Viewing material in docket. To view documents mentioned in this proposed rule as being available in the docket, find the docket as described in the previous paragraph, and then select ''Supporting & Related Material'' in the Document Type column. Public comments will also be placed in our online docket and can be viewed by following instructions on the *https://www.regulations.gov* Frequently Asked Questions web page. We review all comments received, but we will only post comments that address the topic of the proposed rule. We may choose not to post off-topic, inappropriate, or duplicate comments that we receive.

Personal information. We accept anonymous comments. Comments we post to *https://www.regulations.gov* will include any personal information you have provided. For more about privacy and submissions to the docket in response to this document, see DHS's eRulemaking System of Records notice (85 FR 14226, March 11, 2020).

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 is proposing to amend 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. 00170.1, Revision No. 01.2.

■ 2. Add § 165.T05–0040 to read as follows:

§ 165.T05–0040 Security Zone, Delaware River, Philadelphia, PA.

(a) *Location.* The following area is a security zone: All waters within the Delaware River, contiguous with the Pennsylvania shoreline and extending out into the Delaware River approximately 250 yards, within an area bounded by a line connecting the following points: Beginning at the Pennsylvania shoreline at latitude 39°56.87′ N, longitude 075°8.36′ W, thence east to latitude 39°56.85′ N, longitude 075°8.20′ W, thence south to latitude 39°56.45′ N, longitude 075°8.25′ W, thence west to the Pennsylvania shoreline at latitude 39°56.47′ N, longitude 075°8.41′ W, thence north following the shoreline to the originating point. These coordinates are based on North American Datum 83 (NAD83).

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

Designated representative means any Coast Guard commissioned, warrant or petty officer who has been designated by the Captain of the Port Delaware Bay (COTP) to act on his or her behalf. The designated representative may be on an official patrol vessel or may be on shore and will communicate with vessels via VHF–FM radio or loudhailer. In addition, members of the Coast Guard Auxiliary may be present to inform vessel operators of the regulations in this section.

Very important person (VIP) means any person for whom the United States Capital Police request implementation of a security zone in order to supplement protection of said person(s).

Official patrol vessel means any Coast Guard, Coast Guard Auxiliary, State, or local law enforcement vessel assigned or approved by the COTP.

(c) *Regulations.* (1) In accordance with the general regulations contained in subpart D of this part, entry into or remaining in the zone described in paragraph (a) of section is prohibited unless authorized by the COTP, Sector Delaware Bay, or designated representative.

(2) Only vessels or people specifically authorized by the Captain of the Port, Delaware Bay, or designated representative, may enter or remain in the regulated area. Access to the zone will be determined by the COTP or designated representative on a case-by-case basis when the zone is enforced. To seek permission to enter, contact the COTP or the COTP's representative on VHF–FM channel 13 or 16. Those in the security zone must comply with all lawful orders or directions given to them by the COTP or the COTP's designated representative. No person may swim upon or below the surface of the water of this security zone unless authorized by the COTP or his designated representative.

(3) Upon being hailed by an official patrol vessel or the designated representative, by siren, radio, flashing light or other means, the operator of the vessel shall proceed as directed. Failure to comply with lawful direction may result in expulsion from the regulated area, citation for failure to comply, or both.

(4) Unless specifically authorized by on scene enforcement vessels, any vessel granted permission to enter or transit the security zones must comply with the instructions of the COTP or designated representative and operate at bare steerage or no-wake speed while transiting through the Security Zone, and must not loiter, stop, or anchor, and shall do so for the entirety of its time within the boundaries of the security zones.

(d) *Enforcement.* (1) This security zone is effective from 11 a.m. on March 9, 2022, through 11:59 p.m. on March 11, 2022.

(2) This security zone will be enforced with actual notice by the U.S. Coast Guard representatives on scene, as well as other methods listed in § 165.7. The Coast Guard will enforce the security zone created by this section only when it is necessary for the protection and security of the VIPs attending the Democratic National Caucus in the vicinity of Penns Landing located in Philadelphia, PA. The U.S. Coast Guard may be additionally assisted in the patrol and enforcement of the zone by Federal, State, and local agencies.

Dated: February 9, 2022.

Leon McClain, Jr.,

Captain, U. S. Coast Guard, Alternate Captain of the Port, Delaware Bay.

[FR Doc. 2022–03132 Filed 2–14–22; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Parts 3 and 4

RIN 2900–AQ72

Schedule for Rating Disabilities—Ear, Nose, Throat, and Audiology Disabilities; Special Provisions Regarding Evaluation of Respiratory Conditions; Schedule for Rating Disabilities—Respiratory System

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to revise sections that address the ear, nose, throat, audiology, and respiratory systems. The purpose of these changes is to update medical terminology, incorporate medical advances that have occurred since the last review, and provide well-defined criteria in accordance with actual clinical practice. VA will also rename the body system currently designated for conditions related to hearing and the ear, to include the nose and throat. VA will also consolidate within the scope of otolaryngology several diagnostic codes (DCs) currently listed within the respiratory system.

DATES: VA must receive comments on or before April 18, 2022.

ADDRESSES: Comments may be submitted through

www.Regulations.gov. Comments received will be available at *www.Regulations.gov* for public viewing, inspection or copies.

FOR FURTHER INFORMATION CONTACT: Gary Reynolds, M.D., Medical Officer, Regulations Staff (210), 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 telephone number.)

SUPPLEMENTARY INFORMATION: As part of its ongoing revision of the Schedule for Rating Disabilities (VASRD, or the Rating Schedule), VA is proposing changes to the portions of the VASRD that address the audiology system, which VA last addressed in 1999 (see 64 FR 25202), as well as the respiratory system, which VA last addressed in 2006 (see 71 FR 52457). The proposed rule reflects advances in medical knowledge, recommendations from VA experts in audiology and respiratory conditions, and comments from experts and the public gathered during an October 2011 forum in New York City.

VA proposes to incorporate more current respiratory and auditory terminology and apply current standards of assessing and evaluating impairment. Where changes to the scientific and/or medical nature of a given condition have been proposed, VA has cited the published, publicly-available sources for these changes. The proposed changes are not a reflection of any particular expert's comments or recommendations but were based on published, peer-reviewed materials. Materials from the public forum are available for public inspection at the Office of Regulation Policy and Management (see the **ADDRESSES** section of this rulemaking), and other deliberative materials are cited herein.

VA also intends to reorganize the Rating Schedule so its classifications of injuries and diseases more closely resemble those used in health care. This reorganization involves moving several diagnostic codes (DCs) from ''The Respiratory System'' to a new body system designated as ''Ear, Nose, Throat, and Auditory Disabilities.''

I. The Respiratory System

A. Proposed Changes to 38 CFR 4.96

VA proposes to revise § 4.96 to clarify, simplify, and eliminate redundancies in the special provisions regarding respiratory conditions. Paragraph (a) currently precludes simultaneous ratings for specific coexisting respiratory conditions. VA proposes to amend paragraph (a) by simply stating that VA may not combine, under 38 CFR 4.25, Combined Ratings Table, coexisting respiratory conditions unless otherwise directed. Under this proposed rule, the only respiratory disability that VA may combine with other respiratory disabilities is DC 6847, sleep apnea. The proposed rule notes which DCs may be combined with DC 6847.

VA does not propose any change to current paragraph (b), which discusses veterans who received, or were entitled to receive, compensation for tuberculosis as of August 19, 1968.

VA proposes to remove paragraph (c), which deals with special monthly compensation (SMC) for complete organic aphonia. Complete organic aphonia, currently evaluated under DC 6519, is among those disabilities that VA is proposing to move to the new body system, ''Ear, Nose, Throat, and Auditory Disabilities,'' as DC 6230, with a footnote discussing SMC. Therefore, the respiratory system no longer requires this paragraph.

As a result of this deletion, VA intends to redesignate current paragraph (d) as paragraph (c). The current paragraph (d) provides information on the use of pulmonary function tests (PFTs) to evaluate the severity of certain respiratory conditions. As discussed in detail below, VA proposes to evaluate a number of respiratory conditions using a General Rating Formula for Respiratory Conditions (General Rating Formula), which reference various PFTs. As such, VA proposes to amend the subheading for revised § 4.96(c) to expand the list of all DCs that VA will rate using the General Rating Formula.

Within revised paragraph (c), VA proposes to amend subparagraph (1). Currently, § 4.96(d)(1)(ii) states that PFTs are not necessary when an individual is diagnosed with pulmonary hypertension, cor pulmonale, or right ventricular hypertrophy. A new DC addressing the requirements for ''pulmonary hypertension'' (discussed below) is being proposed herein. Furthermore, the proposed General Rating Formula for Respiratory Conditions includes METS as an evaluation criteria, which are the same evaluation criteria used in the General Rating Formula for Diseases of the Heart. This means cor pulmonale and right ventricular hypertrophy can both be evaluated within the respiratory system under its General Rating Formula. Therefore, the current subparagraph (d)(1)(ii) will no longer be necessary. With the absence of that subparagraph, VA proposes to redesignate current subparagraphs (d)(1)(iii) and (d)(1)(iv) as subparagraphs (c)(1)(ii) and (c)(1)(iii), respectively.

Current subparagraph (d)(2) discusses the use of diffusion capacity of the lung for carbon monoxide by the single breath method (DLCO (SB)). The new General Rating Formula and proposed pulmonary hypertension code have sufficient alternative criteria to evaluate respiratory disabilities when the DLCO (SB) is not available. VA may still consider using DLCO (SB) to evaluate respiratory disabilities, but VA will not require it and the examiner need not state why the test would not be useful or valid in a particular case. Accordingly, VA proposes to delete current subparagraph (d)(2).

VA proposes to remove current subparagraphs (d)(4) and (d)(5). These paragraphs discuss the need for post-bronchodilator studies during examinations, except in certain circumstances, and the need to utilize post-bronchodilator results as a more accurate value in evaluating respiratory disabilities. VA proposes to remove these subparagraphs because whether pre- or post-bronchodilator studies accurately reflect an individual's medical condition is a medical determination and therefore is more appropriately decided by a medical practitioner and/or examiner; this information should be considered as part of the medical record, to include treatment notes and/or examination. Therefore, there is no need to instruct rating personnel on the use of post-bronchodilator studies.

VA also proposes to remove current subparagraph (d)(7) because it is inaccurate. Obstructive respiratory disease may be present, ratable, and compensable even though both Forced Expiratory Volume in one second (FEV–1) and Forced Vital Capacity (FVC) are greater than 100 percent. *See* Matthew J. Hegewald and Robert O. Crapo, ''Pulmonary Function Testing,'' Murray and Nadel's Textbook of Respiratory Medicine 527–28 (5th ed. 2010).

As a result of the above deletions, VA intends to redesignate current subparagraph (d)(3) as (c)(2), and redesignate current subparagraph (d)(6) as (c)(3), with no substantive changes.

Finally, VA proposes to add a new paragraph (d), Respiratory conditions and comorbid cardiovascular conditions. A MET is defined as the amount of oxygen consumed by a person at rest. This measurement is used to calculate the energy cost of a specific activity in multiples of the amount of oxygen consumed by a person at rest. Oxygen consumption is possible through the integrated operation of two distinct body systems, the cardiovascular and respiratory systems. The respiratory system

captures and collects oxygen, while the cardiovascular system delivers the oxygen to muscles (including the heart itself) performing the work associated with a specific activity. See M. Jette. ''Metabolic Equivalents (METS) in Exercise Testing, Exercise Prescription, and Evaluation of Functional Capacity,'' 13(8) Clin. Cardiol. 555–65 (1990).

Typically, when disability affects either the cardiovascular or respiratory systems, it is easy to apportion disability using METs to the affected system. However, when both the cardiovascular and respiratory systems are involved, it is difficult to apportion the contribution to the observed disability by each system. To avoid the potential rating complications posed by situations where coexistent cardiovascular and respiratory disabilities can be evaluated using METs, VA will instruct raters to evaluate only one body system using METs and evaluate the other body system using criteria other than METs, absent instructions otherwise in individual DCs. (The evaluation levels for METs will be the same in both cardiovascular and respiratory systems—that is, the METs yielding a 60 percent evaluation level in the cardiovascular system will yield the same evaluation in the respiratory system.) The General Rating Formula for Respiratory Conditions in § 4.97 lists several types of test results that can be used to evaluate a respiratory condition. When METs are used to evaluate a respiratory disability under § 4.97, they will not be used to evaluate a comorbid cardiovascular disability under § 4.104, and vice versa. Raters will use METs in the evaluation of the disability that would provide the veteran with the most advantageous combined rating.

B. Proposed Changes to 38 CFR 4.97

This proposed rule addresses VA's outdated organization of the DCs within the current respiratory schedule. This rule also updates diagnostic naming conventions and evaluation criteria according to modern medical practice.

1. Removal of ''Diseases of the Nose and Throat''

VA proposes to remove the heading ''Diseases of the Nose and Throat.'' As discussed in more detail below, VA is relocating DCs 6502 through 6524, currently located under this heading, to 38 CFR 4.87, as they share similarities in features, impairment assessment, and severity levels. Such similarities are more closely related to the disability criteria that VA will propose for the ear, nose, and throat schedule.

2. General Rating Formula for Respiratory Conditions

VA also proposes adding the General Rating Formula to the beginning of the respiratory system. The proposed formula incorporates much of the criteria currently used by several DCs for respiratory conditions, notably DCs 6600, 6603, 6604, 6825 through 6833, and 6840 through 6845. VA designed the proposed General Rating Formula to more succinctly organize the Rating Schedule by referring applicable DCs to a single formula, rather than repeating the same formula after each DC to which it applies. The introduction of the General Rating Formula for Respiratory Conditions revises the criteria for multiple DCs.

VA derived the model for the General Rating Formula from the table entitled ''Pulmonary Dysfunction'' in Guides to the Evaluation of Permanent Impairment 88 (Robert D. Rondinelli et al. eds., 6th ed. 2008). The table defines four different levels of impairment severity based on FVC, FEV–1, DLCO (SB), Maximum Oxygen Consumption (VO2 Max), and METs. VA proposes to modify these levels to rate respiratory conditions. The General Rating Formula VA proposes will utilize common PFT findings, such as FEV–1, FVC, the ratio of FEV–1 to FVC (FEV–1/FVC), and DLCO (SB), and continue to utilize most of the levels found throughout current § 4.97, as they differ only slightly from the levels found in the ''Pulmonary Dysfunction'' table and are generally more advantageous to veterans.

One change from current § 4.97, however, is to require less of a reduction in FEV–1 to qualify for 100 percent disability rating (an FEV–1 of less than 45 percent of predicted value, rather than the current 40 percent), which is advantageous to veterans. Another is to no longer provide a 100 percent rating for outpatient oxygen therapy: The need for oxygen is not a sufficiently accurate measure of the severity of a disability to allow for a consistent evaluation without regard to other more objective measures.

VA also proposes to adjust the values for maximum oxygen consumption, which has a fixed relationship to METs (every 3.5 ml of oxygen consumed is equal to 1 MET). This modification will ensure equity with values already used in other body systems using METs to evaluate disability (in particular, the cardiovascular system). Finally, VA proposes to continue utilizing FEV–1/FVC as a PFT that can be used for rating purposes despite its absence from the ''Pulmonary Dysfunction'' table.

