DEPARTMENT OF VETERANS AFFAIRS

38 CFR Parts 3 and 4

RIN 2900–AQ73

Schedule for Rating Disabilities: Neurological Conditions and Convulsive Disorders

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend the portion of the VA Schedule for Rating Disabilities (VASRD or Rating Schedule) that addresses neurological conditions and convulsive disorders. The purpose of these changes is to incorporate medical advancements that have occurred since the last revision, update current medical terminology, and provide clear evaluation criteria. The proposed rule reflects advances in medical knowledge and recommendations contained in the report from the Institute of Medicine, part of the National Academy of Sciences, titled ''A 21st Century System for Evaluating Veterans for Disability Benefits,'' National Academies Press, 2007.

DATES: Comments must be received on or before January 13, 2025.

ADDRESSES: Comments must be submitted through *www.regulations.gov*. Except as provided below, comments received before the close of the comment period will be available at *www.regulations.gov* for public viewing, inspection, or copying, including any personally identifiable or confidential business information that is included in a comment. We post the comments received before the close of the comment period on *www.regulations.gov* as soon as possible after they have been received. VA will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. VA encourages individuals not to submit duplicative comments; however, we will post comments from multiple unique commenters even if the content is identical or nearly identical to other comments. Any public comment received after the comment period's closing date is considered late and will not be considered in the final rulemaking. In accordance with the Providing Accountability Through Transparency Act of 2023, a plain language summary (not more than 100 words in length) of this proposed rule is available at *www.regulations.gov*, under RIN 2900–AQ73.

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SUPPLEMENTARY INFORMATION: VA has periodically revised portions of the Schedule for Rating Disabilities, to include the Neurological Conditions and Convulsive Disorders (herein referred to as the Neurological body system), since it was created in 1919. Important advances in the neurological sciences—particularly in the areas related to biochemistry, genetics, physiopathology, as well as electrodiagnosis and imaging of the nervous system—have produced drastic changes in the understanding of neurological diseases since the second half of the 20th century. The extent and repercussion of these advances triggered profound changes in approaches to diagnosis, classification of disease, and care of patients with neurological illnesses. As part of VA's ongoing revision of the VA Schedule for Rating Disabilities (VASRD or rating schedule), VA proposes changes to 38 Code of Federal Regulations (38 CFR) §§ 4.120 and 4.123–4.124a, which pertain to the neurological conditions and convulsive disorders. The proposed changes will: (1) update the medical terminology of certain neurological conditions and convulsive disorders; (2) add medical conditions frequently encountered but not currently found in the rating schedule; (3) refine evaluation criteria based on medical advances that have occurred since the last revision and current understanding of functional changes associated with or resulting from disease or injury (pathophysiology), and; (4) remove or modify certain diagnostic codes (DC) that are outdated or obsolete.

I. Retitle and Revise §§ 4.120 Evaluations by Comparison, 4.123 Neuritis, Cranial or Peripheral, and 4.124 Neuralgia, Cranial or Peripheral

VA proposes to retitle and revise § 4.120, *Evaluations by comparison,* because the approach to evaluating neurologic conditions has evolved over the time since this section was included in the 1945 rating schedule. See 29 FR 6718, 6749–6750 (May 22, 1964). As medical understanding has increased, the additional knowledge permits VA to develop evaluation criteria within the individual diagnostic codes that more accurately consider motor, sensory, and mental impairment. The instructions contained in the last sentence of § 4.120, which apply to peripheral nerves, will be updated to better align with modern medical knowledge and relocated to the revised § 4.123, titled ''Cranial and peripheral nerve impairment,'' paragraph (a)(1). VA proposes to relocate instructions relating to organic diseases of the central nervous system to § 4.120. See section II B. Orgranic diseases of the central nervous system below for additional detail.

VA also proposes to retitle and revise §§ 4.123 *Neuritis, cranial or peripheral* and 4.124 *Neuralgia, cranial or peripheral.* These sections provide information regarding symptoms and evaluations associated with neuritis and neuralgia. Neuritis and neuralgia are used to describe symptoms associated with motor and sensory neuropathy involving cranial and peripheral nerves. However, VA proposes their removal in favor of more objective criteria to assess disability in the cranial and peripheral nerves.

In the 1940s, the term neuritis was advanced by Dr. S.A. Kinnier Wilson as an all-encompassing term for most peripheral nerve conditions. Dr. S.A. Kinnier Wilson, ''Neurology,'' 279 (Ninian Bruce ed., 1970). As the field of peripheral neuropathology evolved, it became apparent that use of the term neuritis was obsolete and should be replaced by neuropathy, the preferred term for peripheral nerve diseases. While neuritis is sometimes used as a synonym for neuropathy, this use is erroneous and should only be used for certain specified inflammatory diseases. Drs. A.K. Asbury & Peter Johnson, ''Neurology,'' 258 (James Bennington ed., 1978). While the term neuragia is still used today, for compensation purposes, VA evaluates nerves affected by neuralgia by the sensory impairment caused by neuralgia, not the diagnosis itself. To that end, and as discussed in more detail below, VA proposes to remove neuritis as a separate ratable condition for both cranial nerves (DC series 8300) and peripheral nerves (DC series 8600) and neuralgia as a separate ratable condition for both cranial nerves (DC series 8400) and peripheral nerves (DC series 8700). VA will address evaluations for motor neuropathy and sensory neuropathy in revised § 4.123, as discussed below.

The underlying purpose behind the § 4.123 revision is to provide a central location for instructions specific to cranial and peripheral nerve conditions. This revision will promote rating

quality and consistency. First, VA proposes to retitle the section as ''Cranial and peripheral nerve impairment.'' Next, VA proposes informational language explaining, generally, how disabilities from cranial and peripheral nerve impairment are evaluated. After that, VA proposes to describe how disability from motor neuropathy (complete and incomplete paralysis) will be evaluated. Finally, VA proposes to describe how disability from sensory neuropathy will be evaluated.

Concerning the general instructions described in the revised § 4.123, VA proposes to relocate to this section several instructions that are currently located in multiple areas. The current VASRD contains an instruction directly above diagnostic code 8205; this instruction explains that disability from lesions of peripheral portions of first, second, third, fourth, sixth, and eighth nerves are rated under the Organs of Special Sense. Additionally, it explains that the ratings for the cranial nerves are for unilateral involvement; when bilateral, combine but without the bilateral factor. VA proposes to revise these two sentences, add an additional sentence, and include them in § 4.123. Specifically, proposed § 4.123(a)(3) explains that a cranial nerve will be evaluated strictly as a cranial nerve, regardless of any portions which lie outside the cranium (skull). This is consistent with current medical practice which considers cranial nerves outside of the cranium as separate and distinct from other peripheral nerves. Proposed § 4.123(a)(3) further explains that the evaluations in the rating schedule for the cranial nerves are for unilateral involvement; when bilateral involvement occurs, evaluate separately, then combine under § 4.25 without using the bilateral factor. While all cranial nerves begin inside the cranium, most exit the cranium to insert at various destinations, where they function in a manner similar to peripheral nerves. Nevertheless, VA proposes to evaluate the entire nerve, uniformly, as a cranial nerve. Proposed § 4.123(a)(2) explains that disability from impairments of the first, second, third, fourth, sixth, and eighth cranial nerves will be rated under the Organs of Special Sense. Additionally, the current VASRD contains an instruction directly above diagnostic code 8510; this instruction states, in part, that ratings for the peripheral nerves are for unilateral involvement; when bilateral, combine with application of the bilateral factor. VA will add a reference to evaluate bilateral disabilities separately, then combine using § 4.25 whenever bilateral involvement occurs; this will specify, as opposed to merely imply, how bilateral disabilities are to be evaluated. Additionally, VA will move the instruction to § 4.123(a)(4) because it is a general instruction since it applies to both motor and sensory impairment. Section 4.120 currently includes a sentence explaining that when rating peripheral nerve injuries and their residuals, attention should be given to the site and character of the injury, the relative impairment in motor function, trophic changes, or sensory disturbances. VA proposes the following changes to this sentence: clarify that the sentence applies to cranial and peripheral nerves; remove the reference to trophic changes, which do not consistently correlate to disability; replace the reference to motor function with a reference to movement or muscle strength, corresponding with the proposed evaluation criteria for cranial and peripheral motor nerve function, respectively; and relocate the sentence to § 4.123(a)(1). The purpose of these changes is to remedy confusion and inconsistent application of the instructions caused by the current placement of instructions in multiple locations. Therefore, VA proposes to combine them into a centralized location.

Motor nerve impairment affects muscle function (typically by decreased muscle strength), which can have a significant impact on movement activities, including, but not limited to, walking and grasping. Therefore, VA proposes to focus the complete and incomplete paralysis sections of each cranial and peripheral nerve on motor nerve impairment.

Concerning incomplete paralysis of cranial motor nerves, VA proposes to evaluate disability by replacing the current ''severe'' with ''[a]ttempted movement with inability to complete such movement (muscle twitching present).'' Additionally, VA proposes to revise the cranial evaluation criteria for ''moderate'' incomplete paralysis with ''[m]uscle movement intact, but task performed with difficulty.'' The proposed revisions replace subjective criteria with objective and measurable criteria, which will promote rating consistency and accuracy.

Regarding cranial nerve notes, in the current VASRD, each cranial nerve criteria set contains a note describing functions of that particular nerve. These notes are currently placed after the ''paralysis, incomplete'' diagnostic code section of the individual nerve. VA proposes to update the notes to provide more detailed examples of affected nerve functions and move them, placing them below the evaluation criteria of each individual cranial nerve. VA proposes this change because each note applies to both sensory and motor impairment of the particular cranial nerve.

Concerning peripheral motor nerves, VA proposes to evaluate disability by replacing the current rating criteria, which refer to complete and incomplete paralysis at the severe, moderate, and mild incomplete paralysis level, with criteria that align with the Medical Research Council (MRC) Scale for Muscle Strength (this is also commonly referred to as manual muscle testing). This scale is universally known and used throughout the medical community to evaluate peripheral nerves. ''How to Assess Muscle Strength,'' Merck Manual, *https://www.merckmanuals.com/professional/neurologic-disorders/neurologic-examination/how-to-assess-muscle-strength?query=Medical*, (last reviewed February 2018). The MRC grades muscle strength on a range from ''0'' (completely paralyzed) to ''5'' (normal muscle function). ''To distinguish among the various degrees of muscle strength within a given level, this scale has been modified with the addition of intermediate levels (*e.g.,* 4+ and 4−).'' Frontera, W.R. ''Delisa's Physical Medicine & Rehabilitation: Principles and Practice,'' 5th Edition, p 74 (2010).

Instead of ''mild,'' VA will use Grade 4 muscle strength. This represents measurable muscle weakness. Instead of ''moderate,'' VA will use Grade 3 muscle strength. This represents muscle strength that can oppose gravity, but cannot oppose resistance greater than gravity. Instead of ''moderately severe,'' VA will use Grade 2+ muscle strength. This represents muscle strength that is unable to oppose gravity completely, though muscle strength with gravity eliminated is present. That is, muscle strength that is greater than Grade 2, but less than Grade 3. Only the sciatic nerve has a ''moderately severe'' category. Instead of ''severe,'' VA will use Grade 2 muscle strength. This represents muscle strength that, though present, cannot oppose gravity at all. Complete paralysis will be identified as Grade 0 muscle strength (no muscle contraction or complete paralysis) or Grade 1 muscle strength (meaning a flicker or trace of contraction). Id. The proposed revisions replace subjective criteria with objective and measurable criteria, which will promote rating consistency and accuracy.

Regarding peripheral nerve instructions, in the current VASRD, there is a three-sentence instruction

directly above DC 8510; this instruction explains, in part, that incomplete paralysis with peripheral nerve injuries indicates a degree of impaired function substantially less than the type picture for complete paralysis, whether due to varied level of the nerve lesion or to partial regeneration. VA proposes to leave this sentence intact with two aesthetic revisions. These revisions involve changing ''picture'' to ''pictured'' and ''level'' to ''levels.'' VA believes these revisions will enable the verbiage to flow more smoothly without changing the meaning. The third sentence will remain intact, with the addition of a reference to § 4.25 in the third sentence, as discussed above. Both sentences will be moved to this instructional section. The remaining sentence will be removed, as it refers to sensory nerve evaluation criteria that VA is proposing to revise. The purpose of these changes is to remedy confusion and inconsistent application of the instructions caused by the current placement of instructions in multiple locations. Therefore, VA proposes to combine them into the most appropriate location.

Currently, each peripheral nerve includes a description in the entry for complete paralysis. For example, the entry for complete paralysis for DC 8510 for the upper radicular group (fifth and sixth cervicals) contains a description of all shoulder and elbow movements lost or severely affected, hand and wrist movements not affected. VA proposes to remove all peripheral nerve descriptions. Since VA is changing the subjective criteria to objective criteria and examiners are aware of the muscles affected by each nerve, VA believes the descriptions are no longer needed.

