lower extremity: | |
| Trans-pelvic amputation (involving complete removal of the femur and intrinsic pelvic musculature along with any portion of the pelvic bones) | [2] 100 |
| Disarticulation (involving complete removal of the femur and intrinsic pelvic musculature only) | [2] 90 |
| **Note:** Separately evaluate residuals involving other body systems (*e.g.,* bowel impairment, bladder impairment) under the appropriate diagnostic code. | |
| * * * * * * * | |
| 5170 Toes, all, amputation of, without metatarsal loss or transmetatarsal, amputation of, with up to half of metatarsal loss | 30 |
| * * * * * * * | |

THE SHOULDER AND ARM

| | Rating | |
|---|---|---|
| | Major | Minor |
| * * * * * * * | | |
| 5201 Arm, limitation of motion of: | | |
| Flexion and/or abduction limited to 25° from side | 40 | 30 |
| Midway between side and shoulder level (flexion and/or abduction limited to 45°) | 30 | 20 |
| At shoulder level (flexion and/or abduction limited to 90°) | 20 | 20 |
| 5202 Humerus, other impairment of: | | |
| Loss of head of (flail shoulder) | 80 | 70 |
| Nonunion of (false flail joint) | 60 | 50 |
| Fibrous union of | 50 | 40 |
| Recurrent dislocation of at scapulohumeral joint: | | |
| With frequent episodes and guarding of all arm movements | 30 | 20 |
| With infrequent episodes and guarding of movement only at shoulder level (flexion and/or abduction at 90°) | 20 | 20 |
| Malunion of: | | |
| Marked deformity | 30 | 20 |
| Moderate deformity | 20 | 20 |
| * * * * * * * | | |

THE SPINE

| | Rating |
|---|---|
| *General Rating Formula for Diseases and Injuries of the Spine* | |
| * * * * * * * | |
| 5242 Degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome (also, see either DC 5003 or 5010) | |
| 5243 Intervertebral disc syndrome: Assign this diagnostic code only when there is disc herniation with compression and/or irritation of the adjacent nerve root; assign diagnostic code 5242 for all other disc diagnoses. | |
| * * * * * * * | |
| 5244 Traumatic paralysis, complete: | |
| Paraplegia: Rate under diagnostic code 5110. | |
| Quadriplegia: Rate separately under diagnostic codes 5109 and 5110 and combine evaluations in accordance with § 4.25. | |
| **Note:** If traumatic paralysis does not cause loss of use of both hands or both feet, it is incomplete paralysis. Evaluate residuals of incomplete traumatic paralysis under the appropriate diagnostic code (*e.g.,* § 4.124a, Diseases of the Peripheral Nerves). | |

THE SPINE—Continued

| | Rating |
|---|---|
| * * * * * * * | |

THE HIP AND THIGH

| | Rating |
|---|---|
| * * * * * * * | |
| 5255 Femur, impairment of: | |
| Fracture of shaft or anatomical neck of: | |
| With nonunion, with loose motion (spiral or oblique fracture) | 80 |
| With nonunion, without loose motion, weight bearing preserved with aid of brace | 60 |
| Fracture of surgical neck of, with false joint | 60 |
| Malunion of: | |
| Evaluate under diagnostic codes 5256, 5257, 5260, or 5261 for the knee, or 5250–5254 for the hip, whichever results in the highest evaluation. | |
| * * * * * * * | |