Note (1) to the proposed General Rating Formula will instruct rating personnel to base the impairment assessment on the criteria that reflects the greatest impairment and, therefore, the greatest evaluation. Note (2) will address combined ratings, consistent with proposed § 4.96(a).

Finally, VA will add Note (3) to the proposed General Rating Formula, which will address comorbid respiratory and cardiovascular disabilities in accord with proposed § 4.96(d). As noted above, raters may use METs to evaluate the respiratory disability under § 4.97 or the cardiovascular disability under § 4.104, but not both.

It should be noted that the General Rating Formula does not reference cor pulmonale and right ventricular hypertrophy. Under current § 4.97, some evaluation criteria reference cor pulmonale and right ventricular hypertrophy without an associated respiratory system disability. One of VA's goals with this revision is to ensure that all evaluation criteria within § 4.97 contain at least one element of respiratory disability. Thus, under the proposed rule, any cardiovascular disabilities incorporated within § 4.97 will be associated with at least one respiratory disability as part of any and all evaluation criteria.

3. Other Changes to § 4.97

In addition to incorporating the General Rating Formula, VA proposes a number of organizational changes to the respiratory system. Specifically, VA proposes removing the current headings and subheadings and reorganizing the VASRD Respiratory System under two broad headings. The first heading will be ''Intrinsic Lung Diseases.'' VA proposes to add seven subheadings under Intrinsic Lung Diseases: ''Airway Disorders (Trachea, Bronchi),'' ''Tuberculous Lung Diseases,'' ''Vascular Lung Diseases,'' ''Lung Neoplasms,'' ''Bacterial Lung Diseases,'' ''Parenchymal Lung Disease (Including Interstitium and Alveolar Spaces),'' and ''Mycotic Lung Diseases.'' The second heading that VA proposes is ''Other Respiratory Conditions.'' VA will include these remaining respiratory diagnoses in accordance with modern medical practice. *See* Peter D. Wagner et al., ''Ventilation, Blood Flow and Gas Exchange,'' Murray and Nadel's Textbook of Respiratory Medicine 53–88 (5th ed. 2010).

To help the reader understand VA's proposed changes to the individual DCs within the Respiratory System, VA has organized the following discussion by the seven subheadings under Intrinsic

Lung Diseases in the order of their appearance. VA will then discuss changes within the proposed Other Respiratory Conditions.

i. Airway Disorders (Trachea, Bronchi)

Current DCs 6600 through 6604 shall appear in their current order under this proposed rule after the subheading Airway Disorders (Trachea, Bronchi). VA proposes to modify the rating criteria for DCs 6600, 6601, 6603, and 6604 to refer to the General Rating Formula, which assesses severity using current medical understanding. As discussed above, VA is proposing a General Rating Formula to simplify evaluations and expand the criteria upon which to evaluate respiratory conditions, to include FEV–1 and METs. Regarding DC 6602, bronchial asthma, VA proposes to maintain most of the current evaluation criteria but reorganize how the VASRD presents the various criteria for improved usefulness. This reorganization is similar to the proposed General Rating Formula: Each evaluation requires meeting at least one of its criteria.

ii. Tuberculous Lung Diseases

VA proposes removing the heading ''Diseases of the Lung and Pleura-Tuberculosis'' and replacing it with ''Tuberculous Lung Diseases.'' VA proposes to retain the current subheadings, ''Ratings for Pulmonary Tuberculosis Entitled on August 19, 1968,'' ''Ratings for Pulmonary Tuberculosis Initially Evaluated After August 19, 1968,'' and their corresponding DCs. These changes organize the DCs along current medical practice.

VA will not substantively alter the criteria for evaluating tuberculosis for individuals entitled on August 19, 1968, though it will delete a statutory reference that no longer exists. It also will not substantively change the current rating instructions for chronic, active pulmonary tuberculosis (DC 6730). However, VA proposes to amend the evaluation criteria for DC 6731, Chronic, inactive primary pulmonary tuberculosis. The current criteria evaluate residuals ''as interstitial lung disease, restrictive lung disease, or, when obstructive lung disease is the major residual, as chronic bronchitis (DC 6600).'' The amended rule would refer specifically to the General Rating Formula and provide notes consistent with the language of current DC 6731. VA proposes this change because the General Rating Formula provides sufficient rating criteria for assessing residual lung function of this disorder. VA proposes no substantive change to DC 6732.

iii. Vascular Lung Diseases

VA proposes to replace the current heading, ''Nontuberculous diseases,'' with the subheading ''Vascular Lung Diseases.'' This arrangement will form the third subheading under ''Intrinsic Lung Diseases.'' VA also proposes that DC 6817, presently ''Pulmonary vascular disease,'' be renamed as ''Pulmonary thromboembolic disease.'' The new name reflects current medical terminology for the same condition. *See* Timothy A. Morris and Peter F. Fedullo, ''Pulmonary Thromboembolism,'' Murray and Nadel's Textbook of Respiratory Medicine 1186 (5th ed. 2010).

VA proposes the following changes to the criteria of DC 6817: (1) Removing ''primary pulmonary hypertension'' from the 100 percent evaluation criteria, because it will be rated under new DC 6849, (2) removing references to cor pulmonale, which can be adequately evaluated under the proposed General Rating Formula, (3) recharacterizing the current note as Note (1), (4) adding a note (Note (2)) prohibiting separate evaluations for pulmonary thromboembolic disease with right ventricular hypertrophy and selected comorbid cardiovascular conditions in order to avoid pyramiding, and (5) adding a note (Note (3)) outlining when a rating under DC 6817 can be combined with other ratings under § 4.97.

Additionally, VA proposes adding a new DC 6849 for ''Pulmonary hypertension.'' Currently, VA rates pulmonary hypertension analogously to other respiratory conditions. However, this common condition has its own features and treatments, so evaluations analogous to other respiratory DCs may be inadequate or inappropriate. As indicated previously, medicine assesses impairment by changes in right ventricular diameter, B-natriuretic levels, and mean pulmonary artery pressure. The rating criterion VA proposes for DC 6849 applies such measurements to this unique respiratory condition. VA proposes four levels of disability, similar to the levels of the proposed General Rating Formula. Where rating criteria METs levels conflict with other METs levels found within the cardiovascular system, the conflicting METs levels will conform to those found within the cardiovascular system. *See* Rondinelli, *supra* at 71–73.

Three notes would accompany DC 6849. The first would state that acute pulmonary hypertension is not a disability for ratings purposes. VA compensates disabilities that impair earning capacity, not temporary conditions that generally do not impact earning capacity. *See* 38 U.S.C. 1155; *Davis* v. *Principi,* 276 F.3d 1341, 1345–47 (Fed. Cir. 2002); *see also Moore* v. *Shinseki,* 555 F.3d 1369, 1373 (Fed. Cir. 2009). The second note would prohibit separate evaluations for pulmonary hypertension and selected coexisting cardiovascular conditions; instead, one rating would be assigned either under DC 6849 or under the appropriate cardiovascular DC (38 CFR 4.104), whichever represents the predominant disability. Compensating the same disability under two different body systems would represent pyramiding, which is impermissible under 38 CFR 4.14. The third note would outline when a rating under DC 6849 can be combined with other ratings under § 4.97.

iv. Lung Neoplasms

VA next proposes to reorganize DCs 6819, ''Neoplasms, malignant, any specified part of respiratory system exclusive of skin growths,'' and 6820, ''Neoplasms, benign, any specified part of respiratory system,'' under the proposed subheading ''Lung Neoplasms.'' DCs 6819 and 6820 are currently listed under ''Nontuberculous Diseases.''

VA also proposes to modify the note for DC 6819, which currently instructs rating personnel to evaluate residuals six months after the cessation of all forms of active treatment. VA intends to refer rating personnel to the General Rating Formula because this evaluation tool provides the most appropriate criteria for assessing residual impairment from a malignant lung neoplasm. Potential residuals include, but are not limited to, removal (resection) of a lung (in part or in whole) or persistent pleural effusions.

Similarly, VA proposes that DC 6820, benign neoplasms of the respiratory system, be rated under the General Rating Formula. Currently, DC 6820 directs rating personnel to ''Evaluate using an appropriate respiratory analogy.'' The General Rating Formula provides a broad range of alternative criteria with which to assess most respiratory conditions.

v. Bacterial Lung Diseases

VA proposes renaming the heading ''Bacterial Infections of the Lung'' to the subheading ''Bacterial Lung Diseases.'' DCs 6822 through 6824 will continue to appear under Bacterial Lung Diseases. VA does not propose any substantive criteria changes for the rating formula for these DCs.

vi. Parenchymal Lung Disease (Including Interstitium and Alveolar Spaces)

VA proposes to remove the current subheading, ''Interstitial Lung Disease,'' to add instead, ''Parenchymal Lung Disease (Including Interstitium and Alveolar Spaces).'' VA also proposes to relocate DC 6846 (Sarcoidosis) from the current ''Restrictive Lung Disease'' subheading to the newly proposed ''Parenchymal Lung Disease (Including Interstitium and Alveolar Spaces)'' subheading, as sarcoidosis is medically-categorized as a parenchymal lung disease. This new subheading reflects modern medical terminology for the associated DCs. In addition, VA proposes to rate these conditions under the General Rating Formula. This change will incorporate current medical standards for assessing impairment. By applying the General Rating Formula, VA proposes to expand the types of PFT results, to include FEV–1/FVC, and METs, to evaluate these conditions.

In addition, VA proposes to include a note for DCs 6825 through 6833 and DC 6846. This note instructs rating personnel to add an additional 10 percent to any rating during certain kinds of treatment, specifically, oral prednisone greater than 20 milligrams (mg) daily, or daily second-line immunosuppressive medication (*e.g.,* non-steroidal agents; such immunomodulatory drugs as azathioprine or cyclophosphamide; anti-fibrotic agents such as colchicine; penicillamine; or biologic agents such as etanercept). VA proposes to add this additional 10 percent rating because the treatments themselves may result in adverse effects involving the blood-forming organs or the gastrointestinal system. *See* M. Selman et al., ''Idiopathic Interstitial Pneumonias,'' Murray and Nadel's Textbook of Respiratory Medicine 1380–81 (5th ed. 2010).

VA also proposes to rename DC 6825, ''Diffuse interstitial fibrosis (interstitial pneumonitis, fibrosing alveolitis), to ''Diffuse interstitial fibrosis (interstitial pneumonitis, fibrosing alveolitis, idiopathic fibrosis).'' The proposed name reflects current medical terminology. See id. at 1370.

vii. Mycotic Lung Diseases

VA also proposes to rename ''Mycotic Lung Disease'' to ''Mycotic Lung Diseases'' and organize DCs 6834 through 6839 under this subheading. No substantive criteria changes are proposed for these diseases.

viii. Other Respiratory Conditions

The final organizational change VA proposes for the respiratory system is assembling all remaining respiratory disabilities under the heading ''Other Respiratory Conditions.'' VA will arrange DCs 6840 through 6847 under this heading.

In addition to moving these DCs under the new heading, VA proposes to rename DCs 6841 and 6842. Specifically, VA intends to rename DC 6841, currently ''Spinal cord injury with respiratory insufficiency,'' as ''Respiratory insufficiency due to spinal cord injury.'' As for DC 6842, ''Kyphoscoliosis, pectus excavatum, pectus carinatum,'' VA proposes to rename it as ''Pulmonary disease secondary to kyphoscoliosis, pectus excavatum, or pectus carinatum.'' Renaming these DCs clarifies that the primary disability is related to the respiratory system.

VA proposes that DCs 6840 through 6846 be rated under the General Rating Formula. This proposed change modifies the current criteria by, most notably, adding FVC and METs as additional measures. This proposed change favors veterans because it allows additional, alternative criteria to assess disability that do not currently exist in these DCs. As previously discussed, VA proposes to change these criteria to reflect current medical standards for assessing the severity of impairment.

VA also proposes to modernize the rating criteria for DC 6847, ''Sleep Apnea Syndromes (Obstructive, Central, Mixed)'' and retitle that DC as ''Sleep Apnea Syndromes (Obstructive, Central, or Mixed)''. The discipline of sleep medicine has greatly evolved since VA published the existing criteria. The American Academy of Sleep Medicine (AASM), founded since then, conducted in-depth, peer-reviewed research in conjunction with its partners to develop scientifically-refined criteria regarding the definition, measurement, and treatment of sleep apnea. Sleep apnea may be defined as complaints of unintentional sleep episodes and/or awakenings and/or snoring associated with an apnea-hypopnea index (AHI) equal to or greater than 5 per hour or, alternatively, an asymptomatic patient with an AHI greater than 15 per hour. *See* Richard B. Berry, Fundamentals of Sleep Medicine 238 (2012). Additional findings supporting a diagnosis of sleep apnea include oxygen desaturation greater than 4 percent and/or a reduction in airflow below 70 percent. Such measurements can evaluate the effectiveness of treatment intervention or lifestyle modifications such as weight loss.

VA proposes to extensively revise the rating criteria for sleep apnea to primarily provide compensation that is more compatible with earning impairment than the current criteria. The current criteria evaluate based upon treatment rather than actual impairment. VA currently assigns higher ratings to individuals when their physicians prescribe more intensive therapies, such as continuous airway pressure (CPAP) machines, without regard to whether individuals first tried more conservative therapies, such as weight loss or oral appliances, or what actual impairment continues following use of CPAP machines. As discussed below, VA's proposed criteria will focus on the result rather than the type of treatment. Hence, individuals whose treatments are equally effective will receive equal disability ratings, regardless of the treatments. Individuals for whom treatment similarly fails (or is only partially effective) will also receive similar ratings. These proposed changes for sleep apnea comply with 38 U.S.C. 1155 that the VASRD ratings reflect average losses in earning capacity.

Specifically, VA proposes to assign a 0 percent evaluation when sleep apnea syndrome is asymptomatic, with or without treatment. VA would assign a 10 percent evaluation when treatment yields ''incomplete relief.'' VA would assign ratings above 10 percent (*e.g.,* 50 and 100 percent) only when treatment is either ineffective or the veteran is unable to use the prescribed treatment due to comorbid conditions. VA would assign a 100 percent evaluation only if there is also end-organ damage. VA proposes to include an informational note that defines and gives examples of qualifying comorbid conditions, *i.e.,* conditions that, in the opinion of a qualified medical provider, directly impede or prevent the use of, or implementation of, a recognized form of treatment intervention normally shown to be effective.

VA proposes to add a new DC 6848 for ''Lung transplantation.'' Lung transplantation involves a unique treatment that is not addressed in the current Rating Schedule. This procedure for a service connected pulmonary condition results in significant disability that is not adequately captured by the current rating schedule. For one, recovery with pulmonary function testing performance usually takes about 12 months. Yet outcome studies reveal significant variation in return to work time. This can be explained when you look at the two main populations receiving lung

transplants. There is a population who receive the lung transplant due to hereditary/genetic conditions that would preclude military service all together (such as cystic fibrosis), and another population who receive a lung transplant due to acquired conditions (such as chronic obstructive pulmonary disease). VA believes the population with lung transplantation due to acquired conditions is a better characterization of the population of veterans who might receive this procedure and thus would be eligible for compensation. On this basis, VA intends to assign a 100 percent evaluation for lung transplantation surgery, and for one year following discharge from the hospital for such surgery. Thereafter, consistent with other respiratory conditions, VA will base the evaluation on residuals according to the proposed General Rating Formula, but with a minimum evaluation of 30 percent. *See* Lisa Cicutto et al., ''Factors Affecting Attainment of Paid Employment After Lung Transplantation,'' 23 J. Heart Lung Transplant 481–86 (2004); *see also* Dmitry Tumin et al., ''Attained Functional Status Moderates Functional Outcomes of Return to Work After Lung Transplantation,'' 194 Lung 437–45 (2016).