Concerning sensory neuropathy, sensory nerve impairment affects the ability to notice sensations, to include but not limited to, sharpness, heat, or coldness, and it can also produce abnormal spontaneous sensations, to include but not limited to, burning, tingling, and pain (pins and needles). Therefore, VA proposes to focus the sensory neuropathy sections of each nerve on sensory nerve impairment and remove neuritis and neuralgia as separate ratable conditions. Having separate diagnostic codes for neuritis and neuralgia requires VA to change the diagnostic code a veteran is rated under when the impairment associated with the condition changes, which creates additional work and complexity with no benefit to the veteran or VA. VA proposes to remove the diagnostic codes for neuritis and neuralgia, retitle the diagnostic codes addressing paralysis, and address motor and sensory impairment as criteria under the retitled diagnostic codes. Additionally, in light of the removal of DCs 8619 and 8719, VA proposes to number the notes that will appear under DC 8519.

In the current VASRD, the instructions under § 4.124, *Neuralgia, cranial or peripheral,* consist of three sentences. The first two sentences provide information regarding symptoms associated with neuralgia and instructions regarding the maximum evaluations for neuralgia. The last sentence provides rating instructions for tic douloureux. VA proposes to address sensory impairments in a new section, § 4.123(c). Instead of defining neuralgia, § 4.123(c)(1) will address altered sensation, with or without pain, on the basis of incomplete or complete sensory neuropathy. VA proposes to delete the last sentence of § 4.124, which addresses tic douloureux, because it is redundant. A note under the entry for the fifth (trigeminal) cranial nerve provides instructions on how to evaluate tic douloureux.

The current evaluation criteria focus on neuritis, neuralgia, and degrees of paralysis, with a maximum rating for neuritis equal to severe, incomplete, paralysis of the nerve involved, and a maximum rating for neuralgia equal to moderate incomplete paralysis. There is also an instruction at the beginning of the schedule of ratings for diseases of the peripheral nerves indicating that the rating should be for the mild, or at most, the moderate degree when the involvement is wholly sensory. Certain cranial and all peripheral nerves are evaluated using neuritis, neuralgia, and degrees of paralysis, regardless if the nerve has only sensory function, only muscle function, or both sensory function and muscle function (found in mixed nerves). There are several problems with the current approach. While both neuritis and neuralgia involve distorted sensation, the disability associated with these distorted sensations cannot be quantified by objective diagnostic testing and is unpredictable. Furthermore, the evaluation criteria for pure sensory nerves are the same as for pure motor nerves and mixed nerves, which is incorrect from a medical science perspective. For example, the external cutaneous nerve of the thigh and the obturator nerve have the same evaluation criteria (varying degrees of paralysis, which currently form the basis for rating neuritis and neuralgia), even though it is scientifically incorrect to evaluate a pure sensory nerve, such as the external cutaneous nerve of the thigh, for paralysis. It is this difficulty with measurement, unpredictability, and inappropriate application of certain evaluation criteria that VA seeks to remedy with the following proposed changes.

VA proposes to change the sensory evaluation criteria to a more easily measured sensory deprivation standard. Impairment of sensory function will be quantified as either incomplete or complete sensory deprivation. This simplifies the evaluation criteria and is much more easily measured during physical examination. These criteria will be applied to certain cranial nerves as well as all peripheral nerves. Muscle function in certain cranial nerves and all peripheral nerves will be evaluated in isolation using the previously discussed methods.

Using the incomplete/complete characterization of sensory deprivation described above, VA proposes to use a more straightforward description for disability when sensory neuropathy is involved. VA will consider sensory neuropathy as incomplete when sensation is impaired, although not absent, or when unpleasant sensations are experienced by the nerve such as dysesthesia, numbness, or paresthesia. Dysesthesia refers to any unpleasant sensation produced by a stimulus that is normally painless. Numbness refers to a sense of heaviness, weakness, or deadness in part of the body. Paresthesia refers to abnormal spontaneous sensations such as burning, tingling, pins and needles, etc. Clinical Neurology, 11th Edition, 2021, Chapter 10: Sensory Disorders. editors Greenberg, D.A., Aminoff, M.J., and Simon, R.P.

VA will consider sensory neuropathy complete when sensation is absent. In cranial nerves, which have compensable evaluations at the moderate evaluation level, VA will assign an evaluation at the moderate evaluation level if there is incomplete or complete sensory neuropathy. However, this will not be applied to the eleventh cranial nerve, also known as the spinal accessory nerve, because it only has a muscle function. For peripheral nerves, which mostly have compensable evaluations at the mild evaluation level, VA will assign an evaluation similar to the mild evaluation if there is incomplete sensory neuropathy. VA will assign an evaluation similar to the moderate evaluation if there is complete sensory neuropathy. Where the evaluation of a peripheral nerve remains the same whether it is at the mild or moderate evaluation level (DCs 8525, 8527, 8528, 8529, and 8530), VA will assign an evaluation at the moderate evaluation if there is incomplete or complete sensory neuropathy.

II. Schedule of Ratings—Neurological Conditions and Convulsive Disorders

A. Location of Section

Currently, the schedule of ratings for the Neurological body system is located in 38 CFR 4.124a. When the 1945 VA Schedule for Rating Disabilities was originally published in title 38 of the Code of Federal Regulations in 1964, VA organized it such that specific body systems started at specific locations. The Musculoskeletal body system, for example, began in § 4.40 even though the preceding section was § 4.31, leaving sections §§ 4.32 through 4.39 without content. See 29 FR 6718, 6722 (May 22, 1964). VA also designed the Rating Schedule so that the Mental Disorders body system started with § 4.125; however, due to the number of sections necessary to establish the Neurological body system, which precedes the Mental Disorders body system, the schedule of ratings for neurological conditions and convulsive disorders was placed in § 4.124a. See 29 FR 6718, 6749–53 (May 22, 1964). As proposed above, disability previously addressed in § 4.124 will now be addressed in the revision of § 4.123, which makes § 4.124 available. Therefore, VA also proposes to relocate the Schedule of Ratings from § 4.124a to § 4.124 and remove § 4.124a. VA proposes corresponding revisions to the references to § 4.124a in 38 CFR 3.809(d) and 38 CFR 4.71a, DC 5244.

B. Organic Diseases of the Central Nervous System

Currently, the introductory instruction under § 4.124a provides guidance concerning how to evaluate residuals of organic diseases of the central nervous system. There is a note currently located under DC 8025, Myasthenia gravis, which also provides guidance concerning how to evaluate residuals of organic diseases of the central nervous system. VA proposes to consolidate both notes, revising them and relocating them to § 4.120. VA further proposes to specify the diagnostic codes to which the instructions apply in order to promote consistent application of the VASRD.

First, VA proposes to clarify when ascertainable residuals are required. For diagnostic codes 8000–8036, there are 2 categories of diagnostic codes that consider minimum evaluations: unconditional and conditional minimums. Unconditional minimum diagnostic codes are 8002, 8004, 8007, 8010, 8018, 8021, 8023, 8024, and 8025. The aforementioned diagnostic codes do not require ascertainable residuals for a minimum evaluation, and will not require ascertainable residuals in this proposed regulation.

For DCs 8004 and 8007, which have unconditional minimums within the proposed General Rating Formula, VA proposes Note (1) to direct the rater to grant a minimum evaluation of 30 percent for Parkinson's disease (8004), regardless of examination findings. VA proposes Note (2) to direct the rater to grant a minimum evaluation of 10 percent for stroke residuals (8007), regardless of examination findings. No minimum evaluations will be available for DCs 8026, 8027, and 8028.

Conditional minimum DCs 8000, 8003, 8011, 8012, 8019, 8020, 8022, and new 8036 all require ascertainable residuals. Examples of ascertainable residuals to be considered include, but are not limited to, psychotic manifestations, loss of use of an extremity (partial or complete), as well as abnormal speech, vision, gait, or coordination. Finally, in the portion of the instruction addressing determinations as to the presence of residuals not capable of objective verification, VA proposes to specify that such determinations must be approached on the basis of disability related to the diagnosis recorded, rather than simply the diagnosis recorded, as the current instruction provides. The revised language is more consistent with 38 CFR 4.1, which provides that the rating schedule is primarily a guide in the evaluation of disability resulting from diseases and injuries encountered as a result of or incident to military service.

In regard to peripheral nerves and paralysis, VA proposes to replace the reference to mild, moderate, severe, or complete paralysis of peripheral nerves with a reference to complete or incomplete paralysis to account for changes in the way paralysis of peripheral nerves will be evaluated as referenced above.

With respect to ratings in excess of the prescribed minimum ratings, VA proposes to replace the current language directing raters to cite the diagnostic codes utilized as bases of evaluation in addition to the codes identifying the diagnoses with a reference to § 4.27, as that section includes instructions for the use of diagnostic code numbers when a disease is rated on the basis of residual conditions.

C. Diagnostic Code 8000, Encephalitis, Infectious

Current DC 8000 is titled ''Encephalitis, epidemic, chronic.'' The use of the term ''epidemic'' was used to describe an outbreak of encephalitis lethargica from 1918 to 1930. Dr. R.R. Dourmashkin, ''What Caused the 1918–1930 Epidemic of Encephalitis Lethargica?,'' 90 Journal of the Royal Society of Medicine 515, 515–520 (1997). Since that outbreak, a recurrence of the epidemic has not been reported. ''Encephalitis Lethargica Information Page,'' National Institute of Health—National Institute of Neurological Disorders and Stroke, *https://www.ninds.nih.gov/health-information/disorders/encephalitis* (last visited September 18, 2024). Given the infrequency with which this specific type of encephalitis occurs, VA proposes to rename DC 8000 as ''Encephalitis, infectious'' to better reflect the disabilities currently evaluated under this DC.

As a broader disease category, infectious encephalitis refers to an irritation and swelling of the brain caused by viral, bacterial, fungal, or parasitic infection. Symptoms of this disease can be quite severe and include loss of consciousness, seizures, paralysis, and sudden change in mental functions. The residuals of infectious encephalitis vary from full recovery to permanent disabilities and, in some cases, death. ''Encephalitis,'' National Institute of Health—U.S. National Library of Medicine (Aug. 31, 2016), *https://medlineplus.gov/ency/article/001415.htm* (last visited April 3, 2018). No changes to the evaluation criteria are proposed.

D. Diagnostic Code 8002, Brain, New Growth of, Malignant and Diagnostic Code 8003, Brain, New Growth of, Benign

Current DC 8002 is titled ''Malignant,'' and current DC 8003 is titled ''Benign, minimum.'' VA proposes changes to these diagnostic codes to correct current poor formatting. Both are intended to be read in conjunction with the general category of ''Brain, new growth of.'' To clarify the conditions covered under these DCs, VA proposes to rename these disabilities as DC 8002, ''Brain, new growth of, malignant,'' and DC 8003, ''Brain, new growth of, benign.''

Current DC 8002 also contains a note that is located between the 100 percent and the 30 percent evaluation levels. Previously, this diagnostic code had a 100 percent evaluation level and its note contained information regarding the 30 percent minimum rating. See 43 FR 45348, 45362 (Oct. 2, 1978). However, revisions to Part 4 have placed the note between the 100 percent and the 30 percent evaluation levels. Notes are typically found after evaluative criteria. Therefore, VA proposes to relocate this note after the 30 percent evaluation

level and to revise it to ensure that rating personnel understand how it applies to the both the 100 percent and 30 percent evaluation levels.

Current DC 8003 provides a minimum evaluation of 60 percent in the presence of a benign growth of the brain and then directs raters to evaluate based upon residuals, with a minimum evaluation of 10 percent. VA proposes to clarify the 60 percent evaluation by indicating that it applies during the presence of an active benign growth of the brain or during active treatment. By adding this additional information to the 60 percent evaluation criteria, VA will promote consistency of evaluations and avoid premature re-evaluation of the disability prior to successful treatment of the benign growth. VA proposes no other changes to these diagnostic codes.

E. Diagnostic Code 8004, Parkinson's Disease (Paralysis Agitans)

Current DC 8004 is titled ''Paralysis agitans,'' which is Latin for shaking palsy. While these terms are accurate descriptors of the disability, the more commonly used and accepted medical terminology is Parkinson's disease (PD). To clarify the disability evaluated under this diagnostic code as well as to make the VASRD more user-friendly to non-medical personnel, VA proposes to rename this diagnostic code ''Parkinson's disease.'' VA proposes to preserve the historical reference in parentheses.