THE KNEE AND LEG

| | Rating |
|---|---|
| * * * * * * * | |
| 5257 Knee, other impairment of: | |
| *Recurrent subluxation or instability:* | |
| Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes both an assistive device (*e.g.,* cane(s), crutch(es), walker) and bracing for ambulation | 30 |
| One of the following: | |
| (a) Sprain, incomplete ligament tear, or repaired complete ligament tear causing persistent instability, and a medical provider prescribes a brace and/or assistive device (*e.g.,* cane(s), crutch(es), walker) for ambulation. | |
| (b) Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes either an assistive device (*e.g.,* cane(s), crutch(es), walker) or bracing for ambulation | 20 |
| Sprain, incomplete ligament tear, or complete ligament tear (repaired, unrepaired, or failed repair) causing persistent instability, without a prescription from a medical provider for an assistive device (*e.g.,* cane(s), crutch(es), walker) or bracing for ambulation | 10 |
| *Patellar instability:* | |
| A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription by a medical provider for a brace and either a cane or a walker | 30 |
| A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription by a medical provider for one of the following: A brace, cane, or walker | 20 |
| A diagnosed condition involving the patellofemoral complex with recurrent instability (with or without history of surgical repair) that does not require a prescription from a medical provider for a brace, cane, or walker | 10 |
| **Note (1):** For patellar instability, the patellofemoral complex consists of the quadriceps tendon, the patella, and the patellar tendon. | |
| **Note (2):** A surgical procedure that does not involve repair of one or more patellofemoral components that contribute to the underlying instability shall not qualify as surgical repair for patellar instability (including, but not limited to, arthroscopy to remove loose bodies and joint aspiration). | |
| * * * * * * * | |
| 5262 Tibia and fibula, impairment of: | |
| Nonunion of, with loose motion, requiring brace | 40 |
| Malunion of: | |
| Evaluate under diagnostic codes 5256, 5257, 5260, or 5261 for the knee, or 5270 or 5271 for the ankle, whichever results in the highest evaluation. | |
| Medial tibial stress syndrome (MTSS), or shin splints: | |
| Requiring treatment for no less than 12 consecutive months, and unresponsive to surgery and either shoe orthotics or other conservative treatment, both lower extremities | 30 |
| Requiring treatment for no less than 12 consecutive months, and unresponsive to surgery and either shoe orthotics or other conservative treatment, one lower extremity | 20 |
| Requiring treatment for no less than 12 consecutive months, and unresponsive to either shoe orthotics or other conservative treatment, one or both lower extremities | 10 |
| Treatment less than 12 consecutive months, one or both lower extremities | 0 |
| * * * * * * * | |

THE ANKLE

| | Rating |
|---|---|
| * * * * * * * | |
| 5271 Ankle, limited motion of: | |
| Marked (less than 5 degrees dorsiflexion or less than 10 degrees plantar flexion) | 20 |
| Moderate (less than 15 degrees dorsiflexion or less than 30 degrees plantar flexion) | 10 |
| * * * * * * * | |

THE FOOT

| | Rating |
|---|---|
| * * * * * * * | |
| 5285 Plantar fasciitis: | |
| No relief from both non-surgical and surgical treatment, bilateral | 30 |
| No relief from both non-surgical and surgical treatment, unilateral | 20 |
| Otherwise, unilateral or bilateral | 10 |
| **Note (1):** With actual loss of use of the foot, rate 40 percent. | |
| **Note (2):** If a veteran has been recommended for surgical intervention, but is not a surgical candidate, evaluate under the 20 percent or 30 percent criteria, whichever is applicable. | |

THE SKULL

| | Rating |
|---|---|
| * * * * * * * | |

(Authority: 38 U.S.C. 1155)

* * * * *

■ 3. Amend § 4.73 by:

■ a. Designating the introductory note as Note (1) and revising it;

■ b. Adding introductory note (2); and

■ c. Adding add diagnostic codes 5330 and 5331 to the table entitled ''Miscellaneous''.

The revising and additions read as follows:

**§ 4.73 Schedule of ratings—muscle injuries.**

**Note (1):** When evaluating any claim involving muscle injuries resulting in loss of use of any extremity or loss of use of both buttocks (diagnostic code 5317, Muscle Group XVII), refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation.

**Note (2):** Ratings of slight, moderate, moderately severe, or severe for diagnostic codes 5301 through 5323 will be determined based upon the criteria contained in § 4.56.

* * * * *

MISCELLANEOUS

| | Rating |
|---|---|
| * * * * * * * | |
| 5330 Rhabdomyolysis, residuals of: | |
| Rate each affected muscle group separately and combine in accordance with § 4.25. | |
| **Note:** Separately evaluate any chronic renal complications within the appropriate body system. | |
| 5331 Compartment syndrome: | |
| Rate each affected muscle group separately and combine in accordance with § 4.25. | |

* * * * *

■ 4. Amend appendix A to part 4 as follows:

■ a. In § 4.71a, revise diagnostic codes 5001, 5002, 5003, 5012, 5024, 5051, 5052, 5053, 5054, 5055, 5056, 5243, 5255, and 5257;

■ b. In § 4.71a, remove the diagnostic code 5235–5243;

■ c. In § 4.71a, add in numerical order diagnostic codes 5009, 5010, 5011, 5013, 5014, 5015, 5018, 5020, 5022, 5023, 5120, 5160, 5170, 5201, 5202, 5235, 5236, 5237, 5238, 5239, 5240, 5241, 5242, 5244, 5262, 5271, and 5285; and

■ d. In § 4.73, add an introduction note and diagnostic codes 5330 and 5331.