II. Ear, Nose, Throat, and Audiology Disabilities

Otolaryngology is the field of medicine concerned with diseases of, and injury to, the ears, nose, and throat. Currently, the VASRD spreads these diseases and conditions among several systems. This disbursement of diseases and conditions amongst several body systems does not represent the current scientific and medical understanding of the specific anatomy, etiology, and disabling effect of diseases and conditions of the ears, nose, and throat. Reorganization of these diseases and conditions to reflect current medical and scientific practice improves rating efficiency and effectiveness by allowing for easy identification of the medical source for each rating and reducing the need to rely on analogous codes when evaluating certain disabilities.

The system titled ''Impairment of Auditory Acuity,'' found at 38 CFR 4.85–4.87, already includes conditions of hearing and the ear, including the symptom of tinnitus (ringing in the ear), hearing loss, vestibular disorders (dizziness), neoplasms (tumors), and infections. For the reasons discussed above, VA proposes to rename the body system ''Ear, Nose, Throat, and Auditory Disabilities'' and relocate 16 DCs from § 4.97, the Respiratory System, to § 4.87. Under § 4.87, VA will redesignate DCs 6502 through 6524 as DCs 6220 through 6235, respectively. VA discusses in more detail below any changes to the sections and/or DCs under this new arrangement (*e.g.,* §§ 4.85 through 4.87).

A. Audiology and Hearing Loss

1. Defining Hearing Loss Disability

VA considered expanding the current definition of hearing loss, located at 38 CFR 3.385, to include the concept of acoustic ''notches'' (see below). However, VA concluded that the current definition of hearing loss is sufficient and fair for evaluating levels of disability.

Noise exposure is often associated with a pattern of hearing loss across frequencies referred to as ''noise notches'' or a ''notch.'' According to a 2006 Institute of Medicine (IOM) study, a noise notch typically shows hearing that is normal or nearly normal at lower frequencies (less than 2000 Hertz (Hz)), with worse hearing thresholds typically occurring at frequencies in the 3000–6000 Hz region, with better hearing thresholds at 8000 Hz. IOM, Noise and Military Service: Implications for Hearing Loss and Tinnitus 38 (The National Academies Press, 2006). A notched pattern in the 3000–6000 Hz frequency region, together with supporting evidence from a detailed case history, can lead to the diagnosis of noise-induced hearing loss. However, this characteristic pattern in the high frequencies is not limited to noise-induced hearing loss. The high-frequency hearing loss pattern from aging is indistinguishable from the cumulative effects of noise-induced hearing loss. *See* Linda M. Luxon, ''The clinical diagnosis of noise induced hearing loss,'' Biological Effects of Noise 83–113 (Deepak Prasher and Linda Luxon eds. 1998); Victor Osei-Lah and L.H. Yeoh, ''High-frequency audiometric notch: an outpatient clinic survey,'' 49(2) Int'l J. of Audiology 95–98 (2010).

More recent publications examined noise notches in the veteran population to again define the presence or absence of a noise notch more objectively than by simply relying on the visual pattern of high frequency hearing loss. *See, e.g.,* Richard H. Wilson and Rachel McArdle, ''Characteristics of the Audiometric 4,000 Hz Notch (744,553 veterans) and 3,000, 4,000 and 6,000 Hz Notches (539,932 veterans),'' 50 J. of Rehabilitative Research and Development 111–32 (2013); Ross Coles et al., ''Guidelines on the diagnosis of noise-induced hearing loss for medicolegal purposes,'' 25(4) Clin. Otolaryngology 264–73 (2000). However, the observed pattern of hearing loss in these studies neither rebutted nor confirmed noise injuries. In the Wilson and McArdle study, nothing indicated that notched audiograms were characteristic of audiograms in veterans of any age. Similarly, Coles et al. noted that the presence of notches was not indicative of noise exposure because such configurations were found in people with no significant noise exposure and not in persons with known exposure. Given the results of these studies, VA concludes that including notches in a definition of hearing loss disability would not rationally justify compensation benefits to veterans. Therefore, VA proposes no substantive changes to the current definition in § 3.385.

2. Proposed Changes to Audiology

Although VA will not alter its definition of hearing loss for compensation purposes, it proposes several updates of the current terminology found in 38 CFR 3.385, 4.85–4.86. VA also proposes a note to § 4.85 adding a 10 percent evaluation for noncompensable hearing loss with tinnitus present, where tinnitus is related to the diagnosis of hearing loss.

i. Terminology Updates

VA proposes a number of nonsubstantive changes for readability and to update terminology according to current medicine. VA proposes to replace the terms ''speech recognition'' and ''speech discrimination'' with ''word recognition'' in § 3.385 and throughout § 4.85. Although used interchangeably, the term most frequently used today is ''word recognition.''

VA also proposes to replace the term ''hearing impairment'' or ''impaired hearing'' with ''hearing loss'' throughout Part 3 and Part 4, as ''hearing loss'' is more commonly used today.

In addition, VA proposes to change the spelling of ''puretone'' throughout §§ 4.85 and 4.86, to include tables VI and VIA. According to Dorland's Illustrated Medical Dictionary 179 (32d ed. 2012), two words form the correct spelling, *i.e.,* ''pure tone'' or, as a compound adjective before the noun, ''pure-tone threshold.''

During the October 2011 audiology forum, VA received a recommendation to clarify the units that it uses to measures hearing loss. Therefore, VA also proposes to add to 4.85, paragraph (a), ''Hearing levels are measured in decibels and expressed as dB HL.''

Finally, VA proposes to replace the term ''rating veterans service representative'' in § 4.86 with ''rating

activity.'' This terminology update recognizes that not all claims are adjudicated by a rating veterans service representative (RVSR); some decisions are rendered by a decision review officer (DRO) or another individual with the proper authority to adjudicate a claim for benefits. This terminology update does not otherwise change the application of the provisions in § 4.86.

ii. Pure-Tone Air Conduction Threshold

Currently, VA evaluates hearing loss using pure-tone thresholds, but no regulation specifies the type of measurement. Audiology pure-tone threshold uses either air or bone conduction testing. *See* Joe Walter Kutz Jr. et al., ''Audiology Pure-Tone Testing,'' *Medscape Reference, http://emedicine.medscape.com/article/1822962-overview#showall* (last visited July 24, 2018). VA proposes to clarify that pure-tone thresholds refer to air conduction thresholds throughout §§ 3.385, 4.85, and 4.86, to include tables VI and VIA. VA chose this particular technique because it measures the usual mode of hearing. On the other hand, bone conduction testing is simply a diagnostic tool and one of a battery of tests by which audiologists determine the etiology and severity of hearing loss. To reflect this change, VA proposes to replace the term ''puretone threshold'' with ''pure-tone air conduction threshold'' wherever it appears in §§ 4.85 and 4.86. Similarly, VA also proposes to replace the references to ''auditory'' thresholds in § 3.385 with ''pure-tone auditory air conduction'' thresholds.

iii. Word Recognition Testing

Current § 4.85(c) provides that ''Table VIA will be used when the examiner certifies that use of the speech discrimination test is not appropriate because of language difficulties, inconsistent speech discrimination scores, etc., or when indicated under the provisions of § 4.86.'' VA proposes to clarify the term ''language difficulties'' with the addition of the phrase ''*e.g.,* English non-fluency.'' Several VA audiology experts with whom the Veterans Benefits Administration consulted noted that the most common language difficulty in service members is that their first language is not English, thus invalidating the speech discrimination scores. Additionally, an increased number of service members have cognitive difficulties resulting from traumatic brain injuries. These injuries result in decreased speech discrimination scores. *See, e.g.,* Henry L. Lew et al., ''Audiology dysfunction in Traumatic Brain Injury,'' 44(7) J. of Rehabilitation Research & Development 921–28 (2007). Therefore, VA also proposes to add ''cognitive difficulties'' to the list of reasons why word recognition testing may be inappropriate.

iv. Percentage Evaluation for Hearing Loss (Diagnostic Code 6100)

VA proposes to revise the evaluation criteria for this DC in order to provide (1) a 10 percent rating for tinnitus associated with service-connected, noncompensable hearing loss, and (2) two notes pertaining to tinnitus. Tinnitus is defined as the perception of sound in the absence of an external source. In many cases, the patient cannot identify the onset or cause of the tinnitus. J.L. Stouffer and Richard S. Tyler, ''Characterization of tinnitus by tinnitus patients,'' 55(3) J. of Speech and Hearing Disorders, 439–53 (Aug. 1990). However, current medicine reflects that tinnitus likely results from abnormal neural activity at some point or points in the auditory pathway, which is incorrectly interpreted by the brain as an actual sound. *Id.* As a result, it is a symptom associated with an underlying condition, such as hearing loss, Meniere's disease, traumatic brain injury and cerebral atherosclerosis, not an independent disease. *Id.*

Recognition of tinnitus for evaluation purposes dates back to at least 1925, when raters were instructed to ''add 15 [percent] to loss of hearing as a combined rating.'' ''The Schedule for Rating of Disability Ratings,'' U.S. Veterans' Bureau, Table II, p.59 (1925 ed.). Accordingly, tinnitus was rated in conjunction with hearing loss, rather than a disease in and of itself. In a final rule published in 1976, VA's rating criteria recognized tinnitus for evaluation purposes when ''[p]ersistent as a symptom of head injury, concussion, or acoustic trauma.'' 41 FR 11291, 11298 (Mar. 18, 1976). In a final rule published in 1999, in part motivated by an effort to standardize tinnitus evaluations beyond these three specific injuries, the regulation was changed to award a single 10 percent evaluation without mention of the underlying condition resulting in tinnitus. 64 FR 25202, 25206 (May 11, 1999). While not intended by VA, this rulemaking created the impression that tinnitus is an independent condition, rather than a symptom associated with an underlying condition. VA's intent with the presently proposed revision is to accurately restore the medically-supported relationship between tinnitus and an underlying pathology, consistent with current medical practice.

VA proposes to evaluate tinnitus only as part of its underlying pathology and to delete DC 6260 entirely. In other words, tinnitus will be compensated through application of DCs 6100, 6204, 6205, 8045, 8046, or 9305, depending on its service-connected cause. For tinnitus associated with service-connected hearing loss in particular, the presence of tinnitus generally does not impact earning capacity beyond what is already contemplated at the compensable levels of hearing loss, though VA recognizes that the presence of tinnitus combined with noncompensable hearing loss could have more than a 0% impact on earning capacity. Thus, DC 6100 will provide a 10% evaluation for tinnitus associated with hearing loss only when hearing loss is noncompensable (only when hearing loss, on its own, does not warrant a 10% evaluation or higher). If hearing loss is compensable (warranting a 10% evaluation or greater), an additional 10% evaluation for tinnitus associated with the hearing loss shall not be assigned.

To that end, VA will add two notes under DC 6100. The first note will list examples of which disabilities contemplate tinnitus as a symptom of a given underlying pathology. The second note will provide that tinnitus is only compensated as part of an underlying service-connected condition. VA notes that this proposal will have no impact on veterans currently in receipt of service connection for tinnitus under DC 6260; these evaluations are governed under the provisions of 38 CFR 3.951(a).

v. DC 6100 and Extraschedular Consideration

In *Doucette* v. *Shulkin,* 28 Vet. App. 366, 373 (2017), the U.S. Court of Appeals for Veterans Claims noted the potential value if VA ''provide[d] additional guidance on what symptoms the rating criteria [for hearing loss] contemplate.'' *Doucette* involved a veteran who argued for extraschedular consideration under 38 CFR 3.321(b)(1) because his hearing loss resulted in difficulty distinguishing sounds in a crowded environment, locating the source of sounds, understanding conventional speech, hearing the television, and using the telephone. *Id.* at 371. The court held that such functional effects of decreased hearing and difficulty understanding speech in an everyday environment were contemplated by the schedular rating criteria, *id.* at 369, 371–72, though a dissenting judge argued that the ''criteria are inadequate to contemplate a veteran's functional effects and entire disability picture.'' *Id.* at 374 (Schoelen, J., dissenting).

In response to the court's statement concerning additional guidance, we clarify here that DC 6100 contemplates all natural or expected effects of decreased hearing. It is expected and natural that a veteran with hearing loss like Mr. Doucette will, for example, experience difficulties distinguishing sounds or using the telephone. The schedule was designed to determine a veteran's level of hearing loss disability through objective testing and match it to a disability rating that compensates for the average impairment in earning capacity associated with that level of disability. 38 U.S.C. 1155; 38 CFR 4.1, 4.10, 4.85. To the extent a particular veteran's hearing loss may seem more impactful than the rating provided, that is characteristic of a schedule that compensates for ''the average impairments of earning capacity''—it is not an indication that the schedule is inadequate. 38 U.S.C. 1155.

When a symptom of a hearing loss disability properly rated under this code is unusual or exceptional for that disability, and not contemplated by the code, there are alternative methods to ensure that a veteran is adequately compensated. First, if the symptom of the hearing loss disability implicates a disability addressed elsewhere in the schedule, an evaluation may be appropriate under the listed diagnostic code which accounts for the disability. If the symptom implicates a disability that is not listed in the schedule, an evaluation may be appropriate by analogy using a closely related disease or injury, giving due consideration to the functions affected, anatomical localization, and symptomatology. 38 CFR 4.20. In such a case, because another diagnostic code in the schedule addresses a disability analogous to the disability implicated by the symptom, the schedule is not inadequate to rate the veteran's disability. Finally, if the unusual or exceptional symptom of the hearing loss disability does not implicate any other provision or code in the schedule (either directly or through analogy), the schedule may not contemplate the hearing loss disability presented; and 38 CFR 3.321(b)(1) may be considered.

B. Ear, Nose, and Throat Disabilities—Proposed Changes to § 4.87

As noted above, VA proposes to relocate a number of conditions from § 4.97 to § 4.87. It also intends to update several of the relocated codes, as well as DCs already included in § 4.87, to ensure that the medical descriptions reflect the most current knowledge, practice, and standards of care, and that the criteria determining the levels of compensation provide fair and accurate benchmarks for veterans. As VA intends to relocate a number of conditions affecting the nose, throat and larynx (voice box) to § 4.87, VA proposes to retitle this section from ''Schedule of ratings—ear'' to ''Schedule of ratings—ear, nose, and throat.''

1. Diagnostic Code 6200

VA proposes to revise the note under this DC from ''Evaluate hearing loss, and complications such as labyrinthitis, tinnitus, facial nerve paralysis, or bone loss of skull, separately.'' to ''Evaluate hearing loss and complications such as labyrinthitis, facial nerve paralysis, or bone loss of skull, separately.'' This revision is necessary as tinnitus associated with hearing loss is now contemplated under DC 6100.