VA also proposes to adopt evaluation criteria that reflect a modern understanding of this condition within a proposed general rating formula (GRF). VA proposes the creation of a GRF for certain movement disorders within the neurological body system due to the similarities of disabling effects and high frequency of misdiagnosis. By implementing a GRF, the rating process will be standardized as well as simplified based on disability presentation for a group of conditions. Additionally, the use of a GRF for these movement disorders will ensure the avoidance of pyramiding when more than one movement disorder is service connected. Pyramiding occurs when two or more evaluation percentages are awarded for the same disability under various diagnoses. In accordance with 38 CFR 4.14, pyramiding must be avoided. When two or more movement disorders are service-connected, unless none of the symptomatology of a movement disorder is duplicative of or overlapping with the symptomatology of another movement disorder, one evaluation percentage will be awarded based on the highest level of disability represented by the rating criteria that more nearly approximates the disability picture attributable to the service-connected movement disorders. 38 CFR 4.7. VA proposes to title the GRF ''General Rating Formula for Specified Neurologic Conditions (DCs 8004, 8007, 8026, 8027, and 8028)''. VA proposes 0, 10, 30, 60, and 100 percent evaluations to the newly proposed GRF, and it will be placed immediately below DC 8004. Lastly, specific to PD, VA proposes to continue the minimum 30 percent evaluation for a formal diagnosis of PD, as explained in the first note following the proposed GRF.

Recent advances in the understanding of PD have produced several assessment scales that describe discrete levels of increasing disability. The Revised Unified Parkinson's Disease Rating Scale (2008) is a sophisticated, complex scale widely used by clinicians. The level of sophistication and specificity, however, is not required to describe occupationally significant disability. The Hoehn-Yahr Parkinson's Disease scale, which has been in use since 1967, is far simpler to use and apply. VA proposes to base the disability criteria on this scale with direct reference to Hoehn-Yahr stages and descriptions of functional limitation associated with that severity of disease. VA recognizes that this scale was specifically developed for PD. However, other movement disorder evaluation tools are similar to Hoehn-Yahr. Thus, it was determined this was a reliable tool to adapt to multiple movement disorders. Parkinson's Resource Organization, The Five Stages of Parkinson's Disease, *http://www.parkinsonsresource.org/wp-content/uploads/2012/01/The-FIVE-Stages-of-Parkinsons-Disease.pdf,* May 2002. In addition, where appropriate, VA considered and incorporated features of other movement disorder scales. Those additions are noted under the specific movement disorder discussions below. The GRF will list the evaluation criteria first, followed by several notes.

The first note will direct raters to evaluate all cases of PD with a minimum rating of 30 percent. A second note is specific to stroke residuals rated under DC 8007 and directs raters to evaluate stroke residuals with a minimum rating of 10 percent. A third note defines activities of daily living. A fourth note instructs the rater how to evaluate symptoms versus separate and distinct diagnoses. For example, when an impairment such as depression is noted as a symptom versus a formal diagnosis, then it will be evaluated using the GRF for Specified Neurologic Conditions. Conversely, if there is a formal diagnosis, then the disorder will be evaluated separately under § 4.130 (Schedule of ratings—mental disorders). These instructions mirror the current instructions related to the Residuals of Traumatic Brain Injury. The fifth note addresses overlap of manifestations. It instructs rating specialists to evaluate comorbid conditions together when they cannot be delineated. These instructions also mirror the current instructions related to the Residuals of Traumatic Brain Injury. The sixth note reminds raters to consider special monthly compensation.

VA proposes the rating criteria under the GRF to consist of the following. A 100 percent evaluation will be given for ''Hoehn-Yahr stage 4 or stage 5, or; the inability to live independently because of neurologically-related disability.'' A 60 percent evaluation will be given for ''Impairment of mobility (*e.g.,* transfers, balance, or gait) requiring daily use of an assistive device such as a wheelchair, brace(s), crutch(es), cane(s), or walker.'' A 30 percent evaluation will be given for ''Hoehn-Yahr stage 3, or; impairment of mobility (*e.g.,* transfers, balance, or gait) requiring less than daily use of an assistive device such as a wheelchair, brace(s), crutch(es), cane(s), or walker.'' A 10 percent evaluation will be given for ''Hoehn-Yahr stage 2, or; impairment in at least one of the following areas: facial expression (*e.g.,* masking, blinking, or eye motion abnormalities); speech (*e.g.,* soft voice, slurring, difficulty speaking or swallowing); posture (*e.g.,* stooping, instability); mobility not requiring an assistive device (*e.g.,* decreased speed with transfers, gait ataxia, unstable balance); problems initiating or controlling motor movements (*e.g.,* stiffness, tremors); cognitive (*e.g.,* memory or executive problems); mental (*e.g.,* anxiety, depression, social phobia); sensory abnormalities (*e.g.,* olfactory deficits); involuntary muscle contractions resulting in pain and impairment, such as but not limited to, spontaneous neck turning or writing difficulty.'' A 0 percent evaluation will be given for ''Hoehn-Yahr stage 1, or; formal diagnosis without impairment.''

F. Diagnostic Code 8007, Stroke (Ischemic, Hemorrhagic, or Thrombotic), Including Cerebral Infarction or Cerebrovascular Accident (Brain, Vessels, Embolism, Thrombosis, and Hemorrhage); Diagnostic Code 8008 Brain, Vessels, Thrombosis of (Delete); Diagnostic Code 8009 Brain, Vessels, Hemorrhage From (Delete)

VA proposes to combine three DCs (8007, Brain, vessels, embolism of; 8008, Brain, vessels, thrombosis of; and 8009, Brain, vessels, hemorrhage from) under

DC 8007 and rename it as ''Stroke (ischemic, hemorrhagic, or thrombotic), including cerebral infarction or cerebrovascular accident (Brain, vessels, embolism, thrombosis, and hemorrhage).'' Since most clinicians document the condition as ''stroke'' rather than embolism, thrombosis, or hemorrhage, raters are unable to distinguish which title most accurately aligns with ''stroke,'' which means there is a risk that rating specialists will not consistently apply these DCs. For example, three raters evaluate three veterans diagnosed with residuals of a stroke. One rater chooses to use DC 8007; another uses DC 8008; and the other uses DC 8009. All three disabilities currently have the same evaluation criteria. Therefore, the veterans are not at a disadvantage from receiving one DC over the other. However, for statistical purposes, combining these three DCs would promote consistency in future research associated with stroke residuals. Because all three of the current diagnostic codes evaluate stroke residuals in the same way, VA proposes to combine them in order to create diagnostic code application consistency. Additionally, while the distinction concerning the type of stroke is a medical necessity for treatment purposes, it is irrelevant for rating purposes. This proposed update will create more consistent data tracking for disability compensation research purposes.

Currently, rating personnel grant a 100 percent evaluation for the first six months, then assign a minimum rating of 10 percent for stroke residuals, unless an evaluation of residuals under separate body systems results in a higher evaluation. Under the proposed changes, whenever diagnostic imaging, which is part of standard care for a stroke, identifies a stroke, rating personnel will continue to grant a 100 percent evaluation for the first six months; they will also continue to assign a minimum 10 percent for stroke residuals regardless of examination findings. Rating personnel will assign evaluations higher than the minimum in accordance with the General Rating Formula for Specified Neurologic Conditions (GRF). As explained in the fourth note of the GRF, if a residual is a symptom of the stroke, it will be evaluated as such. Contrarily, if a residual has a separate and distinct formal diagnosis, it will be service connected and evaluated separately. For example, if depression is noted as a symptom, it will be evaluated as part of the minimum 10 percent evaluation. However, if depression is a separate and distinct formal diagnosis, it will be service connected on a secondary basis and evaluated under § 4.130 (Schedule of ratings—mental disorders). See DC 8004 for details about the GRF.

G. Diagnostic Code 8018, Multiple Sclerosis and Other Demyelinating Diseases of the Central Nervous System

VA proposes to revise the title for this diagnostic code. The new title will be Multiple sclerosis (MS) and other demyelinating diseases of the Central Nervous System. The underlying basis for this revision is the existence of two conditions which present with disabilities similar to MS. VA proposes to evaluate neuromyelitis optica spectrum disorder (NMOSD) under this DC. Previously, NMOSD was rated analogously with DC 8010, Myelitis. Myelin oligodendrocyte glycoprotein antibody—associated disease (MOGAD) is the other condition to be captured with this DC. Like NMOSD, MOGAD also presents with a similar disability picture to MS. Wu, H. and Fisher, K., Current Diagnosis & Treatment Pediatric Neurology, Chapter 35. 2023.

H. Diagnostic Code 8021, Spinal Cord, New Growths of, Malignant and Diagnostic Code 8022, Spinal Cord, New Growths of, Benign

Current DC 8021 is titled ''Malignant,'' and current DC 8022 is titled ''Benign.'' VA proposes changes to these DCs to correct current poor formatting. Both were intended to be read in conjunction with the general category ''Spinal cord, new growths of.'' For the same reasons set forth above in the discussion for DC 8002, VA proposes to rename DC 8021 ''Spinal cord, new growths of, malignant,'' and DC 8022 ''Spinal cord, new growths of, benign.'' VA also proposes to clarify the 60 percent evaluation criteria for DC 8022 for the same reasons set forth in the discussion for DC 8003.

Additionally, current DC 8021 also contains a note that is located between the 100 percent and the 30 percent evaluation levels. Previously, this DC had a 100 percent evaluation level and its note contained information regarding the 30 percent minimum rating. See 43 FR 45348, 45362 (Oct. 2, 1978). However, revisions to Part 4 have placed the note between the 100 percent and the 30 percent evaluation levels. Notes are typically found after evaluative criteria. Therefore, VA proposes to relocate this note after the 30 percent evaluation level and to revise it to ensure that rating personnel understand how it applies to the both the 100 percent and 30 percent evaluation levels. VA proposes no other changes to these DCs.

I. Diagnostic Code 8025, Myasthenia Gravis

VA proposes to relocate and modify the note currently located directly below the rating criteria of DC 8025. It will be relocated to the introductory instruction under § 4.124. Refer to the above section, ''B. Organic diseases of the central nervous system,'' and § 4.124 for further details concerning this instruction.

J. New Diagnostic Code 8026, Parkinson's Plus, or Secondary Parkinsonism Syndromes

VA proposes to add a new DC 8026, titled ''Parkinson's plus, or secondary parkinsonism syndromes,'' in order to account for impairment due to this condition in the veteran population. Parkinson's plus syndromes cause similar symptoms and impairment to Parkinson's disease, but have other features that make them different. Parkinson's plus syndromes have several causes, which include but are not limited to different location of protein buildup, brain injury, encephalitis, meningitis, stroke, medications, and chemical poisonings. Parkinson's plus syndromes can cause impairment in facial expressions, problems with initiating or controlling motor movements, paralysis, vocal impairment, stiffness, and tremor. Treatment for Parkinson's plus syndromes, as well as the likelihood and extent of residual disability, depends on the underlying cause of the disorder. This is in contrast to primary Parkinson's, or Parkinson's disease, where there is a predictable progression. For this reason, Parkinson's plus syndrome will not have a minimum evaluation. ''Secondary Parkinsonism,'' National Institute of Health—U.S. National Library of Medicine (Jan. 19, 2018), *https://medlineplus.gov/ency/article/000759.htm* (last visited April 3, 2018). VA is proposing a specific diagnostic code for Parkinson's plus syndromes to allow for proper tracking of Parkinson's plus and Parkinson's disease in the veteran population. Parkinson's plus will be evaluated under the General Rating Formula for Specified Neurologic Conditions (GRF). See DC 8004 for details about the GRF.

K. New Diagnostic Code 8027, Essential Tremor

VA proposes to add a new DC 8027, titled ''Essential tremor,'' in order to account for impairment due to this condition. There is currently no standalone diagnostic code to account

for essential tremor, forcing rating personnel to rely on analogous coding and leading to inconsistent evaluations.

''Tremor is defined as a rhythmical, involuntary, oscillatory movement of a body part and is one of the most frequent movement disorders.'' Teive, H.A.G., ''Essential Tremor: phenotypes,'' (18) S1, pp 140–142, 140, Parkinsonism and Related Disorders (2012). ''Essential tremor (ET) is one of the most common neurological diseases and the [most common] cause of pathological tremor.'' Id. ''Historically[,] ET was defined as a benign entity.'' Id. However, recently it ''was suggested that it is time to remove the 'benign' from the ET label, as it has been shown to be progressive in nature and quite disabling for most patients.'' Id. ''In the last [several] years[,] ET has evolved into two different meanings.'' Id. First, ''the classical ET, as a monosymptomatic disorder, and second, a heterogeneous disorder, the Essential Tremors, or a family of diseases.'' Id. Currently, ''ET can be classified with both motor and non-motor elements. Tremor may occur also in the legs, feet, trunk, jaw, chin, tongue, and voice. Although postural and kinetic tremors are the main features of ET, intentional tremor and tremor at rest may also occur in some patients. Other motor features described in patients with ET are gait ataxia, postural instability[,] and eye-motion abnormalities. Non-motor features include cognitive (memory and executive problems and dementia), psychiatric (anxiety, depression[,] and social phobia), and sensory abnormalities (olfactory deficits [and] hearing loss).'' Id.