The revisions and additions read as follows:

**Appendix A to Part 4—Table of Amendments and Effective Dates Since 1946**

| Sec. | Diagnostic code No. | |
|---|---|---|
| * * | * | * * * * * |
| 4.71a | 5001 | Evaluation March 11, 1969; criterion February 7, 2021. |
| | 5002 | Evaluation March 1, 1963; title, criteria, note February 7, 2021. |
| | 5003 | Added July 6, 1950; title February 7, 2021. |
| * * | * | * * * * * |
| | 5009 | Title, evaluation, note February 7, 2021. |
| | 5010 | Title, criteria February 7, 2021. |
| | 5011 | Title, criteria February 7, 2021. |
| | 5012 | Criterion March 10, 1976; title, note February 7, 2021. |
| | 5013 | Title February 7, 2021. |
| | 5014 | Title February 7, 2021. |
| | 5015 | Title February 7, 2021. |
| | 5018 | Removed February 7, 2021. |
| | 5020 | Removed November 30, 2020. |
| | 5022 | Removed February 7, 2021. |
| | 5023 | Title February 7, 2021. |
| | 5024 | Criterion March 1, 1963; title, criteria February 7, 2021. |
| * * | * | * * * * * |
| | 5051 | Added September 22, 1978; note February 7, 2021. |
| | 5052 | Added September 22, 1978; note February 7, 2021. |
| | 5053 | Added September 22, 1978; note February 7, 2021. |
| | 5054 | Added September 22, 1978; title, criterion, and note February 7, 2021. |
| | 5055 | Added September 22, 1978; title, criterion, and note February 7, 2021. |
| | 5056 | Added September 22, 1978; note February 7, 2021. |
| * * | * | * * * * * |
| | 5120 | Title, criterion February 7, 2021. |
| | 5160 | Title, criterion, note February 7, 2021. |
| * * | * | * * * * * |
| | 5170 | Title February 7, 2021. |
| * * | * | * * * * * |
| | 5201 | Criterion February 7, 2021. |
| | 5202 | Criterion February 7, 2021. |
| * * | * | * * * * * |
| | 5235 | Replaces 5285–5295 September 26, 2003. |
| | 5236 | Replaces 5285–5295 September 26, 2003. |
| | 5237 | Replaces 5285–5295 September 26, 2003. |
| | 5238 | Replaces 5285–5295 September 26, 2003. |
| | 5239 | Replaces 5285–5295 September 26, 2003. |
| | 5240 | Replaces 5285–5295 September 26, 2003. |
| | 5241 | Replaces 5285–5295 September 26, 2003. |
| | 5242 | Replaces 5285–5295 September 26, 2003; Title February 7, 2021. |
| | 5243 | Replaces 5285–5295 September 26, 2003; Criterion September 26, 2003; Title February 7, 2021. |
| | 5244 | Added February 7, 2021. |
| * * | * | * * * * * |
| | 5255 | Criterion July 6, 1950; criterion February 7, 2021. |
| * * | * | * * * * * |
| | 5257 | Evaluation July 6, 1950; criterion and note February 7, 2021. |
| * * | * | * * * * * |
| | 5262 | Criterion February 7, 2021. |
| * * | * | * * * * * |
| | 5271 | Criterion February 7, 2021. |
| * * | * | * * * * * |
| | 5285 | Added February 7, 2021. |
| * * | * | * * * * * |
| 4.73 | | Introduction **Note** criterion July 3, 1997; second **Note** added February 7, 2021. |
| * * | * | * * * * * |
| | 5330 | Added February 7, 2021. |
| | 5331 | Added February 7, 2021. |

| Sec. | Diagnostic code No. |
|---|---|
| * | * * * * * * * |

■ 5. Amend appendix B to part 4 as follows:

■ a. Revise diagnostic codes 5002, 5003, 5009, 5010, 5011, 5012, 5013, 5014, 5015, 5018, 5020, 5022, 5023, 5024, 5054, 5055, 5120, 5160, 5170, and 5242; and

■ b. Add diagnostic codes 5244, 5285, 5330, and 5331;

The revisions and additions read as follows:

**Appendix B to Part 4—Numerical Index of Disabilities**

| Diagnostic code No. | |
|---|---|
| **The Musculoskeletal System Acute, Subacute, or Chronic Diseases** | |
| * * * * * * * | |
| 5002 | Multi-joint arthritis (except post-traumatic and gout), 2 or more joints, as an active process. |
| 5003 | Degenerative arthritis, other than post-traumatic. |
| * * * * * * * | |
| 5009 | Other specified forms of arthropathy (excluding gout). |
| 5010 | Post-traumatic arthritis. |
| 5011 | Decompression illness. |
| 5012 | Bones, neoplasm, malignant, primary or secondary. |
| 5013 | Osteoporosis, residuals of. |
| 5014 | Osteomalacia, residuals of. |
| 5015 | Bones, neoplasm, benign. |
| * * * * * * * | |
| 5018 | [Removed] |
| * * * * * * * | |
| 5020 | [Removed] |
| * * * * * * * | |
| 5022 | [Removed] |
| 5023 | Heterotopic ossification. |
| 5024 | Tenosynovitis, tendinitis, tendinosis or tendinopathy. |
| * * * * * * * | |
| 5054 | Hip, resurfacing or replacement (prosthesis). |
| 5055 | Knee, resurfacing or replacement (prosthesis). |
| * * * * * * * | |
| **Amputations: Upper Extremity** | |
| Arm, amputation of: | |
| 5120 | Complete amputation, upper extremity. |
| * * * * * * * | |
| **Amputations: Lower Extremity** | |
| Thigh, amputation of: | |
| 5160 | Complete amputation, lower extremity. |
| * * * * * * * | |
| 5170 | Toes, all, amputation of, without metatarsal loss or transmetatarsal, amputation of, with up to half of metatarsal loss. |
| * * * * * * * | |
| **Spine** | |
| * * * * * * * | |
| 5242 | Degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome (also, see either DC 5003 or 5010). |
| * * * * * * * | |
| 5244 | Traumatic paralysis, complete. |

| Diagnostic code No. | | | | | | |
|---|---|---|---|---|---|---|
| * | * | * | * | * | * | * |
| **The Foot** | | | | | | |
| * | * | * | * | * | * | * |
| 5285 ..... | Plantar fasciitis. | | | | | |
| * | * | * | * | * | * | * |
| MUSCLE INJURIES | | | | | | |
| * | * | * | * | * | * | * |
| **Miscellaneous** | | | | | | |
| * | * | * | * | * | * | * |
| 5330 ..... | Rhabdomyolysis, residuals of. | | | | | |
| 5331 ..... | Compartment syndrome. | | | | | |
| * | * | * | * | * | * | * |

■ 6. Amend appendix C to part 4 as follows:
■ a. Revising the entries for ''Amputation'' and ''Arthritis'';
■ b. Adding in alphabetical order an entry for ''Arthropathy'';
■ c. Revising the entry for ''Bones'';
■ d. Adding in alphabetical order entries for ''compartment syndrome'', ''decompression illness'', and ''heterotopic ossification'';
■ e. Revising the entry for ''Hip'';
■ f. Removing entries for ''Hydrarthrosis, intermittent'', and ''Myositis ossificans''
■ g. Revising entries for ''Osteomalacia'', ''Osteoporosis, with joint manifestations'', and ''Paralysis'';
■ h. Removing entry for ''Periostitis'';
■ i. Adding in alphabetical order an entry for ''Plantar fasciitis'';
■ j. Revising entry for ''Prosthetic implants'';
■ k. Adding in alphabetical order entries for ''Rhabdomyolysis, residuals of'' and ''Spine: Degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome'';
■ l. Removing entry for ''Synovitis''; and
■ m. Revising entry for ''Tenosynovitis''

The revisions and additions read as follows:

**Appendix C to Part 4—Alphabetical Index of Disabilities**

| | Diagnostic code No. |
|---|---|
| * * * * * * * | |
| Amputation: | |
| Arm: | |
| Complete amputation, upper extremity | 5120 |
| Above insertion of deltoid | 5121 |
| Below insertion of deltoid | 5122 |
| Digits, five of one hand | 5126 |
| Digits, four of one hand: | |
| Thumb, index, long and ring | 5127 |
| Thumb, index, long and little | 5128 |
| Thumb, index, ring and little | 5129 |
| Thumb, long, ring and little | 5130 |
| Index, long, ring and little | 5131 |
| Digits, three of one hand:. | |
| Thumb, index and long | 5132 |
| Thumb, index and ring | 5133 |
| Thumb, index and little | 5134 |
| Thumb, long and ring | 5135 |
| Thumb, long and little | 5136 |
| Thumb, ring and little | 5137 |
| Index, long and ring | 5138 |
| Index, long and little | 5139 |
| Index, ring and little | 5140 |
| Long, ring and little | 5141 |
| Digits, two of one hand: | |
| Thumb and index | 5142 |
| Thumb and long | 5143 |
| Thumb and ring | 5144 |
| Thumb and little | 5145 |
| Index and long | 5146 |

| | Diagnostic code No. |
|---|---|
| Index and ring | 5147 |
| Index and little | 5148 |
| Long and ring | 5149 |
| Long and little | 5150 |
| Ring and little | 5151 |
| Single finger: | |
| Thumb | 5152 |
| Index finger | 5153 |
| Long finger | 5154 |
| Ring finger | 5155 |
| Little finger | 5156 |
| Forearm: | |
| Above insertion of pronator teres | 5123 |
| Below insertion of pronator teres | 5124 |
| Leg: | |
| With defective stump | 5163 |
| Not improvable by prosthesis controlled by natural knee action | 5164 |
| At lower level, permitting prosthesis | 5165 |
| Forefoot, proximal to metatarsal bones | 5166 |
| Toes, all, amputation of, without metatarsal loss or transmetatarsal, amputation of, with up to half of metatarsal loss | 5170 |
| Toe, great | 5171 |
| Toe, other than great, with removal metatarsal head | 5172 |
| Toes, three or more, without metatarsal involvement | 5173 |
| Thigh: | |
| Complete amputation, lower extremity | 5160 |
| Upper third | 5161 |
| Middle or lower thirds | 5162 |
| * * * * * * * | |
| Arthritis: | |
| Degenerative, other than post-traumatic | 5003 |
| Gonorrheal | 5004 |
| Other specified forms (excluding gout) | 5009 |
| Pneumococcic | 5005 |
| Post-traumatic | 5010 |
| Multi-joint (except post-traumatic and gout) | 5002 |
| Streptococcic | 5008 |
| Syphilitic | 5007 |
| Typhoid | 5006 |
| Arthropathy | 5009 |
| * * * * * * * | |
| Bones: | |
| Neoplasm, benign | 5015 |
| Neoplasm, malignant, primary or secondary | 5012 |
| Shortening of the lower extremity | 5275 |
| * * * * * * * | |
| Compartment syndrome | 5331 |
| * * * * * * * | |
| Decompression illness | 5011 |
| * * * * * * * | |
| Heterotopic ossification | 5023 |
| Hip: | |
| Flail joint | 5254 |
| * * * * * * * | |
| Osteomalacia, residuals of | 5014 |
| * * * * * * * | |
| Osteoporosis, residuals of | 5013 |
| * * * * * * * | |
| Paralysis: | |
| Accommodation | 6030 |
| Agitans | 8004 |
| Complete, traumatic | 5244 |
| * * * * * * * | |
| Plantar fasciitis | 5285 |

| | Diagnostic code No. |
|---|---|
| * * * * * * * | |
| Prosthetic implants: | 5056 |
| Ankle replacement | 5052 |
| Elbow replacement | 5054 |
| Hip, resurfacing or replacement. | |
| Knee, resurfacing or replacement | 5055 |
| Shoulder replacement | 5051 |
| Wrist replacement | 5053 |
| * * * * * * * | |
| Rhabdomyolysis, residuals of | 5330 |
| * * * * * * * | |
| Spine: | |
| Degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome | 5242 |
| * * * * * * * | |
| Tenosynovitis, tendinitis, tendinosis or tendinopathy | 5024 |
| * * * * * * * | |