2. Diagnostic Code 6202

VA currently evaluates otosclerosis under DC 6202. To ensure greater consistency in decision making, VA proposes to rename this code to include residuals of stapedectomy and stapedotomy. Surgeons perform these procedures involving the middle ear to prevent further deterioration of hearing caused by otosclerosis by improving the movement of sound to the inner ear. The primary residual of stapedectomy and stapedotomy is continued hearing loss, albeit without further deterioration of hearing, so VA may evaluate these conditions similarly to otosclerosis by the degree of the hearing loss. *See* S. George Lesinski, ''Causes of Conductive Hearing Loss After Stapedectomy or Stapedotomy: A Prospective Study of 279 Consecutive Surgical Revisions,'' 23(3) Otology & Neurotology 281–88 (May 2002).

3. Diagnostic Code 6204

Peripheral vestibular disorders (DC 6204) may originate in one or both ears and may cause varying degrees of disability. B. Gurr and N. Moffat, ''Psychological consequences of vertigo and the effectiveness of vestibular rehabilitation for brain injury patients,'' 15 Brain Injury 387 (2001); Hannelore K. Neuhauser et al., ''Burden of dizziness and vertigo in the community,'' 168 Archives of Internal Medicine 2118 (2008). DC 6204 currently evaluates such disorders using only dizziness and staggering (*i.e.,* alteration of gait). VA therefore proposes to amend DC 6204 to better reflect the full scope of these disorders and their effect on a veteran's ability to work and engage in other activities that impact earning capacity.

Specifically, VA proposes to provide increasingly higher ratings depending on the impact of a veteran's vestibular disorder on activities of self-care. VA may evaluate self-care activities for the purposes of this DC using assessments by qualified health care providers that address the capacity to bathe, dress, eat, manage hygiene, and/or move the body from place to place. VA will also evaluate the ability to work, to include whether the veteran requires significant modification and/or accommodation to accomplish tasks. Additionally, VA intends to expand the current disability evaluation levels from two (10 and 30 percent) to three (10, 30, and 100 percent); the 100 percent evaluation will include veterans whose vestibular disorders severely impact their life and result in the substantial inability to work.

The proposed criteria provide a 10 percent evaluation for a documented vestibular disorder with symptoms during the last six months that require brief and temporary modification of activity but do not prevent continuation of normal activities such as self-care and/or work. VA proposes a 30 percent evaluation for symptoms that occur with sufficient frequency to require routine limitation in activities, which the individual can overcome with effort and some modification and/or accommodation. VA proposes a 100 percent evaluation for symptoms that result in an inability to independently perform self-care and/or work activities, even with modification of activity or accommodation. Finally, VA proposes two notes for this DC—one defining self-care activities and another continuing this DC's current requirement of objective findings supporting the diagnosis.

4. Diagnostic Code 6205

Originating in the inner ear, the specific causes of Meniere's syndrome (DC 6205) remain unclear. However, the effects, which may include vertigo, tinnitus, hearing loss, and unstable gait, may impact a veteran's earning capacity. The current rating criteria for DC 6205 provide for 30, 60, and 100 percent evaluations depending upon the presence of hearing loss and the frequency of attacks of vertigo and cerebellar gait. Alternatively, rating personnel must separately evaluate vertigo (as a peripheral vestibular disorder) and hearing loss if a higher combined rating for Meniere's syndrome results.

VA does not intend to significantly alter the current rating criteria for DC 6205. However, it does propose to change evaluative criteria so they are consistent and clear. VA proposes to alter the frequency for the 100 percent evaluation from ''more than once

weekly'' to ''five or more times a month'' to be consistent with the monthly timeframes provided in the 30 and 60 percent levels. VA also proposes to eliminate the current reference to ''attacks of vertigo and cerebellar gait.'' Individuals with Meniere's syndrome experience attacks of dizziness (or vertigo) that appear suddenly but may or may not result in gait disturbance. *See* ''Meniere's disease,'' National Institute on Deafness and Other Communication Disorders, *https://www.nidcd.nih.gov/health/balance/pages/meniere.aspx* (last visited July 24, 2018). Occasionally, however, an individual's vertigo is so extreme and frequent that it results in disequilibrium or gait instability. *Id.* Therefore, VA proposes to include vertigo in all evaluation levels, with the only reference to gait being the 100 percent evaluation. VA proposes a 100 percent evaluation for hearing loss with either persistent disequilibrium and gait instability, or with vertigo occurring five or more times a month. Finally, VA proposes to reorganize the criteria within each evaluation for improved clarity and usability. Specifically, VA notes that each evaluation currently includes hearing loss. The crucial point is the frequency of vertigo or, for a 100-percent evaluation, the presence of persistent disequilibrium. VA proposes to reorganize the criteria to emphasize this.

VA intends to amend the current note to DC 6205 and redesignate it as Note (3). For reasons explained in this preamble's discussion of tinnitus, proposed Note (3) will no longer include any reference to a separate evaluation for tinnitus.

To ensure consistent evaluations, VA proposes to include a new Note (1), which will indicate that the Meniere's diagnosis must be made by a otolaryngologist or neurologist. *Id.* The requirement for a specialist evaluation is based on the complexity of the diagnostic work up. This work up is best performed by those whose focus is on this area of medical care, as opposed to a provider without focused expertise, to ensure the proper diagnostic assessment is made. In addition, VA proposes a new Note (2) to direct rating personnel to calculate the average vertigo frequency using a six-month period. This period ensures that the assigned evaluation represents the average level of impairment, taking into account occasional flare-ups that may not represent a true increase in the overall severity of the disease.

5. Diagnostic Code 6260

As previously noted under revisions to § 4.85, VA proposes to remove DC 6260.

6. Relocated Diagnostic Codes

As previously noted, VA proposes to move 16 conditions from § 4.97 (the Respiratory System) to § 4.87 (the proposed ENT System). VA will redesignate these DCs, currently designated 6502 through 6524, as DCs 6220 through 6240, respectively. VA proposes to change the evaluation criteria for a number of these relocated DCs. However, VA proposes no substantive changes to the following codes: DC 6502, Septum, nasal, deviation of (proposed DC 6220); DC 6515, Laryngitis, tuberculous, active or inactive (proposed DC 6227); DC 6516, Laryngitis, chronic (proposed DC 6228); DC 6518, Laryngectomy, total (proposed DC 6229); DC 6519, Aphonia, complete organic (proposed DC 6230); and DC 6521, Pharynx, injuries to (proposed DC 6232). VA will update accordingly any references to these DCs within other codes.

i. Diagnostic Code 6504

In relocating DC 6504, loss of part of the nose or nasal scars, to § 4.87, VA proposes to redesignate it as DC 6221. The current criteria for DC 6504 assign 10 or 30 percent evaluations based on the exposure of nasal passages, loss of ala (the wings of the nose), or other obvious disfigurement. This focus on loss of particular nasal parts, rather than on the overall quantifiable loss of nasal tissue and/or structure, may result in inconsistent evaluations for similarly disabling conditions. As such, VA proposes to assign evaluations based on defined loss of the nose (*i.e.,* more or less than half). Additionally, because the use of nasal prosthetics often has a positive impact on an individual's psychosocial functioning, VA proposes to incorporate the mitigating value of any nasal prosthetics used. VA intends to provide for higher ratings when the loss is not amenable to the use of prosthesis. *See* Satyabodh S. Guttal et al., ''Interim Prosthetic Rehabilitation of a Patient Following Partial Rhinectomy: A Clinical Report,'' 4(4) European J. of Dentistry 482, 482–83 (Oct. 2010).

Under the proposed criteria, VA would assign a 0 percent evaluation for any loss or disfigurement of the nose for which a qualified medical provider does not require or recommend a prosthesis. VA would assign a 10 percent evaluation for any loss of the nose for which a qualified medical provider requires or recommends a prosthesis and the patient is capable of using it. VA proposes a 20 percent evaluation for a loss that a prosthesis cannot treat (as documented by a qualified provider) and that loss involves less than 50 percent of the nose. Finally, VA proposes a 30 percent evaluation for a loss that a prosthesis cannot treat (as documented by a qualified provider) and that loss involves at least 50 percent or more of the nose. VA intends to retain the current note directing rating personnel to alternatively evaluate any loss or scar under DC 7800, disfiguring scars of the head, face, or neck.

ii. Diagnostic Codes 6510, 6511, 6512, 6513, and 6514

Current DCs 6510 through 6514 all refer to various types of chronic sinusitis evaluated using the General Rating Formula for Sinusitis, located under DC 6514. VA proposes to redesignate these codes as DCs 6222 through 6226, respectively, under § 4.87; additionally, VA proposes to rename each code to reflect current medical terminology. VA proposes to rename the redesignated DC 6222 as ''Rhinosinusitis, pansinusitis.'' VA proposes to rename the redesignated DC 6223 as ''Rhinosinusitis, ethmoid.'' VA proposes to rename the redesignated DC 6224 as ''Rhinosinusitis, frontal.'' VA proposes to rename the redesignated DC 6225 as ''Rhinosinusitis, maxillary.'' VA proposes to rename the redesignated DC 6226 as ''Rhinosinusitis, sphenoid.'' VA also proposes to reflect current medical terminology by renaming the General Rating Formula for Sinusitis as General Rating Formula for Chronic Rhinosinusitis and Recurrent Acute Rhinosinusitis. VA will place this renamed rating formula immediately before the redesignated DC 6222.

To modernize the rating schedule in regard to chronic sinusitis, VA will first introduce current medical terminology and definitions. Rhinosinusitis is defined as symptomatic inflammation of the paranasal sinuses and nasal cavity. Modern medicine understands three different clinical presentations of inflamed nasal passages and sinuses (rhinosinusitis): Acute, recurrent acute, and chronic. Richard M. Rosenfeld et al., ''Clinical practice guideline: Adult sinusitis,'' 137(3 Supp.) Otolaryngology-Head and Neck Surgery S19, Table 10 (2007).

Acute rhinosinusitis (ARS) is defined as up to four weeks of purulent drainage (anterior, posterior, or both) accompanied by nasal obstruction, facial fullness, or both. Acute rhinosinusitis can occur as viral rhinosinusitis (or VRS, defined as rhinosinusitis caused by a virus and

typically lasting less than 10 days). Acute rhinosinusitis can also occur as acute bacterial rhinosinusitis (or ABRS, defined as a bacterial infection that causes symptoms of rhinosinusitis for at least 10 days after the onset of an upper respiratory infection or causes recurrence of symptoms within seven days after initial improvement). If rhinosinusitis symptoms last at least four but less than 12 weeks, it is defined as subacute rhinosinusitis (SAR). *Id.*

Recurrent acute rhinosinusitis (RARS) is defined as four or more episodes of ABRS without signs or symptoms of rhinosinusitis between episodes. *Id.*

Finally, chronic rhinosinusitis, or CRS, is defined as 12 weeks or more of at least two of the following—mucopurulent drainage (anterior, posterior, or both); nasal obstruction (congestion); facial pain-pressure-fullness; or decreased sense of smell—in combination with inflammation as documented by at least one of the following: Purulent mucus (not clear) in the middle meatus or ethmoid region; polyps in the nasal cavity or the middle meatus; or radiographic imaging showing inflammation of the paranasal sinuses. *Id.*

VA compensates disabilities that impair earning capacity, not temporary conditions that generally do not impact earning capacity. *See* 38 U.S.C. 1155; *Davis,* 276 F.3d at 1345–47; *see also Moore,* 555 F.3d at 1373. In that regard, CRS and RARS are distinguishable from ARS and SAR. To assist the public and rating activity in better understanding what disabilities are compensated under this General Rating Formula, VA proposes to include a note identifying which conditions are eligible for compensation and another note specifying which conditions are explicitly excluded from compensation.

The present rating criteria evaluate chronic sinusitis predominantly on the frequency of ''incapacitating episodes,'' which includes prolonged antibiotic treatment, as well as the need for ''bed rest'' and ''treatment by a physician.'' Current standards of medical care, however, no longer describe incapacitating episodes or bed rest as treatment. VA therefore proposes to retain those elements of the existing criteria—namely, frequency/duration of antibiotic treatment—that still relate to current medical practice and eliminate reference to incapacitating episodes. VA also proposes to retain the 50 percent criteria that require unresponsiveness to surgery to reflect the severity of disability that accompanies that rating level.

In light of the above, VA's proposed General Rating Formula for Chronic Rhinosinusitis (CRS) and Recurrent Acute Rhinosinusitis (RARS) will retain the same rating levels as the current General Rating Formula for Sinusitis (*i.e.,* 0, 10, 30, and 50 percent). The criteria begin with a 50 percent evaluation granted for CRS/RARS which requires 12 weeks or more of treatment with antibiotics and unresponsiveness to surgical intervention with endoscopy or other surgical procedure designed to treat CRS/RARS. A 30 percent evaluation will be granted for CRS/RARS that requires 12 weeks or more of treatment with antibiotics during the preceding 12-month period. A 10 percent evaluation will be granted for CRS/RARS which requires antibiotic treatment for at least four weeks but less than 12 weeks during the preceding 12-month period. Finally, a 0 percent evaluation will be granted when there has been less than four weeks treatment with antibiotics during the preceding 12-month period. Rosenfeld, *supra,* at S1–31; *see also* Thomas A. Tami, ''Granulomatous Diseases and Chronic Rhinosinusitis,'' 38 Otolaryngol. Clin. N. Am. 1267–78 (2005).

Finally, DC 6514 currently contains a note that defines an ''incapacitating episode'' for purposes of assigning evaluations. The proposed criteria above render this note no longer necessary, so VA proposes to delete it.

iii. Diagnostic Code 6520

VA proposes to redesignate stenosis of the larynx, currently evaluated under DC 6520, as DC 6231. It also proposes to amend the rating criteria for this DC, which will result in evaluations based upon the measured degree of stenosis, rather than the current utilization of PFTs. While stenosis of the trachea may affect PFTs, many other diseases may also impact them. Advances in diagnostic devices, including fiber optics, have improved visualization of the larynx and its associated structures and allowed more accurate assessment of anatomy. L. Sulica, ''Hoarseness,'' 137 Archives of Otolaryngology-Head and Neck Surgery 616 (2011). Hence, VA proposes to update its evaluative criteria.

Specifically, VA proposes to evaluate partial obstruction of the larynx with less than 25 percent narrowing of the airways as 30 percent disabling. VA proposes a 50 percent evaluation for partial obstruction of the larynx, with 25 percent to less than 50 percent narrowing of airways. Partial obstruction of the larynx, with 50 percent or more narrowing of airways, will warrant a 70 percent evaluation. Finally, VA proposes to assign a 100 percent evaluation for obstruction of the larynx, requiring permanent tracheostomy. VA will retain the current note allowing for an alternative evaluation as aphonia. VA notes that research indicates airway cross-sectional area reduced by 50 percent or more impairs breathing. *See* Sylvia Verbanck et al., ''Detecting upper airway obstruction in patients with tracheal stenosis,'' 109 J. of Applied Physiology 47 (July 2010). As such, obstruction less than 50 percent reflects no more than moderate disability (*i.e.,* warranting a 30 or 50 percent evaluation).

iv. Diagnostic Code 6522

The current DC 6522 is ''Allergic or vasomotor rhinitis'' and VA will rename it ''Rhinitis, allergic or nonallergic (vasomotor).'' VA proposes to redesignate this DC as 6240 under § 4.87. VA also proposes to modify the rating criteria to reflect current medical understanding and practice. First, VA proposes to modify the criteria for a 10 percent rating to require continuous therapy (almost always self-administered) to control symptoms. VA also proposes a 30 percent rating for the presence of polyps, preserving the prior rating criteria. VA will add a note that directs personnel to rate under proposed DC 6233 (rhinosinusitis, allergic and nonallergic (vasomotor) related) using the General Rating Formula for Rhinosinusitis instead of proposed DC 6240 (Rhinitis, allergic or nonallergic (vasomotor)) if either chronic or recurrent acute form of rhinosinusitis is present. *See* Rosenfeld, *supra* at S1–31.

v. Diagnostic Code 6523

Currently, DC 6523 (bacterial rhinitis) addresses chronic residuals related to bacterial infection of the sinuses. VA proposes to redesignate DC 6523 as 6234 under § 4.87. Additionally, VA proposes to rename this DC, ''Rhinosinusitis, infection related,'' for clarity to ensure that readers understand that it includes rhinosinusitis caused by bacterial or fungal agents.