In developing evaluation criteria for ET, one of the most significant challenges is little, if any, outcomes research that would assist in criteria development. However, there are two well-recognized tools VA used to research this condition. The first tool is the International Classification of Functioning, Disability, and Health (2001), published by the World Health Organization, that provided terminology and definitions. According to this resource, ET involves the dysfunction of specific elements within the central nervous system. The tremors with ET are the impairments resulting from that nervous system dysfunction. Those tremors cause activity limitations and participation restrictions that can lead to earnings loss. The second tool is the 6th Edition Guides to the Evaluation of Permanent Impairment (2008), published by the American Medical Association. The guide has impairment tables for the upper extremities, gait, and station. These tools were considered in the creation of a general rating formula.

Another significant challenge in developing evaluation criteria for ET is the high rate of misdiagnosis with other movement disorders, such as dystonia and Parkinson's disease. Misdiagnosis occurs in up to 50 percent of cases, with Parkinson's disease (particularly in elderly patients) and dystonia (tremulous cervical dystonia) being the most common disorders mistaken for ET. Therefore, VA proposes the creation and use of a General Rating Formula for Specified Neurologic Conditions (GRF) for this and other movement disorders, allowing evaluation to focus on the symptoms and impairment present, even when misdiagnosis and/or a change in diagnosis occurs. See diagnostic code 8004 for details about the GRF. Teive, H.A.G., ''Essential Tremor: phenotypes,'' (18) S1, pp 140–142, Parkinsonism and Related Disorders (2012).

L. New Diagnostic Code 8028, Dystonia

VA proposes to add a new DC 8028, titled ''Dystonia,'' in order to account for impairment due to this condition. There is currently no standalone diagnostic code to account for dystonia, forcing rating personnel to rely on analogous coding and leading to inconsistent evaluations.

Dystonia causes involuntary muscle contractions that lead to slow, repetitive, and sometimes painful movement or abnormal posture. Dystonia can affect only one muscle, groups of muscles (torticollis), or muscles throughout the entire body. The specific symptoms and impairment experienced depend highly on the type of dystonia and the muscles affected, but can include difficulty walking, involuntary neck turning, difficulty speaking, writing, and uncontrollable blinking. Some cases of dystonia only affect a muscle group when performing a specific action. ''Dystonias Fact Sheet,'' National Institute of Health—National Institute of Neurological Disorders and Stroke (June 3, 2014), *https://www.ninds.nih.gov/health-information/disorders/tremor#toc-where-can-i-find-more-information-about-tremor-* (last visited September 18, 2024).

The Dystonia Study Group composed of renowned international movement disorder experts developed the unified dystonia rating scale and the global dystonia rating scale to serve as instruments to medically assess dystonia severity. ''Rating Scales for Dystonia: A Multicenter Assessment,'' Comella C et al., 2003 Movement Disorders 18 No.3 pp 303–12. These scales were considered during the creation of the general rating formula. Due to similarity and overlap of symptoms with other movement disorders, along with the high prevalence of misdiagnosis, VA proposes application of a General Rating Formula for Specified Neurologic Conditions (GRF). See DC 8004 for details about the GRF.

M. New Diagnostic Code 8036, Primary Lateral Sclerosis

VA proposes to add a new DC 8036, titled ''Primary lateral sclerosis,'' in order to account for impairment due to this condition. There is currently no standalone diagnostic code to account for primary lateral sclerosis (PLS). A standalone diagnostic code will permit more accurate tracking of this condition, and its associated disability.

PLS is a motor neuron disease that affects the upper motor neurons in the arms, legs, and face. Individuals with PLS first experience loss of muscle control in the feet and legs, then the disease progresses up the trunk and into the arms, hands, and the muscles that control speech, swallowing, and chewing. PLS can be differentiated from amyotrophic lateral sclerosis in that it only affects the upper motor neurons and progresses gradually. While there is no cure for PLS, it is not considered a fatal disease, and many individuals maintain the ability to walk without assistance, although they may eventually need a cane or walker due to the development of high degrees of spasticity. Due to the wide range of symptoms and severity upon confirmation of diagnosis, VA proposes to evaluate PLS according to the residual impairment under the appropriate diagnostic code with a minimum rating of 10 percent when there are ascertainable residuals. See R. Ramanathan, et al., ''Demographics and clinical characteristics of primary lateral sclerosis: case series and a review of literature,'' Neurodegener. Dis. Manag., vol 8(1), pp 17–23. 2018.

N. Diagnostic Code 8103, Hemifacial Spasm (Tic, Convulsive)

Current DC 8103 is titled ''Tic, convulsive,'' a facial nerve disorder that causes involuntary spasms and contractions of the facial nerves. For consistency, clarity, and ease of use of the VASRD by non-medical personnel, VA proposes to rename this diagnostic code ''Hemifacial spasm.'' Hemifacial spasm, an alternative name for convulsive tic, provides a much more explicit indication as to the condition to be evaluated under this diagnostic code

in terms of the anatomical location to be considered. VA proposes to preserve the historical reference to the nomenclature in parentheses. VA proposes no other changes to this diagnostic code.

O. Diagnostic Code 8104, Paramyoclonus Multiplex (Convulsive State, Myoclonic Type)

The current evaluation criteria for DC 8104, Paramyoclonus multiplex (convulsive state, myoclonic type), directs rating personnel to rate this condition as convulsive tic, which is DC 8103. As discussed above, VA is updating this term to hemifacial spasm in order to reflect current medical terminology. As such, VA proposes to replace ''tic; convulsive'' in the evaluation criteria of DC 8104 to maintain consistency throughout this portion of the VASRD. VA proposes no other changes to this DC.

P. Diagnostic Code 8107, Athetosis, Acquired

Current DC 8107, Athetosis, acquired, directs rating personnel to evaluate this condition as chorea. To clarify these instructions and promote consistency in evaluations, VA proposes to specify that this condition should be evaluated as Sydenham's chorea, matching the title of the DC that provides the appropriate evaluation criteria. VA proposes no other changes to this DC.

Q. Title Changes to Certain Peripheral Nerves

To reflect current medical terminology, VA proposes to update the names of the following peripheral nerves. The proposed titles are the current accepted nomenclature to describe these nerves. VA proposes to preserve the historical reference to the nomenclature in parentheses.

Diagnostic code	Current title for nerve	Proposed title for nerve
8514	Musculospiral nerve (radial nerve)	Radial nerve (musculospiral).[1]
8518	Circumflex nerve	Axillary nerve (circumflex).[2]
8521	External popliteal nerve (common peroneal)	Common peroneal nerve (external popliteal).[3]
8522	Musculocutaneous nerve (superficial peroneal)	Superficial peroneal nerve (musculocutaneous).[1]
8523	Anterior tibial nerve (deep peroneal)	Deep peroneal nerve (anterior tibial).[1]
8524	Internal popliteal nerve (tibial)	Tibial nerve (internal popliteal).[4]
8526	Anterior crural nerve (femoral)	Femoral nerve (anterior crural).[5]
8527	Internal saphenous nerve	Saphenous nerve (internal saphenous).[1]
8529	External cutaneous nerve of thigh	Lateral cutaneous nerve of the thigh (external cutaneous).[5]

[1] ''Dorland's Illustrated Medical Dictionary,'' 1123 (Douglas M. Anderson et al. eds., 27th ed. 1988).
[2] Wolf, J., ''Segmental Neurology'', page 20, 1981.
[3] ''Common Peroneal Nerve Dysfunction,'' National Institute of Health—U.S. National Library of Medicine (Aug. 7, 2017), *https://medlineplus.gov/ency/article/000791.htm* (last visited April 3, 2018).
[4] ''Dorland's Illustrated Medical Dictionary,'' 1124 (Douglas M. Anderson et al. eds., 27th ed. 1988).
[5] ''Dorland's Illustrated Medical Dictionary,'' 1120 (Douglas M. Anderson et al. eds., 27th ed. 1988).

R. Diagnostic Code 8514, Paralysis of the Musculospiral (Radial) Nerve

Current DC 8514 addresses motor impairment from diseases affecting the musculospiral nerve. The current evaluation criteria include a note that references dissociation of extensor communis digitorum and paralysis below the extensor communis digitorum, as well as instructing evaluations of these findings should not exceed a moderate rating. As stated previously, this nerve will be retitled as the radial nerve. Additionally, the note will be revised, as the evaluation criteria will be revised to employ the grade of muscle strength as the means to distinguish evaluation levels, with the maximum evaluation level corresponding to Grade 3 muscle strength for dissociation of extensor communis digitorum and paralysis below the extensor communis digitorum.

S. Diagnostic Code 8520, Paralysis of the Sciatic Nerve

Current DC 8520 addresses motor impairment due to diseases of the sciatic nerve. The nerve referenced by this diagnostic code stimulates the muscles of the entire lower extremity. While all other peripheral nerve criteria consist of mild, moderate, and severe, this one includes an extra category labeled moderately severe. In order to preserve the current evaluation levels and account for this extra category, VA proposes to revise the incomplete paralysis criteria at the 60 percent, 40 percent, 20 percent, and 10 percent levels. A 60 percent evaluation will be granted for muscles that have grade 2 strength (previously labeled severe). A 40 percent evaluation will be granted for muscles that have grade 2+ strength (previously labeled moderately severe). A 20 percent evaluation will be granted for muscles that have grade 3 strength (previously labeled moderate). A 10 percent evaluation will be granted for muscles that have grade 4 strength (previously labeled mild). Refer to the discussion above regarding § 4.123 for further details concerning the grading scale for motor impairment.

T. Diagnostic Code 8527, Sensory Neuropathy of the Internal Saphenous Nerve

Current DC 8527 addresses paralysis of the internal saphenous nerve. Paralysis refers to the lack of muscle function in muscle fibers. Posterior roots of the spinal nerves, including the saphenous nerve, do not have motor fibers, making it a pure sensory nerve. M. De Maeseneer, et al., ''Normal Anatomy and Compression Areas of Nerves of the Foot and Ankle: US and MR Imaging With Anatomic Correlation,'' Radiographics, vol 35, 1474–1475, 1469–1482 (2015). As a purely sensory nerve, the saphenous nerve has no muscle involvement and therefore using paralysis to describe impairment of this nerve is medically inaccurate. VA proposes to retitle DC 8527 to improve medical accuracy, and motor neuropathy will not be included in the criteria for this nerve. Because this nerve currently has a compensable rating only at the severe to complete paralysis level and sensory neuropathy, wholly sensory evaluations, will only be rated up to the moderate level, this nerve will no longer have a compensable rating.

U. Diagnostic Code 8529, Sensory Neuropathy of the External Cutaneous Nerve of the Thigh

Current DC 8529 addresses paralysis of the external cutaneous nerve of the thigh. Current medical terminology refers to this nerve as the lateral cutaneous nerve of the thigh, or LCNT. This nerve is part of the lumbar plexus. ''It functions primarily as a sensory nerve and its composition varies among individuals with several different

combinations of lumbar nerves that originate from L1 to L3. The LCNT then emerges at the lateral border of the psoas major, crosses the iliacus, to the anterior superior iliac spine. The nerve then passes under the inguinal ligament and over the sartorius muscle and enters the thigh as it divides into an anterior and posterior branch.'' Cheatham, S., et al. ''Meralgia Paresthetica: A Review of the Literature,'' International Journal of Sports Physical Therapy, 8(6): 884, December 2013. Paralysis refers to the lack of muscle function in muscle fibers. This nerve lacks motor fibers. As a purely sensory nerve, it has no muscle involvement and therefore using paralysis to describe impairment of this nerve is medically inaccurate. VA proposes to retitle DC 8529 to improve medical accuracy, and motor neuropathy will not be included in the criteria for this nerve. Because this nerve currently has a compensable rating only at the severe to complete paralysis level and sensory neuropathy, wholly sensory evaluations, will only be rated up to the moderate level, this nerve will no longer have a compensable rating.

V. Diagnostic Code 8540, Soft Tissue Sarcoma of Neurogenic Origin

VA proposes to place a section subheading, ''Other Neoplasms of the Neurological System,'' just above this diagnostic code as a separator between diagnostic codes for peripheral nerves and other neoplasms of the neurological system. No other changes are proposed for this DC.

W. Diagnostic Code 8910, Epilepsy, Grand Mal (Including Tonic-Clonic Seizures)

Current DC 8910 is titled ''Epilepsy, grand mal.'' VA proposes to update the title of this code to indicate that this includes tonic-clonic seizures. Tonic-clonic seizures involve the entire body, and the terminology is synonymous with grand mal seizures. ''Generalized tonic-clonic seizure,'' National Institute of Health—U.S. National Library of Medicine (September 3, 2019), *https://medlineplus.gov/ency/article/000695.htm* (last visited September 10, 2019). VA proposes no other changes to this DC.

X. Diagnostic Code 8911, Epilepsy, Petit Mal (Including Absence Seizures)

Current DC 8911 is titled ''Epilepsy, petit mal.'' VA proposes to update the title of this code to indicate that this includes absence seizures. Absence seizures typically last only a few seconds and may involve staring episodes, also called absence spells. Absence seizure is used synonymously with petit mal seizures. ''Absence Seizure,'' National Institute of Health—U.S. National Library of Medicine (September 3, 2019), *http://www.nlm.nih.gov/medlineplus/ency/article/000696.htm* (last visited September 10, 2019). VA proposes no other changes to this DC.