[FR Doc. 2020–25450 Filed 11–27–20; 8:45 am]

BILLING CODE 8320–01–P

## FEDERAL COMMUNICATIONS COMMISSION

### 47 CFR Parts 1 and 90

**[WP Docket No. 07–100; FCC 20–137; FRS 17146]**

### 4.9 GHz Band

**AGENCY:** Federal Communications Commission.

**ACTION:** Final rule.

**SUMMARY:** In March 2018, the Federal Communications Commission (Commission) released a Sixth Further Notice of Proposed Rulemaking (Sixth FNPRM) seeking comment on ways to stimulate expanded use of and investment in the 4.9 GHz (4940–4990 MHz) band, including allowing licensees the flexibility to engage in spectrum leasing and broadening existing eligibility requirements. On September 8, 2020, the Public Safety and Homeland Security Bureau and the Wireless Telecommunications Bureau issued a Public Notice freezing the 4.9 GHz band to stabilize it while the Commission considered changes to the 4.9 GHz band rules (Freeze Public Notice). In this document, the Commission adopts rules permitting one statewide 4.9 GHz band licensee per state, the State Lessor, to lease some or all of its spectrum rights to third parties—including commercial and public safety users—in those states that the Commission has not identified as a diverter of 911 fees. The Report and Order does not limit or modify the rights of any incumbent public safety licensees. The new rules also eliminate the requirement that leased spectrum must be used to support public safety but requires lessees to adhere to the informal coordination requirements applicable to the band.

**DATES:** Effective December 30, 2020, except for § 90.1217, which is delayed. We will publish a document in the **Federal Register** announcing the effective date.

**ADDRESSES:** Federal Communications Commission, 45 L St. NE SW, Washington, DC 20554.

**FOR FURTHER INFORMATION CONTACT:** Jonathan Markman of the Wireless Telecommunications Bureau, Mobility Division, at (202) 418–7090 or *Jonathan.Markman@fcc.gov.* For information regarding the PRA information collection requirements contained in this PRA, contact Cathy Williams, Office of Managing Director, at (202) 418–2918 or *Cathy.Williams@fcc.gov.*

**SUPPLEMENTARY INFORMATION:** This is a summary of the Commission's *Report and Order* in WP Docket No. 07–100, FCC 20–137 adopted September 30, 2020 and released October 02, 2020. The full text of the *Report and Order,* including all Appendices, is available by downloading the text from the Commission's website at *https://www.fcc.gov/document/fcc-expands-access-and-investment-49-ghz-band-0.* Alternative formats are available for people with disabilities (braille, large print, electronic files, audio format), by sending an email to *FCC504@fcc.gov* or calling the Consumer and Governmental Affairs Bureau at (202) 418–0530 (voice), (202) 418–0432 (TTY).

The Commission will send a copy of this *Report* in a report to be sent to Congress and the Government Accountability Office pursuant to the Congressional Review Act, *see* 5 U.S.C. 801(a)(1)(A).

**Final Regulatory Flexibility Analysis**

The Regulatory Flexibility Act (RFA) requires that an agency prepare a regulatory flexibility analysis for notice and comment rulemakings, unless the agency certifies that ''the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities.'' Accordingly, the Commission has prepared a Final Regulatory Flexibility Analysis (FRFA) concerning the possible impact of the rule changes contained in this *Report and Order* on small entities. As required by the Regulatory Flexibility Act of 1980, as amended (RFA), an Initial Regulatory Flexibility Analysis (IRFA) was incorporated in the *Sixth Further Notice of Proposed Rulemaking* (*Sixth FNPRM*) released in March 2018 in this proceeding (83 FR 20011, May 7, 2018). The Commission sought written public comment on the proposals in the *Sixth FNPRM,* including comments on the IRFA. No comments were filed addressing the IRFA. This present Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.

**Paperwork Reduction Act**

The requirements in § 90.1217 constitute new or modified collections subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104–13. They will be submitted to the Office of Management and Budget (OMB) for review under section 3507(d) of the PRA. OMB, the general public, and