VA proposes that infection-related rhinosinusitis be evaluated under the proposed General Rating Formula for CRS and RARS to, again, reflect current medical understanding.

vi. Diagnostic Code 6524

Current DC 6524 (granulomatous rhinitis) provides for a 100 percent evaluation for Wegener's granulomatosis or lethal midline granuloma; VA assigns a 20 percent evaluation for other types of granulomatous infection. These evaluations are outdated for a number of reasons. Modern medical science has identified lethal midline granuloma (also referred to as lymphomatoid

granulomatosis or polymorphic reticulosis) as a peripheral T-cell lymphoma. Wegener's (now referred to as granulomatous disease with polyangiitis, or GPA), Churg-Strauss disease (now referred to as eosinophilic granulomatous disease with polyangiitis, or EGPA), and sarcoidosis are all autoimmune conditions that can affect the sinuses and nasal passages. They typically require systemic immunosuppressive treatment for extended periods (one to two years, or more) and may recur, requiring resumption of immunosuppressive treatment. As a result, VA proposes several revisions to incorporate current medical understanding of these conditions.

First, VA proposes to redesignate this code as DC 6235 under § 4.87. Second, VA proposes to rename this code ''Rhinosinusitis, autoimmune, granulomatous or other causes,'' to update terminology. Third, VA proposes to ensure consistent application by adding a note that directs rating personnel to evaluate lethal midline granuloma under proposed DC 6238, as such condition is best characterized as a malignant neoplasm. Fourth, VA proposes to transfer the 100 percent evaluation from the current DC 6524 to the new DC 6235, as well as modify its criteria by linking it to the current use of systemic immunosuppressive therapy. Fifth, VA proposes to direct personnel to use the proposed General Rating Formula for CRS and RARS for any evaluation less than 100 percent under proposed DC 6235. This instruction helps ensure appropriate, uniform ratings for any chronic residuals that do not rise to the level of malignancy.

7. Proposed New Diagnostic Codes

In addition to amending current DCs under § 4.87 and relocating those from § 4.97, VA proposes to add several new conditions to better evaluate veterans using a more complete ear, nose and throat schedule.

i. Diagnostic Code 6233

The first new DC VA proposes to add to § 4.87 is Rhinosinusitis, allergic and nonallergic (vasomotor) related (DC 6233). This DC enables rating personnel to capture CRS or RARS as a consequence of DC 6240 (Rhinitis, allergic or nonallergic (vasomotor)). DC 6240 will instruct rating personnel to select DC 6233 (rhinosinusitis, allergic or nonallergic (vasomotor) related) if either CRS or RARS is present.

ii. Diagnostic Code 6236

A new condition frequently present in veterans that VA proposes to add to § 4.87 is vocal cord paralysis (DC 6236). Its primary symptom is hoarseness, so VA proposes to direct rating personnel to evaluate this condition analogous to chronic laryngitis (DC 6228) or aphonia (DC 6230). *See* Seth R. Schwartz et al., ''Clinical practice guideline: Hoarseness (dysphonia),'' 141(Supp. 3) Otolaryngology-Head and Neck Surgery S1 (2009).

iii. Diagnostic Codes 6237 and 6238

Benign and malignant neoplasms of the nasopharynx occur with such sufficient frequency among veterans that VA proposes to add discrete codes (DCs 6237 and 6238, respectively) for these conditions. VA proposes to rate benign neoplasms according to impairment of function by utilizing the most appropriate evaluation criteria because the disability due to these neoplasms varies. The addition of DC 6237 does not represent a substantive change in the evaluation of benign neoplasms, but it allows for better tracking and data analysis of this condition by providing a specific DC.

VA proposes to evaluate malignant neoplasms similarly to other malignancies in the VASRD. Specifically, VA will assign an evaluation of 100 percent for six months beyond the cessation of any surgery, radiation treatment, antineoplastic chemotherapy, or other therapeutic procedures. Then, VA will determine the appropriate disability rating by ordering a mandatory VA examination. VA will apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination. Rating personnel will evaluate residual impairment of function barring subsequent local recurrence or metastasis.

iv. Diagnostic Code 6239

VA proposes to add a new DC for diseases of the salivary glands, other than neoplasms (DC 6239). These conditions generally result in xerostomia (dry mouth), a condition that may lead to secondary effects of dental disease, nutritional deficit, pain, formation of salivary duct stones, and/or changes in taste. *See* James J. Sciubba and David Goldenberg., ''Oral complications of radiotherapy,'' 7 Lancet Oncology 175 (2006); S.B. Jensen et al., ''A systematic review of salivary gland hypofunction and xerostomia induced by cancer therapies: management strategies and economic impact,'' 18 Support Care Cancer 1061 (2010).

VA proposes to assign a 0 percent evaluation for xerostomia (dry mouth) not accompanied by secondary conditions such as difficulty in mastication of food or painless swelling of the salivary glands. VA would assign a 10 percent evaluation for xerostomia with altered sensation of taste and difficulty with lubrication and mastication of food but without associated weight loss or increase in dental caries. VA would also award a 10 percent evaluation if there was chronic inflammation of a salivary gland with pain and swelling on eating; or one or more salivary calculi, or gland stricture. Finally, VA proposes a maximum 20 percent evaluation for xerostomia with altered sensation of taste and difficulty with lubrication and mastication of food that results in either weight loss or an increase in dental caries. Diseases of the salivary glands may also result in neurological residuals and facial disfigurement due to swelling, so VA intends to include a note directing rating personnel to evaluate such residuals under the appropriate code(s).

Executive Orders 12866 and 13563

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. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *www.regulations.gov.*

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed 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). The certification is based on the fact that no small entities or businesses assign evaluations for disability claims. 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.

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 is likely to 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 given year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

Although this proposed rule contains provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521), no new or proposed revised collections of information are associated with this proposed rule. Specifically, the information collection requirements associated with this proposed rule are related to the filing of disability benefits claims (VA Form 21–526EZ) as well as Disability Benefits Questionnaires (DBQs) (Groups 3 and 4) which enable claimants to gather the necessary information from his or her treating physician as to the current symptoms and severity of a disability. The information collection requirements are approved by OMB and have been assigned OMB control numbers 2900–0747, 2900–0778, and 2900–0781.

Assistance Listing

The Assistance Listing numbers and titles for this rule are 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.

List of Subjects

38 CFR Part 3

Claims, Disability benefits, Pensions, Veterans.

38 CFR Part 4

Disability benefits, Pensions, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on July 6, 2021, 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.

Michael P. Shores,

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

For the reasons set forth in the preamble, VA proposes to amend 38 CFR parts 3 and 4 as set forth below:

PART 3—ADJUDICATION

Subpart A—Pension, Compensation, and Dependency and Indemnity Compensation

■ 1. The authority citation for part 3, subpart A, continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

■ 2. Amend § 3.350 by revising paragraphs (e)(1)(iii), (e)(1)(iv), (f)(2)(v), and (f)(2)(vi) to read as follows:

§ 3.350 Special monthly compensation ratings.

* * * * *

(e) * * *

(1) * * *

(iii) Bilateral deafness rated at 60 percent or more disabling (and the hearing loss in either one or both ears is service connected) in combination with service-connected blindness with bilateral visual acuity 20/200 or less.

(iv) Service-connected total deafness in one ear or bilateral deafness rated at 40 percent or more disabling (and the hearing loss in either one of both ears is service-connected) in combination with service-connected blindness of both eyes having only light perception or less.

* * * * *

(f) * * *

(2) * * *

(v) Blindness in both eyes having only light perception or less, or rated under paragraph (f)(2)(iii) of this section, when accompanied by bilateral deafness (and the hearing loss in either one or both ears is service-connected) rated at 10 or 20 percent disabling, will afford entitlement to the next higher intermediate rate, or if the veteran is already entitled to an intermediate rate, to the next higher statutory rate under 38 U.S.C. 1114, but in no event higher than the rate for (o).

(Authority: Sec. 112, Pub. L. 98–223)

(vi) Blindness in both eyes rated under 38 U.S.C. 1114 (l), (m) or (n), or rated under paragraphs (f)(2)(i), (ii) or (iii) of this section, when accompanied by bilateral deafness rated at no less than 30 percent, and the hearing loss in one or both ears is service-connected, will afford entitlement to the next higher statutory rate under 38 U.S.C. 1114, or if the veteran is already entitled to an intermediate rate, to the next higher intermediate rate, but in no event higher than the rate for (o).

(Authority: 38 U.S.C. 1114(p))

■ 3. Amend § 3.383 by revising paragraph (a)(3) and the Cross References to read as follows:

§ 3.383 Special considerations for paired organs and extremities.

(a) * * *

(3) Hearing loss in one ear compensable to a degree of 10 percent or more as a result of service-connected disability and hearing loss as a result of nonservice-connected disability that meets the provisions of § 3.385 in the other ear.

* * * * *

Cross References:

§ 3.385 Disability due to hearing loss; § 4.85 Evaluation of hearing loss.

■ 4. Amend § 3.815 by revising paragraph (d)(6)(viii) to read as follows:

§ 3.815 Monetary allowance under 38 U.S.C. chapter 18 for an individual with disability from covered birth defects whose biological mother is or was a Vietnam veteran; identification of covered birth defects.

* * * * *

(d) * * *

(6) * * *

(viii) Post-infancy deafness/hearing loss (onset after the age of one year);

■ 5. Revise § 3.385 to read as follows:

§ 3.385 Disability due to hearing loss.

For the purposes of administering its laws, VA will consider hearing loss to be a disability when the pure-tone auditory air conduction threshold in any of the frequencies of 500, 1000, 2000, 3000, or 4000 Hertz is 40 decibels or greater; or when the pure-tone auditory air conduction thresholds for at least three of the frequencies of 500, 1,000, 2,000, 3,000, or 4,000 Hertz are 26 decibels or greater; or when word recognition scores using the Maryland CNC Test are less than 94 percent.

PART 4—SCHEDULE FOR RATING DISABILITIES

Subpart B—Disability Ratings

■ 6. The authority citation for part 4 continues to read as follows:

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

■ 7. Revise the undesignated center heading before § 4.85 to read as follows:

Ear, Nose, Throat, and Auditory Disabilities

■ 8. Amend § 4.85 by:
■ a. Revising the section heading;
■ b. Revising paragraphs (a) through (g);
■ c. Revising tables VI, VIA, and VII;
■ d. Adding entry for diagnostic code 6100; and,
■ e. Adding authority citation.

The revisions and additions read as follows:

§ 4.85 Evaluation of hearing loss.

(a) An examination for hearing loss for VA purposes must be conducted by a state-licensed audiologist and must include a controlled word recognition test (Maryland CNC) and a pure-tone audiometry test. Examinations will be conducted without the use of hearing aids. Hearing levels are measured in decibels and expressed as dB HL.

(b) Table VI, ''Numeric Designation of Hearing Loss Based on Pure-Tone Air Conduction Threshold Average and Word Recognition,'' is used to determine a Roman numeral designation (I through XI) for hearing loss based on a combination of the percent of word recognition (horizontal rows) and the pure-tone air conduction threshold average (vertical columns). The Roman numeral designation is located at the point where the percentage of word recognition and pure-tone air conduction threshold average intersect.

(c) Table VIA, ''Special Numeric Designation of Hearing Loss Based Only on Pure-Tone Air Conduction Threshold Average,'' is used to determine a Roman numeral designation (I through XI) for hearing loss based only on the pure-tone air conduction threshold average. Table VIA will be used when the examiner certifies that use of the word recognition test is not appropriate because of language difficulties (*e.g.,* English non-fluency), cognitive difficulties, inconsistent word recognition scores, etc., or when indicated under the provisions of § 4.86.

(d) ''Pure-tone air conduction threshold average,'' as used in Tables VI and VIA, is the sum of the pure-tone air conduction thresholds at 1,000, 2,000, 3,000, and 4,000 Hertz, divided by four. This average is used in all cases (including those in § 4.86) to determine the Roman numeral designation for hearing loss from Table VI or VIA.

(e) Table VII, ''Percentage Evaluations for Hearing Loss,'' is used to determine the percentage evaluation by combining the Roman numeral designations for hearing loss of each ear. The horizontal rows represent the ear having the better hearing and the vertical columns the ear having the poorer hearing. The percentage evaluation is located at the point where the row and column intersect.

(f) If hearing loss is service-connected in only one ear, in order to determine the percentage evaluation from Table VII, the non-service-connected ear will be assigned a Roman Numeral designation for hearing loss of I, subject to the provisions of § 3.383 of this chapter.

(g) When evaluating any claim for hearing loss, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation due either to deafness, or to deafness in combination with other specified disabilities.

* * * * *

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TABLE VI

NUMERIC DESIGNATION OF HEARING LOSS BASED ON PURE-TONE AIR CONDUCTION THRESHOLD AVERAGE AND WORD RECOGNITION

Percent of word recognition	PURE-TONE AIR CONDUCTION THRESHOLD AVERAGE								
	0-41	**42-49**	**50-57**	**58-65**	**66-73**	**74-81**	**82-89**	**90-97**	**98+**
92-100	I	I	I	II	II	II	III	III	IV
84-90	II	II	II	III	III	III	IV	IV	IV
76-82	III	III	IV	IV	IV	V	V	V	V
68-74	IV	IV	V	V	VI	VI	VII	VII	VII
60-66	V	V	VI	VI	VII	VII	VIII	VIII	VIII
52-58	VI	VI	VII	VII	VIII	VIII	VIII	VIII	IX
44-50	VII	VII	VIII	VIII	VIII	IX	IX	IX	X
36-42	VIII	VIII	VIII	IX	IX	IX	X	X	X
0-34	IX	X	XI	XI	XI	XI	XI	XI	XI

TABLE VIA*

SPECIAL NUMERIC DESIGNATION OF HEARING LOSS BASED ONLY ON PURE-TONE AIR CONDUCTION THRESHOLD AVERAGE

PURE-TONE AIR CONDUCTION THRESHOLD AVERAGE										
0-41	42-48	49-55	56-62	63-69	70-76	77-83	84-90	91-97	98-104	105+
I	II	III	IV	V	VI	VII	VIII	IX	X	XI

* This table is for use only as specified in §§ 4.85 and 4.86.