Y. Non-Substantial Changes to Relocated 38 CFR 4.124a

VA will also make some non-substantial changes to relocated 38 CFR 4.124a. In 2008, DC 8045, Residuals of traumatic brain injury (TBI), was revised to include a table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.'' See 73 FR 54693, 54705–54708 (September 23, 2008). This table was added after the table titled ''Organic Diseases of the Central Nervous System.'' This had the effect of placing DC 8046, Cerebral arteriosclerosis, between the evaluation criteria of DC 8045, Residuals of traumatic brain injury, and the newly added table for TBI residuals. To improve readability and ease of use for both DCs 8045 and 8046, VA proposes to relocate the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' directly below the evaluation criteria for DC 8045.

Z. Military Occupational Blast Exposure

VA is currently in the process of investigating the potential neurological residuals of repeated exposure to low-level military occupational blasts or Military Occupational Blast Exposure. VA invites public comment on this subject.

Executive Orders 12866, 13563 and 14094

Executive Order 12866 (Regulatory Planning and Review) directs 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. Executive Order 14094 (Executive Order on Modernizing Regulatory Review) supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866 of September 30, 1993 (Regulatory Planning and Review), and Executive Order 13563 of January 18, 2011 (Improving Regulation and Regulatory Review). The Office of Information and Regulatory Affairs has determined that this rulemaking is a significant regulatory action under Executive Order 12866, Section 3(f)(1), as amended by Executive Order 14094. 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 would 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 factual basis for this certification is based on the fact that no small entities or businesses determine the rating criteria revisions or 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 may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act (PRA)

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

Assistance Listing

The Assistance Listing numbers and titles for the programs affected by this document are 64.102, Compensation for Service-Connected Deaths for Veterans' Dependents; 64.105, Pension to Veterans, Surviving Spouses, and Children; 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

Administrative practice and procedure, Claims, Disability benefits.

38 CFR Part 4

Disability benefits, Pensions, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved and signed this document on October 29, 2024, 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.

Luvenia Potts,

Regulation Development Coordinator, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

For the reasons stated 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 continues to read as follows:

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

■ 2. Amend § 3.809 by revising paragraph (d) to read as follows:

§ 3.809 Specially adapted housing under 38 U.S.C. 2101(a)(2)(A)(i).

* * * * *

(d) *Amyotrophic lateral sclerosis.* VA considers § 3.809(b) satisfied if the veteran or member of the Armed Forces serving on active duty has service-connected amyotrophic lateral sclerosis rated 100 percent disabling under 38 CFR 4.124, diagnostic code 8017.

* * * * *

PART 4—SCHEDULE FOR RATING DISABILITIES

Subpart B—Disability Ratings

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

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

■ 4. In § 4.71a, amend the table The Spine by revising the entry for diagnostic code 5244 under General Rating Formula for Diseases and Injuries of the Spine to read as follows:

§ 4.71a Schedule of ratings—musculoskeletal system.

* * * * *

THE SPINE

	Rating
General Rating Formula for Diseases and Injuries of the Spine	
* * * * * * *	
5244 Traumatic paralysis, complete: *Paraplegia:* Rate under diagnostic code 5110. *Quadriplegia:* Rate separately under diagnostic codes 5109 and 5110 and combine evaluations in accordance with § 4.25. **Note:** If traumatic paralysis does not cause loss of use of both hands or both feet, it is incomplete paralysis. Evaluate residuals of incomplete traumatic paralysis under the appropriate diagnostic code (*e.g.,* § 4.124, Diseases of the Peripheral Nerves).	
* * * * * * *	

■ 5. Revise § 4.120 to read as follows:

§ 4.120 Minimum evaluations for organic diseases of the central nervous system.

(a) *Necessity of residuals for minimum evaluations.* The minimum evaluations for diagnostic codes 8002, 8004, 8007, 8010, 8018, 8021, 8023, 8024, and 8025 do not require ascertainable residuals. However, ascertainable residuals are required to provide the minimum evaluation for diagnostic codes 8000, 8003, 8011, 8012, 8019, 8020, 8022, and 8036.

(b) *Definition.* Ascertainable residuals include, but are not limited to, psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, etc., referring to the appropriate bodily system of the schedule. With partial loss of use of one or more extremities from neurological lesions, rate by comparison with complete or incomplete paralysis of peripheral nerves. Determinations as to the presence of subjective residuals not capable of objective verification, *e.g.,* headaches, dizziness, fatigability, must be approached on the basis of disability related to the diagnosis recorded. VA will only accept subjective residuals when they are consistent with the disease and not more likely attributable to another disease or no disease.

(c) *Ratings in excess of the minimum evaluation.* When one or more compensable evaluations assigned for the residuals of the diagnostic codes noted in this section meet or exceed the minimum evaluation for that diagnostic code, then the minimum evaluation for that diagnostic code is no longer applicable. When a rating in excess of the prescribed minimum rating is assigned based on the presence of ascertainable residuals, the diagnostic codes associated with the evaluation of those residuals must be cited in accordance with § 4.27.

■ 6. Revise § 4.123 to read as follows:

§ 4.123 Cranial and peripheral nerve impairment.

(a) *General.* (1) In rating cranial and peripheral nerve injuries and their residuals, attention should be given to the site and character of the injury, the relative impairment in movement or muscle strength, and sensory disturbances.

(2) Disability from impairments of the first, second, third, fourth, sixth, and eighth cranial nerves will be rated under the Organs of Special Sense.

(3) A cranial nerve will be evaluated strictly as a cranial nerve, regardless of any portions which lie outside the cranium (skull). The evaluations in the rating schedule for the cranial nerves are for unilateral involvement; when bilateral, evaluate separately, then

combine using § 4.25 but without application of the bilateral factor.

(4) The evaluations in the rating schedule for the peripheral nerves are for unilateral involvement; when bilateral, evaluate separately, then combine using § 4.25 with application of the bilateral factor.

(b) *Motor neuropathy (complete and incomplete paralysis).*

(1) *General.* The evaluation criteria for impairment to muscle function, with or without pain, of both cranial and peripheral nerves will be categorized as either complete paralysis or incomplete paralysis.

(2) *Cranial nerves.* Complete paralysis for cranial nerves is characterized by the complete inability to move. Incomplete paralysis is characterized as either movement with difficulty, or attempted movement with inability to complete such movement (muscle twitching present).

(3) *Peripheral nerves.* VA will evaluate peripheral nerve motor neuropathy using the Medical Research Council (MRC) Scale for Muscle Strength (commonly referred to as manual muscle testing). Complete paralysis for peripheral nerves will be identified as Grade 0 or Grade 1 muscle strength (no movement for Grade 0 and a flicker or trace of contraction for Grade 1). Incomplete paralysis will be determined by the following muscle strength grades: Grade 2 (only able to move if gravity is eliminated; unable to move at all against gravity), Grade 2+, which only applies to DC 8520 Sciatic nerve, (muscle strength, which, though present, can only partially move against gravity), Grade 3 (only able to move against gravity; unable to move against resistance), or Grade 4 (weakness is present, but able to move against resistance and gravity). If muscle strength falls in between grades (Grade + or −) for peripheral nerves other than Grade 2+ for DC 8520, then evaluate as follows: (1). for a − grade, reduce the grade by one integer (*e.g.,* Grade 3 − shall be evaluated as Grade 2), and (2.) for a + grade, maintain the current grade (*e.g.,* a Grade 3+ shall be evaluated as Grade 3). The term ''incomplete paralysis,'' with this and other peripheral nerve injuries, indicates a degree of lost or impaired function substantially less than the type pictured for complete paralysis given with each nerve, whether due to varied levels of the nerve lesion or to partial regeneration.

(4) *Mixed nerves.* When mixed nerves within a single diagnostic code are involved, an evaluation for both motor and sensory neuropathy is not permitted. The evaluation should be based on motor neuropathy with or without sensory neuropathy involvement.

(c) *Sensory neuropathy (complete and incomplete).*

(1) *General.* Impairments, with or without pain, to the sensory function of the cranial and peripheral nerves may be categorized as either incomplete or complete sensory neuropathy.

(2) *Complete sensory neuropathy.* Complete sensory neuropathy is characterized by the complete absence of sensation in an affected nerve.

(3) *Incomplete sensory neuropathy.* Incomplete sensory neuropathy involves sensation that is impaired, but not absent, or unpleasant sensations experienced by the nerve such as dysesthesia, numbness, or paresthesia. Dysesthesia refers to any unpleasant sensation produced by a stimulus that is normally painless. Numbness refers to a sense of heaviness, weakness, or deadness in part of the body. Paresthesia refers to abnormal spontaneous sensations such as burning, tingling, pins and needles, etc. VA will only accept subjective sensations when they are consistent with the disease and not more likely attributable to another disease or no disease.

§ 4.124 [Removed]

■ 7. Remove § 4.124.

§ 4.124a [Redesignated as § 4.124]

■ 8. Redesignate § 4.124a as § 4.124.

■ 9. Revise and republish newly redesignated § 4.124 to read as follows:

§ 4.124 Schedule of ratings—Neurological conditions and convulsive disorders.

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM

	Rating
Guidance for rating organic diseases of the central nervous system is located under § 4.120.	
8000 Encephalitis, infectious:	
As active febrile disease	100
Rate residuals, minimum	10
8002 Brain, new growth of, malignant	100
Minimum rating	30
Note: The 100 percent evaluation will be continued for 2 years following cessation of surgical, chemotherapeutic or other treatment modality. At this point, if the residuals have stabilized, the rating will be made on neurological residuals according to symptomatology or the minimum rating, whichever results in a higher evaluation.	
8003 Brain, new growth of, benign:	
Minimum during active disease or during a treatment phase	60
Rate residuals, minimum	10
General Rating Formula for Specified Neurologic Conditions (DCs 8004, 8007, 8026, 8027, and 8028):	
Hoehn-Yahr stage 4 or stage 5, or; the inability to live independently because of neurologically-related disability	100
Impairment of mobility (*e.g.,* transfers, balance, or gait) requiring daily use of an assistive device such as a wheelchair, brace(s), crutch(es), cane(s), or walker	60
Hoehn-Yahr stage 3, or; impairment of mobility (*e.g.,* transfers, balance, or gait) requiring less than daily use of an assistive device such as a wheelchair, brace(s), crutch(es), cane(s), or walker	30
Hoehn-Yahr stage 2, or; impairment in at least one of the following areas:	10
• facial expression (*e.g.,* masking, blinking, or eye motion abnormalities);	
• speech (*e.g.,* soft voice, slurring, difficulty speaking or swallowing);	
• posture (*e.g.,* stooping, instability);	
• mobility not requiring an assistive device (*e.g.,* decreased speed with transfers, gait ataxia, unstable balance);	
• problems initiating or controlling motor movements (*e.g.,* stiffness, tremors);	
• cognitive (*e.g.,* memory or executive problems);	
• mental (*e.g.,* anxiety, depression, social phobia);	
• sensory abnormalities (*e.g.,* olfactory deficits);	
• involuntary muscle contractions resulting in pain and impairment, such as but not limited to, spontaneous neck turning or writing difficulty	
Hoehn-Yahr stage 1, or; formal diagnosis without impairment	0