TABLE VII

PERCENTAGE EVALUATION FOR HEARING LOSS (DIAGNOSTIC CODE 6100)

Better Ear \ Poorer Ear	XI	X	IX	VIII	VII	VI	V	IV	III	II	I
XI	100*										
X	90	80									
IX	80	70	60								
VIII	70	60	50	50							
VII	60	60	50	40	40						
VI	50	50	40	40	30	30					
V	40	40	40	30	30	20	20				
IV	30	30	30	20	20	20	10	10			
III	20	20	20	20	20	10	10	10	0		
II	10	10	10	10	10	10	10	0	0	0	
I	10	10	0	0	0	0	0	0	0	0	0

* Review for entitlement to special monthly compensation under § 3.350 of this chapter.

BILLING CODE 8320–01–C

	Rating
6100 Hearing Loss:	
If hearing loss is evaluated at 0 percent under Table VII and tinnitus is diagnosed as associated with underlying hearing loss Otherwise, evaluate using the Tables above.	10
Note (1): The 10 percent evaluation is only applicable to tinnitus diagnosed as associated with non-compensable service-connected hearing loss. Tinnitus diagnosed as associated with another service-connected disability (i.e., Meniere's disease, residuals of traumatic brain injury (TBI), cerebral arteriosclerosis, vascular neurocognitive disorder) must be evaluated as a part of that disability without a separate evaluation for tinnitus under diagnostic code 6100.	
Note (2): Tinnitus will only be compensated as part of an underlying service-connected condition.	

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

■ 9. Revise § 4.86 to read as follows:

§ 4.86 Exceptional patterns of hearing loss.

(a) When the pure-tone air conduction threshold at each of the four specified frequencies (1000, 2000, 3000, and 4000 Hertz) is 55 dB HL or more, the rating activity will determine the Roman numeral designation for hearing loss from either Table VI or Table VIA, whichever results in the higher numeral. Each ear will be evaluated separately.

(b) When the pure-tone air conduction threshold is 30 dB HL or less at 1000 Hertz, and 70 dB HL or more at 2000 Hertz, the rating activity will determine the Roman numeral designation for hearing loss from either Table VI or Table VIA, whichever results in the higher numeral. That numeral will then be elevated to the next higher Roman numeral. Each ear will be evaluated separately.

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

■ 10. Amend § 4.87 by:

■ a. Revising the section heading;

■ b. Removing the heading ''Diseases of the Ear'';

■ c. Revising entries for diagnostic codes 6200 through 6205;

■ d. Adding entries for diagnostic codes 6220 through 6240 in numerical order; and

■ e. Removing entry for diagnostic code 6260.

The revisions and additions read as follows:

§ 4.87 Schedule of ratings—ear, nose, and throat.

	Rating
* * * * * * *	
6200 Chronic suppurative otitis media, mastoiditis, or cholesteatoma (or any combination):	
During suppuration, or with aural polyps	10
Note: Evaluate hearing loss and complications such as labyrinthitis, facial nerve paralysis, or bone loss of skull, separately.	
6201 Chronic nonsuppurative otitis media with effusion (serious otitis media):	
Rate based on hearing loss.	
6202 Otosclerosis, stapedectomy, stapedotomy, residuals of:	
Rate based on hearing loss.	
6204 Peripheral vestibular disorders:	
Vestibular disorder in one or both ears with symptoms during the last six months of sufficient frequency and intensity to result in an inability to engage in work and/or self-care and an inability to perform routine activities of daily living without assistance of others, even with modification of activity or accommodation	100
Vestibular disorder with symptoms during the last six months that occur with sufficient frequency to require routine limitation in activities such as those related to work and/or self-care but that enable independent activity with effort and some modification and/or accommodation	30
Vestibular disorder with symptoms during the last six months that require brief and temporary modification of activity but do not prevent continuation of normal functions such as work and/or self-care	10
Note (1): Self-care activities for the purposes of this DC consist of bathing, dressing, eating, managing hygiene, handling basic transfers, and/or mobility; a qualified health care provider must determine that the individual has difficulties with these activities.	
Note (2): VA requires objective findings supporting the diagnosis of peripheral vestibular disorder before assigning a compensable evaluation under this code. VA will separately evaluate and combine hearing loss or suppuration.	
6205 Meniere's syndrome (endolymphatic hydrops):	
In all cases, with hearing loss, with or without tinnitus; and	
Either:	
Vertigo occurring five or more times a month; or	
With persistent disequilibrium and gait instability	100
Vertigo occurring one to four times a month	60
Vertigo less than once a month	30
Note (1): The Meniere's syndrome diagnosis must be made by a otolaryngologist or neurologist.	
Note (2): For evaluation purposes, calculate the average vertigo frequency using a six-month period.	
Note (3): Evaluate Meniere's syndrome either under these criteria or by separately evaluating vertigo (as a peripheral vestibular disorder) and hearing loss, whichever method results in a higher overall evaluation. However, do not combine an evaluation for hearing loss or vertigo with an evaluation under this diagnostic code.	
* * * * * * *	
6220 Septum, nasal, deviation of:	
Traumatic only,	
With 50 percent obstruction of the nasal passage on both sides or complete obstruction on one side	10
6221 Nose, loss of part of, or scars:	
Loss of half or more, unable to use prosthesis (as documented by a qualified medical provider)	30
Loss of less than half, unable to use prosthesis (as documented by a qualified medical provider)	20
Any loss of the nose for which a prosthesis is required or recommended by a qualified medical provider and is capable of use	10

	Rating
Loss or disfigurement for which a prosthesis is not required or recommended by a qualified medical provider	0
Note: Or evaluate as DC 7800 (scars, disfiguring, head, face, or neck).	
General Rating Formula for Chronic Rhinosinusitis (CRS) and Recurrent Acute Rhinosinusitis (RARS): DCs 6222–6226; 6233–6235	
12 or more weeks of treatment with antibiotics for CRS/RARS during the preceding 12-month period AND unresponsive to endoscopic or other surgery used to treat CRS/RARS	50
12 or more weeks of treatment with antibiotics for CRS/RARS during the preceding 12-month period	30
At least four weeks, but less than 12 weeks of treatment with antibiotics for CRS/RARS during the preceding 12-month period	10
Less than four weeks of treatment with antibiotics for CRS/RARS during the preceding 12-month period	0
Note (1): VA will only compensate chronic rhinosinusitis (CRS) and recurrent acute rhinosinusitis (RARS). CRS is defined as 12 weeks or more of at least two of the following—(a) mucopurulent drainage (anterior, posterior, or both); (b) nasal obstruction (congestion); (c) facial pain-pressure-fullness; or (d) decreased sense of smell—in combination with inflammation as documented by either (a) purulent mucus (not clear) in the middle meatus or ethmoid region; (b) polyps in the nasal cavity or the middle meatus; or (c) radiographic imaging showing inflammation of the paranasal sinuses. RARS is defined as four or more episodes of acute bacterial rhinosinusitis (ABRS) without signs or symptoms of rhinosinusitis (inflammation of the paranasal sinuses and nasal cavity) between episodes.	
Note (2): VA will not compensate the following conditions: (a) Acute rhinosinusitis (ARS), which is defined as up to four weeks of purulent drainage (anterior, posterior, or both) accompanied by nasal obstruction, facial fullness, or both; (b) Viral rhinosinusitis (VRS), which is defined as rhinosinusitis caused by a virus and typically lasting less than 10 days); (c) ABRS, which is defined as a bacterial infection which causes symptoms of rhinosinusitis for at least 10 days after the onset of an upper respiratory infection, or causes recurrence of symptoms within seven days after initial improvement); and (d): Subacute rhinosinusitis (SAR), which is defined as rhinosinusitis symptoms lasting at least four but less than 12 weeks.	
6222 Rhinosinusitis, pansinusitis.	
6223 Rhinosinusitis, ethmoid.	
6224 Rhinosinusitis, frontal.	
6225 Rhinosinusitis, maxillary.	
6226 Rhinosinusitis, sphenoid.	
6227 Laryngitis, tuberculous, active or inactive. Rate under §§ 4.88c or 4.89, whichever is appropriate.	
6228 Laryngitis, chronic:	
Hoarseness, with thickening or nodules of cords, polyps, submucous infiltration, or pre-malignant changes on biopsy	30
Hoarseness, with inflammation of cords or mucous membranes	10
6229 Laryngectomy, total	[1]100
Rate the residuals of partial laryngectomy as laryngitis (DC 6228), aphonia (DC 6230), or stenosis of larynx (DC 6231).	
6230 Aphonia, complete organic:	
Constant inability to communicate by speech	[1]100
Constant inability to speak above a whisper	60
Note: Evaluate incomplete aphonia as laryngitis, chronic (DC 6228).	
6231 Larynx, stenosis of, including residuals of laryngeal trauma (unilateral or bilateral):	
Total obstruction of larynx, requiring permanent tracheostomy	100
Partial obstruction of larynx with 50 percent or more narrowing of airways	70
Partial obstruction of larynx with 25 percent to less than 50 percent narrowing of airways	50
Partial obstruction of larynx with less than 25 percent narrowing of airways	30
Note: Or, evaluate as aphonia (DC 6230).	
6232 Pharynx, injuries to:	
Stricture or obstruction of pharynx or nasopharynx; absence of soft palate secondary to trauma, chemical burn, or granulomatous disease; or paralysis of soft palate with swallowing difficulty (nasal regurgitation) and speech impairment	50
6233 Rhinosinusitis, allergic or nonallergic (vasomotor) related.	
6234 Rhinosinusitis, infection related.	
6235 Rhinosinusitis, autoimmune, granulomatous or other causes:	
While receiving systemic immunosuppressive treatment, or for a period of six months after cessation of treatment	100
Otherwise evaluate using the General Rating Formula for CRS and RARS.	
Note: Evaluate lethal midline granuloma (also referred to as lymphomatoid granulomatosis or polymorphic reticulosis) under neoplasm, malignant (DC 6238).	
6236 Vocal cord paralysis:	
Evaluate under laryngitis, chronic (DC 6228) or aphonia, complete organic (DC 6230).	
6237 Neoplasm, nasopharyngeal, and/or sinus, benign:	100
Rate on impairment of function.	
6238 Neoplasm, nasopharyngeal, and/or sinus, malignant	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgery, radiation treatment, antineoplastic chemotherapy, or other prescribed therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, evaluate on residual impairment of function.	
6239 Disease of the salivary glands and/or associated ducts, other than neoplasm:	
Xerostomia (dry mouth) with altered sensation of taste and difficulty with lubrication and mastication of food resulting in either weight loss (as defined in § 4.112 of this chapter) or an increase in dental caries	20
Xerostomia (dry mouth) with altered sensation of taste and difficulty with lubrication and mastication of food without weight loss or an increase in dental caries; chronic inflammation of salivary gland with pain and swelling on eating; or one or more salivary calculi or salivary gland stricture	10
Xerostomia (dry mouth) without difficulty in mastication of food or painless swelling of salivary gland	0
Note: Evaluate facial nerve (cranial nerve VII) impairment under diagnostic code 8207 (paralysis of seventh (facial) cranial nerve), and any disfigurement due to facial swelling under diagnostic code 7800 (disfigurement or scars of the head, face, or neck).	
6240 Rhinitis, allergic or nonallergic (vasomotor):	

	Rating
With documented evidence of polyps	30
Requires continuous therapy (*e.g.*, inhaled corticosteroids, oral or inhaled antihistamines)	10
Note: If complicated by either chronic or recurrent acute rhinosinusitis, evaluate instead under rhinosinusitis, allergic or non-allergic (vasomotor) related (DC 6233).	

[1] Review for entitlement to special monthly compensation under § 3.350 of this chapter.

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

■ 11. Amend § 4.96 by:
■ a. Revising paragraph (a);
■ b. Removing paragraph (c);
■ c. Redesignating paragraph (d) as paragraph (c);
■ d. Revising newly redesignated paragraph (c); and
■ e. Adding new paragraph (d).

The revisions and additions read as follows:

§ 4.96 Special provisions regarding evaluation of respiratory conditions.

(a) *Rating coexisting respiratory conditions.* Unless otherwise directed in § 4.97, do not combine ratings under that section. Assign a single rating under the diagnostic code that reflects the predominant disability, elevating it to the next higher evaluation when warranted by the severity of the overall disability picture. When permitted, combine coexisting conditions in accordance with § 4.25.

* * * * *

(c) *Special provisions regarding Diagnostic Codes 6600 through 6604, 6731, 6820, 6825 through 6833, 6840 through 6846, and 6848.* (1) Pulmonary Function Tests (PFTs) are required to evaluate these conditions except when one of the following circumstances exists:

(i) When the results of a maximum exercise capacity test are of record and are 20 milliliters per kilogram per minute (ml/kg/min) or less. If a maximum exercise capacity test is not of record, evaluate based on alternative criteria.

(ii) When there have been one or more episodes of acute respiratory failure.

(iii) When outpatient oxygen therapy is required.

(2) When the PFTs are not consistent with clinical findings, evaluate based on the PFTs unless the examiner states why they are not a valid indication of respiratory functional impairment in a particular case.

(3) When there is a disparity between the results of different PFTs (FEV–1 (Forced Expiratory Volume in one second), FVC (Forced Vital Capacity), etc.), so that the level of evaluation would differ depending on which test result is used, use the test result that the examiner states most accurately reflects the level of disability.

(d) *Respiratory conditions and comorbid cardiovascular conditions.* Absent instructions otherwise in individual diagnostic codes, if there are comorbid respiratory and cardiovascular conditions that can be evaluated by METs, only the disability from one body system may be evaluated using METs, while the disability involving the other body system must be evaluated by criteria other than METs.

■ 12. In § 4.97 amend the table by:
■ a. Removing the heading ''DISEASES OF THE NOSE AND THROAT'';
■ b. Removing entries for diagnostic codes 6502 through 6524;
■ c. Adding introductory text;
■ d. Adding entry for ''General Rating Formula for Respiratory Conditions'';
■ e. Removing the heading ''DISEASE OF THE TRACHEA AND BRONCHI'' and adding in its place ''INTRINSIC LUNG DISEASES'';
■ f. Adding the subheading ''Airway Disorders (Trachea, Bronchi)'' under ''INTRINSIC LUNG DISEASES'';
■ g. Revising entries for diagnostic codes 6600 through 6604;
■ h. Removing the heading ''DISEASES OF THE LUNGS AND PLEURA—TUBERCULOSIS'' and adding in its place ''Tuberculous Lung Diseases'';
■ i. Revising entries for diagnostic codes 6704, 6724, 6730, and 6731;
■ j. Removing the heading ''NONTUBERCULOUS DISEASES'' and adding in its place ''Vascular Lung Diseases'';
■ k. Revising entry for diagnostic code 6817;
■ l. Adding entry for diagnostic code 6849 under diagnostic code 6817;
■ m. Adding the subheading ''Lung Neoplasms'' above diagnostic code 6819;
■ n. Revising entries for diagnostic codes 6819 and 6820;
■ o. Removing the subheading ''Bacterial Infections of the Lung'' and adding in its place ''Bacterial Lung Diseases'';
■ p. Adding entry for ''General Rating Formula for Bacterial Lung Diseases'' above diagnostic code 6822;
■ q. Republishing entry for diagnostic code 6822;
■ r. Removing the subheading ''Interstitial Lung Disease'' and adding in its place ''Parenchymal Lung Disease (Including Interstitium and Alveolar Spaces)'';
■ s. Adding note above diagnostic code 6825;
■ t. Revising entry for diagnostic code 6825;
■ u. Republishing entry for diagnostic code 6833;
■ v. Adding entry for diagnostic code 6846 under diagnostic code 6833;
■ w. Removing entry for ''General Rating Formula for Interstitial Lung Disease (diagnostic codes 6825 through 6833)'';
■ x. Removing the subheading ''Mycotic Lung Disease'' and adding in its place ''Mycotic Lung Diseases'';
■ y. Adding entry for ''General Rating Formula for Mycotic Lung Disease'' above diagnostic code 6834;
■ z. Republishing entry for diagnostic code 6834;
■ aa. Removing entry for ''General Rating Formula for Mycotic Lung Disease (diagnostic codes 6834 through 6839)'';
■ bb. Removing the subheading ''Restrictive Lung Disease'' and adding in its place ''OTHER RESPIRATORY CONDITIONS'';
■ cc. Revising entries for diagnostic codes 6841 and 6842;
■ dd. Removing entry for ''General Rating Formula for Lung Diseases (diagnostic codes 6840 through 6845)'';
■ ee. Removing entry for diagnostic code 6846 under diagnostic code 6845;
■ ff. Revising entry for diagnostic code 6847; and
■ gg. Adding entry for diagnostic code 6848.

The revisions and additions read as follows:

§ 4.97 Schedule of Ratings—Respiratory System.

	Rating
Unless otherwise directed, evaluate diseases of the Respiratory System under the General Rating Formula for Respiratory Conditions.	
General Rating Formula for Respiratory Conditions:	
At least one of the following: Forced Vital Capacity (FVC) less than 50 percent of predicted value; or Forced Expiratory Volume in one second (FEV–1) less than 45 percent of predicted value; or Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO(SB)) less than 40 percent predicted; or The ratio of FEV–1 to FVC (FEV–1/FVC) less than 40 percent; or Maximum Oxygen Consumption measured in milliliters per kilogram per minute (mL/Kg/min) (VO2 Max) less than 10.5; or Workload of 3 Metabolic Equivalents (METs) or less.	100
At least one of the following: FVC of 50 to 64 percent predicted; or FEV–1 of 45 to 55 percent predicted; or DLCO(SB) of 40 to 55 percent predicted; or FEV–1/FVC of 40 to 55 percent; or VO2 Max of 10.5 to 17.5; or Workload of 3.1–5.0 METs.	60
At least one of the following: FVC of 65 to 74 percent predicted; or FEV–1 of 56 to 70 percent predicted; or DLCO(SB) of 56 to 65 percent predicted; or FEV–1/FVC of 56 to 70 percent; or VO2 Max of 17.6 to 24.5; or Workload of 5.1–7.0 METs.	30
At least one of the following: FVC of 75 to 80 percent predicted; or FEV–1 of 71 to 80 percent predicted; or DLCO(SB) of 66 to 80 percent predicted; or FEV–1/FVC of 71 to 80 percent.	10
Note (1): Base the rating on the criteria that reflects the greatest impairment and, therefore, the greatest disability percentage, unless otherwise directed by the examiner (see § 4.96(c)(3)).	
Note (2): Do not combine a rating assigned from this formula with other ratings under § 4.97, except for sleep apnea syndromes (DC 6847).	
Note (3): Per § 4.96(d), when METs are used to evaluate a respiratory disability under § 4.97, do not use METs to evaluate a comorbid cardiovascular disability under § 4.104, and vice versa.	
INTRINSIC LUNG DISEASES	
Airway Disorders (Trachea, Bronchi)	
6600 Bronchitis, chronic.	
6601 Bronchiectasis.	
6602 Asthma, bronchial:	
At least one of the following: FEV–1 less than 45 percent predicted; or FEV–1/FVC less than 40 percent; or More than one attack per week with episodes of respiratory failure; or Requires daily use of systemic (oral or parenteral) high-dose corticosteroids or immuno-suppressive medications.	100
At least one of the following: FEV–1 of 45 to 55 percent predicted; or FEV–1/FVC of 40 to 55 percent; or At least monthly visits to a physician for required care of exacerbations; or Intermittent (at least three per year) courses of systemic (oral or parenteral) corticosteroids.	60
At least one of the following: FEV–1 of 56 to 70 percent predicted; or FEV–1/FVC of 56 to 70 percent; or Daily inhalational or oral bronchodilator therapy or inhalational anti-inflammatory medication.	30
At least one of the following: FEV–1 of 71 to 80 percent predicted; or FEV–1/FVC of 71 to 80 percent; or less than daily inhalational or oral bronchodilator therapy.	10
Note (1): In the absence of clinical findings of asthma at the time of examination, a verified history of asthmatic attacks must be of record.	
Note (2): Do not combine a rating assigned under this diagnostic code with other ratings under § 4.97, except for sleep apnea syndromes (DC 6847).	
6603 Emphysema, pulmonary.	
6604 Chronic obstructive pulmonary disease.	
Tuberculous Lung Diseases	
Ratings for Pulmonary Tuberculosis Entitled on August 19, 1968	

	Rating
* * * * * * *	
6704 Tuberculosis, pulmonary, chronic, active, advancement unspecified	100
General Rating Formula for Inactive Pulmonary Tuberculosis:	
For two years after date of inactivity, following active tuberculosis, which was clinically identified during service or subsequently	100
Thereafter for four years, or in any event, to six years after date of inactivity	50
Thereafter, for 5 years, or to 11 years after date of inactivity	30
Following far advanced lesions diagnosed at any time while the disease process was active, minimum	30
Following moderately advanced lesions, provided there is continued disability, emphysema, dyspnea on exertion, impairment of health, etc	20
Otherwise	0
Note (1): The 100 percent rating under codes 6701 through 6724 is not subject to a requirement of precedent hospital treatment. It will be reduced to 50 percent for failure to submit to examination or to follow prescribed treatment upon report to that effect from the medical authorities. When a veteran is placed on the 100 percent rating for inactive tuberculosis, the medical authorities will be appropriately notified of the fact, and of the necessity to notify the Veterans Service Center in the event of failure to submit to examination or to follow treatment.	
Note (2): The graduated 50 percent and 30 percent ratings and the permanent 30 percent and 20 percent ratings for inactive pulmonary tuberculosis are not to be combined with ratings for other respiratory disabilities. Following thoracoplasty, the rating will be for removal of ribs combined with the rating for collapsed lung. Resection of the ribs incident to thoracoplasty will be evaluated as removal.	
* * * * * * *	
6724 Tuberculosis, pulmonary, chronic, inactive, advancement unspecified.	
* * * * * * *	
6730 Tuberculosis, pulmonary, chronic, active	100
Note: Active pulmonary tuberculosis will be considered permanently and totally disabling for non-service-connected pension purposes in the following circumstances:	
(a) Associated with active tuberculosis involving other than the respiratory system.	
(b) With severe associated symptoms or with extensive cavity formation.	
(c) Reactivated cases, generally.	
(d) With advancement of lesions on successive examinations or while under treatment.	
(e) Without retrogression of lesions or other evidence of material improvement at the end of 6 months hospitalization or without change of diagnosis from ''active'' at the end of 12 months hospitalization. Material improvement means lessening or absence of clinical symptoms, and X-ray findings of a stationary or retrogressive lesion.	
6731 Tuberculosis, primary, chronic, inactive:	
Depending on the specific findings, evaluate respiratory residuals using General Rating Formula for Respiratory Conditions.	
Note (1): Evaluate thoracoplasty as removal of ribs under DC 5297.	
Note (2): Request a mandatory examination immediately following notification that active tuberculosis evaluated under DC 6730 has become inactive. Implement any change in evaluation under the provisions of § 3.105(e).	
* * * * * * *	
Vascular Lung Diseases	
6817 Pulmonary thromboembolic disease:	
Chronic pulmonary thromboembolism with evidence of either pulmonary hypertension or right ventricular hypertrophy	100
At least one of the following	60
Chronic pulmonary thromboembolism requiring anticoagulant therapy; or	
Following inferior vena cava surgery without evidence of pulmonary hypertension or right ventricular dysfunction.	
Symptomatic, following resolution of acute pulmonary embolism	30
Asymptomatic, following resolution of pulmonary thromboembolism	0
Note (1): Evaluate other residuals following pulmonary embolism under the most appropriate diagnostic code, such as chronic bronchitis (DC 6600) or chronic pleural effusion or fibrosis (DC 6844), but do not combine that evaluation with any of the above evaluations.	
Note (2): Do not assign separate evaluations for pulmonary thromboembolic disease with right ventricular hypertrophy and a comorbid cardiovascular condition listed under § 4.104, diagnostic codes (DCs) 7000–7020. Assign a single rating under this diagnostic code or under DCs 7000–7020, whichever reflects the predominant disability.	
Note (3): Do not combine a rating assigned under this diagnostic code with other ratings under § 4.97, except for sleep apnea syndromes (DC 6847).	
6849 Pulmonary hypertension:	
Echocardiogram with severe right ventricular (RV) enlargement (greater than 4 cm), and at least one of the following:	
Maximum Oxygen Consumption measured in milliliters per kilogram per minute (mL/Kg/min) (VO2 Max) less than 15; or	
Workload of 3 Metabolic Equivalents (METs) or less	100
Echocardiogram with severe RV enlargement (greater than 4 cm), and at least one of the following:	
Brain natriuretic peptide (BNP) greater than 500;	
VO2 Max of 15 to 20; or	
Workload of 3.1 to 5.0 METs	60
Echocardiogram with moderate RV enlargement (3 to 4 cm), and at least one of the following:	
BNP of 100 to 500; or	
Workload of 5.1 to 7.0 METs	30
One of the following:	
BNP less than 100; or	
VO2 Max greater than 20	0

	Rating
Note (1): Acute pulmonary hypertension is not a disability for rating purposes. *Note (2):* Do not assign separate evaluations for pulmonary hypertension and a comorbid cardiovascular condition listed under § 4.104, diagnostic codes (DCs) 7000–7020. Assign a single rating under this diagnostic code or under DCs 7000–7020, whichever reflects the predominant disability. *Note (3):* Do not combine a rating assigned under this diagnostic code with other ratings under § 4.97, except for sleep apnea syndromes (DC 6847).	
Lung Neoplasms	
6819 Neoplasms, malignant, any specified part of respiratory system exclusive of skin growths	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy, or other prescribed therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, evaluate on residuals by using the General Rating Formula for Respiratory Conditions.	
6820 Neoplasms, benign, any specified part of respiratory system.	
Bacterial Lung Diseases	
General Rating Formula for Bacterial Lung Diseases:	
Active infection with systemic symptoms such as fever, night sweats, weight loss, or hemoptysis	100
Depending on the specific findings, evaluate the most severe residual analogously.	
Note: Do not combine a rating assigned under this formula with other ratings under § 4.97, except for sleep apnea syndromes (DC 6847).	
6822 Actinomycosis.	
* * * * * * *	
Parenchymal Lung Disease (Including Interstitium and Alveolar Spaces)	
Note (1): Evaluate using the General Rating Formula for Respiratory Conditions. *Note (2):* For DCs 6825 through 6833 and DC 6846, add 10 percent to any rating if a physician prescribes either of the following: Oral prednisone greater than 20mg daily or daily second-line (*i.e.*, non-steroidal) immunosuppressive medication.	
6825 Diffuse interstitial fibrosis (interstitial pneumonitis, fibrosing alveolitis, or idiopathic fibrosis).	
* * * * * * *	
6833 Asbestosis.	
6846 Sarcoidosis.	
Mycotic Lung Diseases	
General Rating Formula for Mycotic Lung Diseases:	
Chronic pulmonary mycosis with persistent fever, weight loss, night sweats, or massive hemoptysis	100
Chronic pulmonary mycosis requiring suppressive therapy with no more than minimal symptoms such as occasional minor hemoptysis or productive cough	50
Chronic pulmonary mycosis with minimal symptoms such as occasional minor hemoptysis or productive cough	30
Healed and inactive mycotic lesions, asymptomatic	0
Note (1): Coccidioidomycosis has an incubation period up to 21 days, and the disseminated phase is ordinarily manifest within 6 months of the primary phase. However, there are instances of dissemination delayed for years after the initial infection, which may have been unrecognized. Accordingly, when considering service connection, in the absence of record or other evidence of the disease in service, service in southwestern United States, where the disease is endemic, and absence of prolonged residence in this locality before or after service will be the deciding factor.	
Note (2): Do not combine a rating assigned under this formula with other ratings under § 4.97, except for sleep apnea syndromes (DC 6847).	
6834 Histoplasmosis of lung.	
OTHER RESPIRATORY CONDITIONS	
* * * * * * *	
6841 Respiratory insufficiency due to spinal cord injury.	
6842 Pulmonary disease secondary to kyphoscoliosis, pectus excavatum, or pectus carinatum.	
* * * * * * *	
6847 Sleep apnea syndromes (obstructive, central, or mixed):	
Treatment ineffective (as determined by sleep study) or unable to use treatment due to comorbid conditions; and with end-organ damage	100
Treatment ineffective (as determined by sleep study) or unable to use treatment due to comorbid conditions; and without end-organ damage	50
Incomplete relief (as determined by sleep study) with treatment	10
Asymptomatic with or without treatment	0
Note: Qualifying comorbidities are conditions that, in the opinion of a qualified medical provider, directly impede or prevent the habitual use of a recognized form of treatment shown by sleep study to be effective in the affected veteran's case (*e.g.*, contact dermatitis where the mask or interface touches the face or nares, Parkinson's disease, missing limbs, facial disfigurement, or skull fracture).	

	Rating
6848 Lung transplantation:	
Following transplant surgery	100
Thereafter, evaluate residuals under the General Rating Formula for Respiratory Conditions, minimum rating	30
Note (1): A rating of 100 percent shall be assigned as of the date of hospital admission for lung transplant. One year following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
Note (2): Do not combine a rating assigned under this diagnostic code with other ratings under § 4.97, except for sleep apnea syndromes (DC 6847).	

■ 13. Amend § 4.104 by:
■ a. Removing Note (1);
■ b. Redesignating Note (2) as Note (1); and
■ c. Redesignating Note (3) as Note (2).

The revisions read as follows:

§ 4.104 Schedule of ratings—cardiovascular system.

* * * * *

	Rating
Note (1): One MET (metabolic equivalent) is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. When the level of METs at which breathlessness, fatigue, angina, dizziness, or syncope develops is required for evaluation, and a laboratory determination of METs by exercise testing cannot be done for medical reasons, a medical examiner may estimate the level of activity (expressed in METs and supported by specific examples, such as slow stair climbing or shoveling snow) that results in those symptoms.	
Note (2): For this general formula, heart failure symptoms include, but are not limited to, breathlessness, fatigue, angina, dizziness, arrhythmia, palpitations, or syncope.	

* * * * * * *

■ 14. Amend appendix A to part 4 by:
■ a. Adding entry for § 4.85;
■ b. Revising entries for §§ 4.87 and 4.87a;
■ c. Revising entries for diagnostic codes 6502 through 6516, 6518 through 6604, 6731, and 6817, 6819, 6820, and 6822 through 6847; and
■ d. Adding entries for diagnostic codes 6848 and 6849 in numerical order.