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
Note (1): Regardless of examination findings, the minimum rating for Parkinson's disease (DC 8004) shall be 30 percent.	
Note (2): Regardless of examination findings, the minimum rating for stroke residuals (DC 8007) shall be 10 percent.	
Note (3): Activities of daily living (ADLs) refers to basic self-care and includes bathing or showering, dressing, eating, getting in or out of bed or a chair, and using the toilet.	
Note (4): Evaluate any residual under the appropriate body system when there is a formal diagnosis of a condition. When there is no formal diagnosis, evaluate the residual under the General Rating Formula for Specified Neurologic Conditions. For example, evaluate emotional dysfunction under § 4.130 (Schedule of ratings—mental disorders) when there is a diagnosis of a mental disorder. When there is no diagnosis of a mental disorder, evaluate emotional symptoms under the General Rating Formula for Specified Neurologic Conditions.	
Note (5): There may be an overlap of manifestations of conditions evaluated under the General Rating Formula for Specified Neurologic Conditions with manifestations of a comorbid mental or neurologic or other physical disorder that can be separately evaluated under another diagnostic code. In such cases, do not assign more than one evaluation based on the same manifestations. If the manifestations of two or more conditions cannot be clearly separated, assign a single evaluation under whichever set of diagnostic criteria allows the better assessment of overall impaired functioning due to both conditions. However, if the manifestations are clearly separable, assign a separate evaluation for each condition.	
Note (6): Consider the need for special monthly compensation.	
Note (7): When evaluating a neurological condition under the General Rating Formula for Specified Neurological Conditions based on subjective symptoms and not a Hoehn-Yahr stage, a medical opinion finding that the subjectively reported symptom(s) is consistent with the claimed disease and not another disease or no disease is required.	
8004 Parkinson's disease (paralysis agitans):	
Rate under the General Rating Formula for Specified Neurologic Conditions (DCs 8004, 8007, 8026, 8027, and 8028).	
8005 Bulbar palsy	100
8007 Stroke (ischemic, hemorrhagic, or thrombotic), including cerebral infarction or cerebrovascular accident (Brain, vessels, embolism, thrombosis, and hemorrhage):	
During and for six months following a stroke, documented by diagnostic imaging	100
Thereafter, rate under the General Rating Formula for Specified Neurologic Conditions (DCs 8004, 8007, 8026, 8027, and 8028).	
8010 Myelitis:	
Minimum rating	10
8011 Poliomyelitis, anterior:	
As active febrile disease	100
Rate residuals, minimum	10
8012 Hematomyelia:	
For 6 months	100
Rate residuals, minimum	10
8013 Syphilis, cerebrospinal.	
8014 Syphilis, meningovascular.	
8015 Tabes dorsalis.	
Note: Rate upon the severity of convulsions, paralysis, visual impairment or psychotic involvement, etc.	
8017 Amyotrophic lateral sclerosis	100
Note: Consider the need for special monthly compensation.	
8018 Multiple sclerosis and and other demyelinating diseases of the central nervous system:	
Minimum rating	30
8019 Meningitis, cerebrospinal, epidemic:	
As active febrile disease	100
Rate residuals, minimum	10
8020 Brain, abscess of:	
As active disease	100
Rate residuals, minimum	10
8021 Spinal cord, new growths of, malignant	100
Minimum rating	30
Note: The 100 percent evaluation will be continued for 2 years following cessation of surgical, chemotherapeutic or other treatment modality. At this point, if the residuals have stabilized, the rating will be made on neurological residuals according to symptomatology or the minimum rating, whichever results in a higher evaluation.	
8022 Spinal cord, new growths of, benign:	
Minimum during active disease or during a treatment phase	60
Rate residuals, minimum	10
8023 Progressive muscular atrophy:	
Minimum rating	30
8024 Syringomyelia:	
Minimum rating	30
8025 Myasthenia gravis:	
Minimum rating	30
8026 Parkinson's plus, or secondary parkinsonism syndromes.	
Rate under the General Rating Formula for Specified Neurologic Conditions (DCs 8004, 8007, 8026, 8027, and 8028).	
8027 Essential tremor.	
Rate under the General Rating Formula for Specified Neurologic Conditions (DCs 8004, 8007, 8026, 8027, and 8028).	
8028 Dystonia.	
Rate under the General Rating Formula for Specified Neurologic Conditions (DCs 8004, 8007, 8026, 8027, and 8028).	
8036 Primary lateral sclerosis:	
Rate residuals, minimum	10
8045 Residuals of traumatic brain injury (TBI):	

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
There are three main areas of dysfunction that may result from TBI and have profound effects on functioning: cognitive (which is common in varying degrees after TBI), emotional/behavioral, and physical. Each of these areas of dysfunction may require evaluation. Cognitive impairment is defined as decreased memory, concentration, attention, and executive functions of the brain. Executive functions are goal setting, speed of information processing, planning, organizing, prioritizing, self-monitoring, problem solving, judgment, decision making, spontaneity, and flexibility in changing actions when they are not productive. Not all of these brain functions may be affected in a given individual with cognitive impairment, and some functions may be affected more severely than others. In a given individual, symptoms may fluctuate in severity from day to day. Evaluate cognitive impairment under the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.'' Subjective symptoms may be the only residual of TBI or may be associated with cognitive impairment or other areas of dysfunction. Evaluate subjective symptoms that are residuals of TBI, whether or not they are part of cognitive impairment, under the subjective symptoms facet in the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.'' However, separately evaluate any residual with a distinct diagnosis that may be evaluated under another diagnostic code, such as migraine headache or Meniere's disease, even if that diagnosis is based on subjective symptoms, rather than under the ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' table. Evaluate emotional/behavioral dysfunction under § 4.130 (Schedule of ratings—mental disorders) when there is a diagnosis of a mental disorder. When there is no diagnosis of a mental disorder, evaluate emotional/behavioral symptoms under the criteria in the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.'' Evaluate physical (including neurological) dysfunction based on the following list, under an appropriate diagnostic code: Motor and sensory dysfunction, including pain, of the extremities and face; visual impairment; hearing loss and tinnitus; loss of sense of smell and taste; seizures; gait, coordination, and balance problems; speech and other communication difficulties, including aphasia and related disorders, and dysarthria; neurogenic bladder; neurogenic bowel; cranial nerve dysfunctions; autonomic nerve dysfunctions; and endocrine dysfunctions. The preceding list of types of physical dysfunction does not encompass all possible residuals of TBI. For residuals not listed here that are reported on an examination, evaluate under the most appropriate diagnostic code. Evaluate each condition separately, as long as the same signs and symptoms are not used to support more than one evaluation, and combine under § 4.25 the evaluations for each separately rated condition. The evaluation assigned based on the ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' table will be considered the evaluation for a single condition for purposes of combining with other disability evaluations. Consider the need for special monthly compensation for such problems as loss of use of an extremity, certain sensory impairments, erectile dysfunction, the need for aid and attendance (including for protection from hazards or dangers incident to the daily environment due to cognitive impairment), being housebound, etc.	

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
Memory, attention, concentration, executive functions.	0	No complaints of impairment of memory, attention, concentration, or executive functions.
	1	A complaint of mild loss of memory (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing.
	2	Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment.
	3	Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment.
	Total	Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment.
Judgment	0	Normal.
	1	Mildly impaired judgment. For complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.
	2	Moderately impaired judgment. For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions.
	3	Moderately severely impaired judgment. For even routine and familiar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.
	Total	Severely impaired judgment. For even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision. For example, unable to determine appropriate clothing for current weather conditions or judge when to avoid dangerous situations or activities.
Social interaction	0	Social interaction is routinely appropriate.
	1	Social interaction is occasionally inappropriate.
	2	Social interaction is frequently inappropriate.
	3	Social interaction is inappropriate most or all of the time.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
Orientation	0	Always oriented to person, time, place, and situation.
	1	Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation.
	2	Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation.
	3	Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation.
	Total	Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation.
Motor activity (with intact motor and sensory system).	0	Motor activity normal.
	1	Motor activity normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function).
	2	Motor activity mildly decreased or with moderate slowing due to apraxia.
	3	Motor activity moderately decreased due to apraxia.
	Total	Motor activity severely decreased due to apraxia.
Visual spatial orientation	0	Normal.
	1	Mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system).
	2	Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system).
	3	Moderately severely impaired. Gets lost even in familiar surroundings, unable to use assistive devices such as GPS (global positioning system).
	Total	Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment.
Subjective symptoms	0	Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples are: mild or occasional headaches, mild anxiety.
	1	Three or more subjective symptoms that mildly interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light.
	2	Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days.
Neurobehavioral effects	0	One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction. Examples of neurobehavioral effects are: Irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, belligerence, apathy, lack of empathy, moodiness, lack of cooperation, inflexibility, and impaired awareness of disability. Any of these effects may range from slight to severe, although verbal and physical aggression are likely to have a more serious impact on workplace interaction and social interaction than some of the other effects.
	1	One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them.
	2	One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them.
	3	One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others.
Communication	0	Able to communicate by spoken and written language (expressive communication), and to comprehend spoken and written language.
	1	Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.
	2	Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time. Can generally communicate complex ideas.
	3	Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs.
	Total	Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
Consciousness	Total	Persistently altered state of consciousness, such as vegetative state, minimally responsive state, coma.

	Rating
8046 Cerebral arteriosclerosis:	
Purely neurological disabilities, such as hemiplegia, cranial nerve paralysis, etc., due to cerebral arteriosclerosis will be rated under the diagnostic codes dealing with such specific disabilities, with citation of a hyphenated diagnostic code (*e.g.,* 8046–8207).	
Purely subjective complaints such as headache, dizziness, tinnitus, insomnia and irritability, recognized as symptomatic of a properly diagnosed cerebral arteriosclerosis, will be rated 10 percent and no more under diagnostic code 9305. This 10 percent rating will not be combined with any other rating for a disability due to cerebral or generalized arteriosclerosis. Ratings in excess of 10 percent for cerebral arteriosclerosis under diagnostic code 9305 are not assignable in the absence of a diagnosis of multi-infarct dementia with cerebral arteriosclerosis.	
Note: The ratings under code 8046 apply only when the diagnosis of cerebral arteriosclerosis is substantiated by the entire clinical picture and not solely on findings of retinal arteriosclerosis.	
Miscellaneous Diseases	
8100 Migraine:	
With very frequent completely prostrating and prolonged attacks productive of severe economic inadaptability	50
With characteristic prostrating attacks occurring on an average once a month over last several months	30
With characteristic prostrating attacks averaging one in 2 months over last several months	10
With less frequent attacks	0
8103 Hemifacial spasm (tic, convulsive):	
Severe	30
Moderate	10
Mild	0
Note: Depending upon frequency, severity, muscle groups involved.	
8104 Paramyoclonus multiplex (convulsive state, myoclonic type):	
Rate as hemifacial spasm; severe cases	60
8105 Chorea, Sydenham's:	
Pronounced, progressive grave types	100
Severe	80
Moderately severe	50
Moderate	30
Mild	10
Note: Consider rheumatic etiology and complications.	
8106 Chorea, Huntington's.	
Rate as Sydenham's chorea. This, though a familial disease, has its onset in late adult life, and is considered a ratable disability.	
8107 Athetosis, acquired.	
Rate as Sydenham's chorea.	
8108 Narcolepsy.	
Rate as for epilepsy, petit mal.	
Diseases of the Cranial Nerves	
Guidance for rating cranial nerves is located under § 4.123.	
Fifth (trigeminal) cranial nerve	
8205 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis	50
Incomplete paralysis:	
Attempted movement with inability to complete such movement (muscle twitching present)	30
Muscle movement intact, but task performed with difficulty	10
Sensory neuropathy, complete or incomplete	10
Note (1): Tic douloureux may be rated under DC 8205 in accordance with severity, up to complete paralysis.	
Note (2): Rate dependent upon relative loss of sensation or muscle function. Examples of nerve functions include, but are not limited to, movement and sensation to the scalp, forehead, nose, cheeks, lower eye lid, nasal mucosa, upper lip, upper teeth, palate, anterior tongue, skin over mandible and lower teeth, and muscles of mastication.	
Seventh (facial) cranial nerve	
8207 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis	30
Incomplete paralysis:	
Attempted movement with inability to complete such movement (muscle twitching present)	20
Muscle movement intact, but task performed with difficulty	10
Sensory neuropathy, complete, or incomplete	10
Note: Rate dependent upon relative loss of sensation or muscle function. Examples of nerve functions include, but are not limited to, facial expressions, taste, and production/drainage of tears.	

	Rating
Ninth (glossopharyngeal) cranial nerve	
8209 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis	30
Incomplete paralysis:	
Attempted movement with inability to complete such movement (muscle twitching present)	20
Muscle movement intact, but task performed with difficulty	10
Sensory neuropathy, complete, or incomplete	10
Note: Rate dependent upon relative loss of ordinary sensation or muscle function. Examples of nerve functions include, but are not limited to, taste and sensing carotid blood pressure.	
Tenth (pneumogastric, vagus) cranial nerve	
8210 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis	50
Incomplete paralysis:	
Attempted movement with inability to complete such movement (muscle twitching present)	30
Muscle movement intact, but task performed with difficulty	10
Sensory neuropathy, complete, or incomplete	10
Note: Rate dependent upon relative loss of sensation or muscle function. Examples of nerve functions include, but are not limited to, speech and taste, along with movement and sensation to the larynx, pharynx, thoracic viscera, and abdominal viscera.	
Eleventh (spinal accessory, external branch) cranial nerve	
8211 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis	30
Incomplete paralysis:	
Attempted movement with inability to complete such movement (muscle twitching present)	20
Muscle movement intact, but task performed with difficulty	10
Note: Rate dependent upon relative loss of muscle function. Examples of nerve functions include, but are not limited to, movement of the sternocleidomastoid and trapezius muscles.	
Twelfth (hypoglossal) cranial nerve	
8212 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis	50
Incomplete paralysis:	
Attempted movement with inability to complete such movement (muscle twitching present)	30
Muscle movement intact, but task performed with difficulty	10
Sensory neuropathy, complete, or incomplete	10
Note: Rate dependent upon relative loss of sensation or muscle function. Examples of nerve functions include, but are not limited to, movement and sensation to the tongue.	