The revisions and additions read as follows:

APPENDIX A TO PART 4—TABLE OF AMENDMENTS AND EFFECTIVE DATES SINCE 1946

Sec.	Diagnostic code No.	
*	*	* * * * * *
4.85	6100	Criterion [*effective date of final rule*].
4.87		Tables VI and VII replaced by new Tables VI, VIA, and VII December 18, 1987.
	6200	Revised and redesignated § 4.87 June 10, 1999; criterion [*effective date of final rule*].
	6201	Revised and redesignated § 4.87 June 10, 1999; criterion [*effective date of final rule*].
	6202	Revised and redesignated § 4.87 June 10, 1999; title [*effective date of final rule*].
	6204	Revised and redesignated § 4.87 June 10, 1999; criterion [*effective date of final rule*].
	6205	Revised and redesignated § 4.87 June 10, 1999; criterion [*effective date of final rule*].
	6207–6211	Revised and redesignated § 4.87 June 10, 1999.
	6220–6240	Added [*effective date of final rule*].
	6260	Revised and redesignated § 4.87 June 10, 1999; Removed [*effective date of final rule*].
4.87a	6275–6276	Moved from § 4.87b June 10, 1999.
*	*	* * * * * *
4.97	6502–6514	Criterion October 7, 1996; Revised and moved to § 4.87 [*effective date of final rule*].
	6515	Criterion March 11, 1969; Revised and moved to § 4.87 [*effective date of final rule*].
	6516	Criterion October 7, 1996; Revised and moved to § 4.87 [*effective date of final rule*].
	6517	*Removed October 7, 1996.*
	6518–6520	Criterion October 7, 1996; Revised and moved to § 4.87 [*effective date of final rule*].
	6521–6524	Added October 7, 1996; Revised and moved to § 4.87 [*effective date of final rule*].
	6600	Evaluation September 9, 1975; criterion October 7, 1996; criterion [*effective date of final rule*].
	6601	Criterion October 7, 1996; criterion [*effective date of final rule*].
	6602	Criterion September 9, 1975; criterion October 7, 1996; criterion [*effective date of final rule*].
	6603	Added September 9, 1975; criterion October 7, 1996; criterion [*effective date of final rule*].
	6604	Added October 7, 1996; criterion [*effective date of final rule*].
*	*	* * * * * *
	6731	Evaluation September 22, 1978; criterion October 7, 1996; criterion [*effective date of final rule*].
*	*	* * * * * *
	6817	Evaluation October 7, 1996; title, criterion [*effective date of final rule*].

APPENDIX A TO PART 4–TABLE OF AMENDMENTS AND EFFECTIVE DATES SINCE 1946—Continued

Sec.	Diagnostic code No.	
*	*	*
	6819	Criterion March 10, 1976; criterion October 7, 1996; criterion [*effective date of final rule*].
	6820	Criterion [*effective date of final rule*].
	6821	August 23, 1948; Removed October 7, 1996.
	6822–6824	Added October 7, 1996; criterion [*effective date of final rule*].
	6825	Added October 7, 1996; title, criterion [*effective date of final rule*].
	6826–6840	Added October 7, 1996; criterion [*effective date of final rule*].
	6841–6842	Added October 7, 1996; title, criterion [*effective date of final rule*].
	6843–6847	Added October 7, 1996; criterion [*effective date of final rule*].
	6848	Added [*effective date of final rule*].
	6849	Added [effective date of final rule].
*	*	*

■ 15. Amend appendix B to part 4 by:

■ a. Removing the heading ''THE EAR'' and adding in its place ''EAR, NOSE, and THROAT'';

■ b. Adding entry for diagnostic code 6100;

■ c. Revising diagnostic code 6202;

■ d. Adding diagnostic codes 6220 through 6240;

■ e. Removing diagnostic code 6260;

■ f. Removing the subheading ''Nose and Throat'';

■ g. Removing diagnostic codes 6502 through 6524;

■ h. Removing the subheading ''Trachea and Bronchi'' and adding in its place ''Airway Disorders (Trachea, Bronchi)'';

■ i. Removing the subheading ''Lungs and Pleura Tuberculosis'' and adding in its place ''Tuberculosis Lung Disease'';

■ j. Removing the subheading ''Nontuberculous Diseases'' and adding in its place ''Vascular Lung Disease'';

■ k. Revising diagnostic code 6817;

■ l. Adding entry for diagnostic code 6849 under diagnostic code 6817;

■ m. Adding the subheading ''Lung Neoplasms'' above diagnostic code 6819;

■ n. Republishing diagnostic code 6819;

■ o. Removing the subheading ''Bacterial Infections of the Lung'' and adding in its place ''Bacterial Lung Diseases'';

■ p. Removing the subheading ''Interstitial Lung Disease'' and adding in its place ''Parenchymal Lung Disease (Including Interstitium and Alveolar Spaces)'';

■ q. Revising diagnostic codes 6825, 6829, and 6830;

■ r. Removing the subheading ''Mycotic Lung Disease'' and adding in its place ''Mycotic Lung Diseases'';

■ s. Removing the subheading ''Restrictive Lung Disease'' and adding in its place ''Other Respiratory Conditions'';

■ t. Revising diagnostic codes 6841 and 6842; and

■ u. Adding diagnostic code 6848.

The revisions and additions read as follows:

APPENDIX B TO PART 4—NUMERICAL INDEX OF DISABILITIES

Diagnostic code No.	
*	* * * * * * *
	EAR, NOSE, and THROAT
6100	Hearing loss.
*	* * * * * * *
6202	Otosclerosis, stapedectomy, stapedotomy, residuals of.
*	* * * * * * *
6220	Septum, nasal, deviation of.
6221	Nose, loss of part of, or scars.
6222	Rhinosinusitis, pansinusitis, chronic; infectious.
6223	Rhinosinusitis, ethmoid, chronic; infectious.
6224	Rhinosinusitis, frontal, chronic; infectious.
6225	Rhinosinusitis, maxillary, chronic; infectious.
6226	Rhinosinusitis, sphenoid, chronic; infectious.
6227	Laryngitis, tuberculous, active or inactive.
6228	Laryngitis, chronic.
6229	Laryngectomy, total.
6230	Aphonia, complete organic.
6231	Larynx, stenosis of, including residuals of laryngeal trauma (unilateral or bilateral).
6232	Pharynx, injuries to.
6233	Rhinosinusitis, allergic or nonallergic (vasomotor) related.
6234	Rhinosinusitis, infection related.
6235	Rhinosinusitis, autoimmune, granulomatous, or other causes.
6236	Vocal cord paralysis.

APPENDIX B TO PART 4—NUMERICAL INDEX OF DISABILITIES—Continued

Diagnostic code No.	
6237	Neoplasm, nasopharyngeal and/or sinus, benign.
6238	Neoplasm, nasopharyngeal, and/or sinus, malignant.
6239	Salivary gland and/or associated ducts disease other than neoplasm.
6240	Rhinitis, allergic or nonallergic (vasomotor).
* * * * * * *	
THE RESPIRATORY SYSTEM	
Airway Disorders (Trachea, Bronchi)	
* * * * * * *	
Tuberculous Lung Diseases	
* * * * * * *	
Vascular Lung Diseases	
6817	Pulmonary thromboembolic disease.
6849	Pulmonary hypertension.
Lung Neoplasms	
6819	Neoplasms, malignant.
* * * * * * *	
Bacterial Lung Diseases	
* * * * * * *	
Parenchymal Lung Disease (Including Interstitium and Alveolar Spaces)	
6825	Diffuse interstitial fibrosis.
* * * * * * *	
6829	Drug-induced pulmonary pneumonitis and fibrosis.
6830	Radiation-induced pulmonary pneumonitis and fibrosis.
* * * * * * *	
Mycotic Lung Diseases	
* * * * * * *	
Other Respiratory Conditions	
* * * * * * *	
6841	Respiratory insufficiency due to spinal cord injury.
6842	Pulmonary disease secondary to kyphoscoliosis, pectus excavatum, pectus carinatum.
* * * * * * *	
6848	Lung transplantation.
* * * * * * *	

■ 16. Amend appendix C to part 4 by:
■ a. Revising entries for ''Aphonia, organic'' and ''Injury: Pharynx'';
■ b. Removing entry for ''Injury: Sacroiliac: Spinal cord'' and ''Kyphoscoliosis, pectus excavatum/carinatum'';
■ c. Adding entry for ''Hearing loss'';
■ d. Revising entries for ''Laryngectomy'', ''Laryngitis:'', ''Larynx, stenosis of'', and ''Loss of: Nose, part of, or scars'';
■ e. Adding entries for ''Lung, transplantation of'', ''Neoplasms: Benign: Nasopharyngeal'', and ''Neoplasms: Malignant: Nasopharyngeal'';
■ f. Revising entry for ''Otosclerosis'';
■ g. Adding entries for ''Pulmonary: Disease secondary to kyphoscoliosis, pectus excavatum, pectus carinatum'' and ''Pulmonary: Hypertension'';

■ h. Removing entry for ''Pulmonary: Vascular disease'' and adding in its place ''Pulmonary: Thromboembolic disease'';

■ i. Adding entry for ''Respiratory insufficiency due to spinal cord injury'';

■ j. Revising entry for ''Rhinitis'';

■ k. Adding entries for ''Rhinosinusitis'', ''Salivary gland and/or associated ducts disease other than neoplasm'', and ''Septum, nasal, deviation of'';

■ l. Removing entry for ''Sinusitis'';

■ m. Revising entry for ''Sleep Apnea Syndrome'';

■ n. Removing entry for ''Tinnitus, recurrent''; and

■ o. Adding entry for ''Vocal cord paralysis''.

The revisions and additions read as follows:

Appendix C to Part 4—Alphabetical Index of Disabilities

	Diagnostic code No.
* * * * * * *	
Aphonia, organic	6230
* * * * * * *	
Pharynx	6232
* * * * * * *	
Hearing loss	6100
* * * * * * *	
Laryngectomy	6229
Laryngitis, chronic	6228
Laryngitis, tuberculosis	6227
Larynx, stenosis of	6231
* * * * * * *	
Loss of:	
* * * * * * *	
Nose, part of, or scars	6221
* * * * * * *	
Lung, transplantation of	6848
* * * * * * *	
Neoplasms:	
Benign:	
* * * * * * *	
Nasopharyngeal	6237
* * * * * * *	
Malignant:	
Nasopharyngeal	6328
* * * * * * *	
Otosclerosis, stapedectomy, stapedotomy	6202
* * * * * * *	
Pulmonary:	.....
Disease secondary to kyphoscoliosis, pectus excavatum, pectus carinatum	6842
Hypertension	6849
Thromboembolic disease	6817
* * * * * * *	
Respiratory insufficiency due to spinal cord injury	6841
* * * * * * *	
Rhinitis, allergic or nonallergic (vasomotor)	6240
Rhinosinusitis:	
Allergic or nonallergic (vasomotor) related	6223
Autoimmune, granulomatous or other causes	6235
Ethmoid	6233
Frontal	6224
Infection related	6234
Maxillary	6225
Pansinusitis	6222
Sphenoid	6226
* * * * * * *	
Salivary gland and/or associated ducts disease other than neoplasm	6239

APPENDIX C TO PART 4—ALPHABETICAL INDEX OF DISABILITIES—Continued

	Diagnostic code No.
* * * * * * *	
Septum, nasal, deviation of	6220
* * * * * * *	
Sleep apnea syndromes	6847
* * * * * * *	
Vocal cord paralysis	6236
* * * * * * *	

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BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AQ82

Schedule for Rating Disabilities: Mental Disorders

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend the portion of the rating schedule dealing with mental disorders, including revising the General Rating Formula for Mental Disorders and combining currently separate General Rating Formula for Mental Disorders with the General Rating Formula for Eating Disorders in the VA Schedule for Rating Disabilities (VASRD or rating schedule). The proposed rule reflects changes made by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders 5 (DSM–5), advances in medical knowledge, and recommendations from VA's Mental Disorders Work Group.

DATES: VA must receive comments on or before April 18, 2022.

ADDRESSES: Comments may be submitted through *www.Regulations.gov.* Comments received will be available at *www.Regulations.gov* for public viewing, inspection or copies.

FOR FURTHER INFORMATION CONTACT: Ioulia Vvedenskaya, M.D., M.B.A., Medical Officer, Regulations Staff, (210A), Compensation Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, *211PolicyStaff.Vbavaco@va.gov,* (202) 461–9700. (This is not a toll-free telephone number.)

SUPPLEMENTARY INFORMATION:

I. The Need for Updated Rating Criteria

As part of its ongoing revision of the VASRD, VA proposes changes to the rating schedule for mental disorders, including the General Rating Formula for Mental Disorders codified at 38 CFR 4.130. The proposed changes would update evaluation criteria based on the DSM–5, medical advances since the last substantive revision of the rating schedule for mental disorders in 1996, and current understanding of functional impairment associated with, or resulting from, mental disorders. These changes also reflect comments received from subject matter experts in the Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), Board of Veterans' Appeals (BVA), Department of Defense (DoD), and Veterans Service Organizations (VSOs). Overall, VA did not rely on one particular input for these proposed changes, but the multitude of published, publicly available, and peer-reviewed, scientific and medical sources cited below.

In 2006, the Veterans' Disability Benefits Commission (VDBC) asked the Institute of Medicine (IOM) (now named the National Academy of Medicine) to study and recommend improvements for the VASRD. The IOM recommended updating the medical content of the rating schedule, by placing greater emphasis on a disabled veteran's ability to function in the work setting, rather than focusing on symptoms alone. Institute of Medicine, ''A 21st Century System for Evaluating Veterans for Disability Benefits'' 113–14 (Michael McGeary et al. eds., 2007).

In March 2015, VA published a final rule (RIN 2900–AO96) that updated the nomenclature for mental disorders and removed outdated references to the fourth editions of DSM (DSM–IV and DSM–IV–TR), replacing them with references to the latest fifth edition (DSM–5). While this rule updated the nomenclature to conform to the DSM–5, VA did not update the rating criteria used to evaluate mental disorders.

VA now proposes, however, to update the rating criteria for mental disorders in accord with IOM's recommendation and the latest medical science. VA's updates are based on the framework associated with the International Classification of Functioning, Disability, and Health (ICF) and its companion assessment instrument, the World Health Organization (WHO) Disability Assessment Schedule 2.0 (WHODAS 2.0), as well as the International Classification of Diseases (ICD), and concepts and methodology from the DSM–5.

The WHODAS 2.0 is a validated instrument that assesses health and disability across all diseases, including mental, neurological, and addictive disorders. O. Garin et al., ''Validation of the 'World Health Organization Disability Assessment Schedule, WHODAS–2' in patients with chronic diseases,'' 8 Health and Quality of Life Outcomes 51 (2010). It assesses the ability to perform tasks in six functional domains by measuring the impact of a disability across various life functions and assigning a score for each domain. ''WHO Disability Assessment Schedule 2.0 (WHODAS 2.0),'' World Health Organization, *https://www.who.int/classifications/icf/whodasii/en/* (last visited Nov. 19, 2019) (hereinafter ''WHODAS 2.0'').

The ICD is a standard tool for the diagnosis of disabilities for the purposes of epidemiology, health management, and clinical practice. By employing a standardized numerical labeling system, the ICD allows disease to be classified, monitored, and analyzed for statistical purposes. ''Classifications,'' World Health Organization, *https://www.who.int/classifications/en/* (last visited Nov. 19, 2019).

Finally, the DSM–5 is a standardized classification of mental disorders for mental health professionals in the