Schedule of ratings	Rating	
	Major	Minor
Diseases of the Peripheral Nerves		
Guidance for rating peripheral nerves, along with a description of the grading system, is located under § 4.123.		
Upper radicular group (fifth and sixth cervicals)		
8510 Motor neuropathy (complete and incomplete paralysis):		
Complete paralysis (Grade 0 or 1)	70	60
Incomplete paralysis:		
Grade 2	50	40
Grade 3	40	30
Grade 4	20	20
Sensory neuropathy, complete	40	30
Sensory neuropathy, incomplete	20	20
Middle radicular group		
8511 Motor neuropathy (complete and incomplete paralysis):		
Complete paralysis (Grade 0 or 1)	70	60
Incomplete paralysis:		
Grade 2	50	40
Grade 3	40	30
Grade 4	20	20
Sensory neuropathy, complete	40	30
Sensory neuropathy, incomplete	20	20
Lower radicular group		
8512 Motor neuropathy (complete and incomplete paralysis):		
Complete paralysis (Grade 0 or 1)	70	60
Incomplete paralysis:		
Grade 2	50	40
Grade 3	40	30
Grade 4	20	20
Sensory neuropathy, complete	40	30
Sensory neuropathy, incomplete	20	20

Schedule of ratings	Rating	
	Major	Minor
All radicular groups		
8513 Motor neuropathy (complete and incomplete paralysis):		
Complete paralysis (Grade 0 or 1)	90	80
Incomplete paralysis:		
Grade 2	70	60
Grade 3	40	30
Grade 4	20	20
Sensory neuropathy, complete	40	30
Sensory neuropathy, incomplete	20	20
Radial nerve (musculospiral)		
8514 Motor neuropathy (complete and incomplete paralysis):		
Complete paralysis (Grade 0 or 1)	70	60
Incomplete paralysis:		
Grade 2	50	40
Grade 3	30	20
Grade 4	20	20
Sensory neuropathy, complete	30	20
Sensory neuropathy, incomplete	20	20
Note: Lesions involving only ''dissociation of extensor communis digitorum'' and ''paralysis below the extensor communis digitorum,'' will not exceed Grade 3 for diagnostic code 8514.		
The median nerve		
8515 Motor neuropathy (complete and incomplete paralysis):		
Complete paralysis (Grade 0 or 1)	70	60
Incomplete paralysis:		
Grade 2	50	40
Grade 3	30	20
Grade 4	10	10
Sensory neuropathy, complete	30	20
Sensory neuropathy, incomplete	10	10
The ulnar nerve		
8516 Motor neuropathy (complete and incomplete paralysis):		
Complete paralysis (Grade 0 or 1)	60	50
Incomplete paralysis:		
Grade 2	40	30
Grade 3	30	20
Grade 4	10	10
Sensory neuropathy, complete	30	20
Sensory neuropathy, incomplete	10	10
Musculocutaneous nerve		
8517 Motor neuropathy (complete and incomplete paralysis):		
Complete paralysis (Grade 0 or 1)	30	20
Incomplete paralysis:		
Grade 2	20	20
Grade 3	10	10
Grade 4	0	0
Sensory neuropathy, complete	10	10
Sensory neuropathy, incomplete	0	0
Axillary nerve (circumflex)		
8518 Motor neuropathy (complete and incomplete paralysis):		
Complete paralysis (Grade 0 or 1)	50	40
Incomplete paralysis:		
Grade 2	30	20
Grade 3	10	10
Grade 4	0	0
Sensory neuropathy, complete	10	10
Sensory neuropathy, incomplete	0	0
Long thoracic nerve		
8519 Motor neuropathy (complete and incomplete paralysis):		
Complete paralysis (Grade 0 or 1)	30	20
Incomplete paralysis:		
Grade 2	20	20
Grade 3	10	10
Grade 4	0	0
Sensory neuropathy, complete	10	10
Sensory neuropathy, incomplete	0	0
Note (1): Not to be combined with lost motion above shoulder level.		
Note (2): Combined nerve injuries should be rated by reference to the major involvement, or if sufficient in extent, consider radicular group ratings.		

	Rating
Sciatic nerve	
8520 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis (Grade 0 or 1)	80
Incomplete paralysis:	
Grade 2	60
Grade 2+	40
Grade 3	20
Grade 4	10
Sensory neuropathy, complete	20
Sensory neuropathy, incomplete	10
Common peroneal nerve (external popliteal)	
8521 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis (Grade 0 or 1)	40
Incomplete paralysis:	
Grade 2	30
Grade 3	20
Grade 4	10
Sensory neuropathy, complete	20
Sensory neuropathy, incomplete	10
Superficial peroneal nerve (musculocutaneous)	
8522 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis (Grade 0 or 1)	30
Incomplete paralysis:	
Grade 2	20
Grade 3	10
Grade 4	0
Sensory neuropathy, complete	10
Sensory neuropathy, incomplete	0
Deep peroneal nerve (anterior tibial)	
8523 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis (Grade 0 or 1)	30
Incomplete paralysis:	
Grade 2	20
Grade 3	10
Grade 4	0
Sensory neuropathy, complete	10
Sensory neuropathy, incomplete	0
Tibial nerve (internal popliteal)	
8524 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis (Grade 0 or 1)	40
Incomplete paralysis:	
Grade 2	30
Grade 3	20
Grade 4	10
Sensory neuropathy, complete	20
Sensory neuropathy, incomplete	10
Posterior tibial nerve	
8525 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis (Grade 0 or 1)	30
Incomplete paralysis:	
Grade 2	20
Grade 3 or Grade 4	10
Sensory neuropathy, complete or incomplete	10
Femoral nerve (anterior crural)	
8526 Motor neuropathy (complete and incomplete paralysis):	
Complete paralysis (Grade 0 or 1)	40
Incomplete paralysis:	
Grade 2	30
Grade 3	20
Grade 4	10
Sensory neuropathy, complete	20
Sensory neuropathy, incomplete	10
Saphenous nerve (internal saphenous)	
8527 Sensory neuropathy, complete or incomplete	0
Obturator nerve	
8528 Motor neuropathy (complete and incomplete paralysis):	
Grade 0, Grade 1, or Grade 2	10
Grade 3 or Grade 4	0
Sensory neuropathy, complete or incomplete	0

	Rating
Lateral cutaneous nerve of the thigh (external cutaneous)	
8529 Sensory neuropathy, complete or incomplete	0
Ilio-inguinal nerve	
8530 Motor neuropathy (complete and incomplete paralysis):	
Grade 0, Grade 1, or Grade 2	10
Grade 3 or Grade 4	0
Sensory neuropathy, complete or incomplete	0
Other Neoplasms of the Neurological System	
8540 Soft-tissue sarcoma (of neurogenic origin)	100
Note: The 100 percent rating will be continued for 6 months following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. At this point, if there has been no local recurrence or metastases, the rating will be made on residuals.	
The Epilepsies	
A thorough study of all material in §§ 4.121 and 4.122 of the preface and under the ratings for epilepsy is necessary prior to any rating action.	
8910 Epilepsy, grand mal (including tonic-clonic seizures).	
Rate under the general rating formula for major seizures.	
8911 Epilepsy, petit mal (including absence seizures).	
Rate under the general rating formula for minor seizures.	
Note (1): A major seizure is characterized by the generalized tonic-clonic convulsion with unconsciousness.	
Note (2): A minor seizure consists of a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head (''pure'' petit mal), or sudden jerking movements of the arms, trunk, or head (myoclonic type) or sudden loss of postural control (akinetic type).	
General Rating Formula for Major and Minor Epileptic Seizures:	
Averaging at least 1 major seizure per month over the last year	100
Averaging at least 1 major seizure in 3 months over the last year; or more than 10 minor seizures weekly	80
Averaging at least 1 major seizure in 4 months over the last year; or 9–10 minor seizures per week	60
At least 1 major seizure in the last 6 months or 2 in the last year; or averaging at least 5 to 8 minor seizures weekly	40
At least 1 major seizure in the last 2 years; or at least 2 minor seizures in the last 6 months	20
A confirmed diagnosis of epilepsy with a history of seizures	10
Note (1): When continuous medication is shown necessary for the control of epilepsy, the minimum evaluation will be 10 percent. This rating will not be combined with any other rating for epilepsy.	
Note (2): In the presence of major and minor seizures, rate the predominating type.	
Note (3): There will be no distinction between diurnal and nocturnal major seizures.	
8912 Epilepsy, Jacksonian and focal motor or sensory.	
8913 Epilepsy, diencephalic.	
Rate as minor seizures, except in the presence of major and minor seizures, rate the predominating type.	
8914 Epilepsy, psychomotor.	
Major seizures:	
Psychomotor seizures will be rated as major seizures under the general rating formula when characterized by automatic states and/or generalized convulsions with unconsciousness.	
Minor seizures:	
Psychomotor seizures will be rated as minor seizures under the general rating formula when characterized by brief transient episodes of random motor movements, hallucinations, perceptual illusions, abnormalities of thinking, memory or mood, or autonomic disturbances.	

Mental Disorders in Epilepsies: A nonpsychotic organic brain syndrome will be rated separately under the appropriate diagnostic code (e.g., 9304 or 9326). In the absence of a diagnosis of non-psychotic organic psychiatric disturbance (psychotic, psychoneurotic or personality disorder) if diagnosed and shown to be secondary to or directly associated with epilepsy will be rated separately. The psychotic or psychroneurotic disorder will be rated under the appropriate diagnostic code. The personality disorder will be rated as a dementia (e.g., diagnostic code 9304 or 9326).

Epilepsy and Unemployability: (1) Rating specialists must bear in mind that the epileptic, although his or her seizures are controlled, may find employment and rehabilitation difficult of attainment due to employer reluctance to the hiring of the epileptic.

(2) Where a case is encountered with a definite history of unemployment, full and complete development should be undertaken to ascertain whether the epilepsy is the determining factor in his or her inability to obtain employment.

(3) The assent of the claimant should first be obtained for permission to conduct this economic and social survey. The purpose of this survey is to secure all the relevant facts and data necessary to permit of a true judgment as to the reason for his or her unemployment and should include information as to:

(a) Education;

(b) Occupations prior and subsequent to service;

(c) Places of employment and reasons for termination;

(d) Wages received;

(e) Number of seizures.

(4) Upon completion of this survey and current examination, the case should have rating board consideration. Where in the judgment of the rating board the veteran's unemployability is due to epilepsy and jurisdiction is not vested in that body by reason of schedular evaluations, the case should be submitted to the Compensation Service or the Director, Pension and Fiduciary Service.

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

■ 10. Amend Appendix A to part 4 by:
■ a. Revising the entry for diagnostic code 5244;
■ b. Adding, in numerical order, entries for §§ 4.120 and 4.123;
■ c. Redesignating the entries for § 4.124a (all diagnostic codes listed under § 4.124a) as new entries for § 4.124;
■ d. Revising and republishing newly redesignated § 4.124; and
■ e. Adding, in numerical order, a new entry for § 4.124a.

The revisions and additions read as follows:

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

Sec.	Diagnostic code No.	
*	*	* * * * * * *
	5244	Added February 7, 2021; note [Effective date of final rule].
*	*	* * * * * * *
4.120		Title and revised [Effective date of final rule].
4.123		Title and revised [Effective date of final rule].
4.124		Re-designated from § 4.124a [Effective date of final rule].
	8000	Title [Effective date of final rule].
	8002	Criteria September 22, 1978; title, note [Effective date of final rule].
	8003	Title, criteria [Effective date of final rule].
	8004	Title, criteria, notes [Effective date of final rule].
	8007	Title, criteria [Effective date of final rule].
	8008	Removed [Effective date of final rule].
	8009	Removed [Effective date of final rule].
	8018	Title [Effective date of final rule].
	8021	Criteria September 22, 1978; criteria October 1, 1961; criteria March 10, 1976; criteria March 1, 1989; title, note [Effective date of final rule].
	8022	Title, criteria [Effective date of final rule].
	8025	Note removed [Effective date of final rule].
	8026	Added [Effective date of final rule].
	8027	Added [Effective date of final rule].
	8028	Added [Effective date of final rule].
	8036	Added [Effective date of final rule].
	8045	Criterion and evaluation October 23, 2008.
	8046	Added October 1, 1961; criterion March 10, 1976; criterion March 1, 1989.
	8100	Evaluation June 9, 1953.
	8103	Title [Effective date of final rule].
	8104	Criteria [Effective date of final rule].
	8107	Criteria [Effective date of final rule].
	8205	Title, criteria, notes [Effective date of final rule].
	8207	Title, criteria, note [Effective date of final rule].
	8209	Title, criteria, note [Effective date of final rule].
	8210	Title, criteria, note [Effective date of final rule].
	8211	Title, criteria, note [Effective date of final rule].
	8212	Title, criteria, note [Effective date of final rule].
	8305	Removed [Effective date of final rule].
	8307	Removed [Effective date of final rule].
	8309	Removed [Effective date of final rule].
	8310	Removed [Effective date of final rule].
	8311	Removed [Effective date of final rule].
	8312	Removed [Effective date of final rule].
	8405	Removed [Effective date of final rule].
	8407	Removed [Effective date of final rule].
	8409	Removed [Effective date of final rule].
	8410	Removed [Effective date of final rule].
	8411	Removed [Effective date of final rule].
	8412	Removed [Effective date of final rule].
	8510	Title, criteria [Effective date of final rule].
	8511	Title, criteria [Effective date of final rule].
	8512	Title, criteria [Effective date of final rule].
	8513	Title, criteria [Effective date of final rule].
	8514	Title, criteria, note [Effective date of final rule].
	8515	Title, criteria [Effective date of final rule].
	8516	Title, criteria [Effective date of final rule].
	8517	Title, criteria [Effective date of final rule].
	8518	Title, criteria [Effective date of final rule].
	8519	Title, criteria, notes [Effective date of final rule].
	8520	Title, criteria [Effective date of final rule].
	8521	Title, criteria [Effective date of final rule].
	8522	Title, criteria [Effective date of final rule].
	8523	Title, criteria [Effective date of final rule].
	8524	Title, criteria [Effective date of final rule].
	8525	Title, criteria [Effective date of final rule].

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

Sec.	Diagnostic code No.	
	8526	Title, criteria [Effective date of final rule].
	8527	Title, criteria [Effective date of final rule].
	8528	Title, criteria [Effective date of final rule].
	8529	Title, criteria [Effective date of final rule].
	8530	Title, criteria [Effective date of final rule].
	8610	Removed [Effective date of final rule].
	8611	Removed [Effective date of final rule].
	8612	Removed [Effective date of final rule].
	8613	Removed [Effective date of final rule].
	8614	Removed [Effective date of final rule].
	8615	Removed [Effective date of final rule].
	8616	Removed [Effective date of final rule].
	8617	Removed [Effective date of final rule].
	8618	Removed [Effective date of final rule].
	8619	Removed [Effective date of final rule].
	8620	Removed [Effective date of final rule].
	8621	Removed [Effective date of final rule].
	8622	Removed [Effective date of final rule].
	8623	Removed [Effective date of final rule].
	8624	Removed [Effective date of final rule].
	8625	Removed [Effective date of final rule].
	8626	Removed [Effective date of final rule].
	8627	Removed [Effective date of final rule].
	8628	Removed [Effective date of final rule].
	8629	Removed [Effective date of final rule].
	8630	Removed [Effective date of final rule].
	8710	Removed [Effective date of final rule].
	8711	Removed [Effective date of final rule].
	8712	Removed [Effective date of final rule].
	8713	Removed [Effective date of final rule].
	8714	Removed [Effective date of final rule].
	8715	Removed [Effective date of final rule].
	8716	Removed [Effective date of final rule].
	8717	Removed [Effective date of final rule].
	8718	Removed [Effective date of final rule].
	8719	Removed [Effective date of final rule].
	8720	Removed [Effective date of final rule].
	8721	Removed [Effective date of final rule].
	8722	Removed [Effective date of final rule].
	8723	Removed [Effective date of final rule].
	8724	Removed [Effective date of final rule].
	8725	Removed [Effective date of final rule].
	8726	Removed [Effective date of final rule].
	8727	Removed [Effective date of final rule].
	8728	Removed [Effective date of final rule].
	8729	Removed [Effective date of final rule].
	8730	Removed [Effective date of final rule].
	8910	Added October 1, 1961; evaluation September 9, 1975; title [Effective date of final rule].
	8911	Added October 1, 1961; evaluation September 9, 1975; title [Effective date of final rule].
	8912	Added October 1, 1961; evaluation September 9, 1975.
	8913	Added October 1, 1961; evaluation September 9, 1975.
	8914	Added October 1, 1961; evaluation September 9, 1975.
4.124a		Re-designated as § 4.124 [Effective date of final rule].

* * * * * * *

■ 11. Amend Appendix B to part 4 by revising and republishing the entries in the table under ''Neurological Conditions and Convulsive Disorders'' to read as follows:

APPENDIX B TO PART 4—NUMERICAL INDEX OF DISABILITIES

Diagnostic code No.	
* * * * * * *	
Neurological Conditions and Convulsive Disorders	
Organic Diseases of the Central Nervous System	
8000	Encephalitis, infectious.
8002	Brain, new growth of, malignant.
8003	Brain, new growth of, benign.
8004	Parkinson's disease (paralysis agitans).
8005	Bulbar palsy.
8007	Stroke (ischemic, hemorrhagic, or thrombotic), including cerebral infarction or cerebrovascular accident.
8010	Myelitis.
8011	Poliomyelitis, anterior.
8012	Hematomyelia.
8013	Syphilis, cerebrospinal.
8014	Syphilis, meningovascular
8015	Tabes dorsalis.
8017	Amyotrophic lateral sclerosis.
8018	Multiple sclerosis and neuromyelitis optica spectrum disorder (NMOSD).
8019	Meningitis, cerebrospinal, epidemic.
8020	Brain, abscess.
8021	Spinal cord, new growths of, malignant.
8022	Spinal cord, new growths of, benign.
8023	Progressive muscular atrophy.
8024	Syringomyelia.
8025	Myasthenia gravis.
8026	Parkinson's plus, or secondary parkinsonism syndromes.
8027	Essential tremor.
8028	Dystonia.
8036	Primary lateral sclerosis.
8045	Residuals of traumatic brain injury (TBI).
8046	Cerebral arteriosclerosis.
Miscellaneous Diseases	
8100	Migraine.
8103	Hemifacial spasm (tic, convulsive).
8104	Paramyoclonus multiplex (convulsive state, myoclonic type).
8105	Chorea, Sydenham's.
8106	Chorea, Huntington's.
8107	Athetosis, acquired.
8108	Narcolepsy.
The Cranial Nerves	
8205	Fifth (trigeminal), motor neuropathy.
8207	Seventh (facial), motor neuropathy.
8209	Ninth (glossopharyngeal), motor neuropathy.
8210	Tenth (pneumogastric, vagus), motor neuropathy.
8211	Eleventh (spinal accessory, external branch), motor neuropathy.
8212	Twelfth (hypoglossal), motor neuropathy.
Peripheral Nerves	
8510	Upper radicular group, motor neuropathy.
8511	Middle radicular group, motor neuropathy.
8512	Lower radicular group, motor neuropathy.
8513	All radicular groups, motor neuropathy.
8514	Radial nerve (musculospiral), motor neuropathy.
8515	Median nerve, motor neuropathy.
8516	Ulnar nerve, motor neuropathy.
8517	Musculocutaneous nerve, motor neuropathy.
8518	Axillary nerve (circumflex), motor neuropathy.
8519	Long thoracic nerve, motor neuropathy.
8520	Sciatic nerve, motor neuropathy.
8521	Common peroneal nerve (external popliteal), motor neuropathy.
8522	Superficial peroneal nerve (musculocutaneous), motor neuropathy.
8523	Deep peroneal nerve (anterior tibial), motor neuropathy.
8524	Tibial nerve (internal popliteal), motor neuropathy.
8525	Posterior tibial nerve, motor neuropathy.
8526	Femoral nerve (anterior crural), motor neuropathy.
8527	Saphenous nerve (internal saphenous), sensory neuropathy.

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

Diagnostic code No.	
8528	Obturator nerve, motor neuropathy.
8529	Lateral cutaneous nerve of the thigh (external cutaneous), sensory neuropathy.
8530	Ilio-inguinal nerve, motor neuropathy.
	Other Neoplasms of the Neurological System
8540	Soft tissue sarcoma (Neurogenic origin).
	The Epilepsies
8910	Epilepsy, grand mal (includes tonic-clonic seizures).
8911	Epilepsy, petit mal (includes absence seizures).
8912	Jacksonian and focal motor or sensory.
8913	Diencephalic.
8914	Psychomotor.

* * * * * * *

■ 12. Amend Appendix C to part 4 by:
■ a. Adding, in alphabetical order, an entry for ''Dystonia'';
■ b. Removing the entry for ''Embolism, brain'';
■ c. Revising the entry for ''Encephalitis, epidemic'';
■ d. Under the entry for ''Epilepsies'', revising the entries for ''Grand mal'' and ''Petit mal'';
■ e. Adding, in alphabetical order, entries for ''Essential tremor'' and ''Hemifacial spasm (tic, convulsive)'';
■ f. Removing the entry for ''Hemorrhage'';
■ g. Adding, in alphabetical order, an entry for ''Intraocular hemorrhage'';
■ h. Adding, in alphabetical order, an entry for ''Motor/sensory neuropathy'';
■ i. Revising the entry for ''Multiple sclerosis'';
■ j. Removing the entry for ''Neuralgia'';
■ k. Removing the entry for ''Neuritis'';
■ l. Adding an entry for ''Optic neuropathy'';
■ m. Under the entry for ''Paralysis'', removing the entry for ''Agitans'';
■ n. Removing the entry for ''Paralysis, nerve'';
■ o. Revising the entry for ''Paramyoclonus multiplex'';
■ p. Adding, in alphabetical order, entries for ''Parkinson's disease (paralysis agitans)'', ''Parkinson's plus, or secondary parkinsonism syndromes'', ''Primary lateral sclerosis'', and ''Stroke (ischemic, hemorrhagic, or thrombotic), including cerebral infarction or cerebrovascular accident''; and
■ q. Removing the entries for ''Thrombosis, brain'' and ''Tic, convulsive''.

The revisions and additions read as follows:

APPENDIX C TO PART 4—ALPHABETICAL INDEX OF DISABILITIES

	Diagnostic code No.
* * * * * * *	
Dystonia	8028
* * * * * * *	
Encephalitis, infectious	8000
* * * * * * *	
Epilepsies:	
* * * * * * *	
Grand mal (includes tonic-clonic seizures)	8910
* * * * * * *	
Petit mal (includes absence seizures)	8911
* * * * * * *	
Essential tremor	8027
* * * * * * *	
Hemifacial spasm (tic, convulsive)	8103
* * * * * * *	
Intraocular hemorrhage	6007
* * * * * * *	
Motor/sensory neuropathy:	
Cranial nerves:	
Eleventh (spinal accessory, external branch)	8211
Fifth (trigeminal)	8205
Ninth (glossopharyngeal)	8209

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

	Diagnostic code No.
Seventh (facial)	8207
Tenth (pneumogastric, vagus)	8210
Twelfth (hypoglossal)	8212
Peripheral nerves:	
All radicular groups	8513
Axillary (circumflex)	8518
Common peroneal (external popliteal)	8521
Deep peroneal (anterior tibial)	8523
Femoral (anterior crural)	8526
Ilio-inguinal	8530
Lateral cutaneous nerve of the thigh (external cutaneous)	8529
Long thoracic	8519
Lower radicular group	8512
Median	8515
Middle radicular group	8511
Musculocutaneous	8517
Obturator	8528
Posterior tibial	8525
Radial (musculospiral)	8514
Saphenous (internal saphenous)	8527
Sciatic	8520
Superficial peroneal (musculocutaneous)	8522
Tibial (internal popliteal)	8524
Ulnar	8516
Upper radicular group	8510
* * * * * * *	
Multiple sclerosis and other demyelinating diseases of the central nervous system	8018
* * * * * * *	
Optic neuropathy	6026
* * * * * * *	
Paramyoclonus multiplex (convulsive state, myoclonic type)	8104
* * * * * * *	
Parkinson's disease (paralysis agitans)	8004
Parkinson's plus, or secondary parkinsonism syndromes	8026
* * * * * * *	
Primary lateral sclerosis	8036
* * * * * * *	
Stroke (ischemic, hemorrhagic, or thrombotic), including cerebral infarction or cerebrovascular accident	8007
* * * * * * *	

[FR Doc. 2024–25665 Filed 11–8–24; 8:45 am]
BILLING CODE 8320–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 51

[EPA–HQ–OAR–2023–0295; FRL–10823–01–OAR]

RIN 2060–AW00

Air Quality: Revision to the Regulatory Definition of Volatile Organic Compounds—Exclusion of (Z)-1-chloro-2,3,3,3-tetrafluoropropene (HCFO-1224yd(Z))

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The U.S. Environmental Protection Agency (EPA) is proposing to revise the EPA's regulatory definition of volatile organic compounds (VOC) under the Clean Air Act (CAA). This action proposes to add (Z)-1-chloro-2,3,3,3-tetrafluoropropene (also known as HCFO-1224yd(Z); CAS number 111512–60–8) to the list of compounds excluded from the regulatory definition on the basis that this compound makes a negligible contribution to tropospheric ozone (O_3) formation.

DATES: Comments must be received on or before January 13, 2025.

ADDRESSES: You may send comments, identified by Docket ID No. EPA–HQ–OAR–2023–0295, by any of the following methods:

- *Federal eRulemaking Portal: https://www.regulations.gov/* (our preferred method). Follow the online instructions for submitting comments.
- *Mail:* U.S. Environmental Protection Agency, EPA Docket Center, Docket No. EPA–HQ–OAR–2023–0295, Office of Air and Radiation Docket, Mail Code 28221T, 1200 Pennsylvania Avenue NW, Washington, DC 20460.
- *Hand Delivery or Courier:* EPA Docket Center, WJC West Building, Room 3334, 1301 Constitution Avenue NW, Washington, DC 20004. The Docket Center's hours of operations are 8:30 a.m.–4:30 p.m., Monday–Friday (except Federal Holidays).

Instructions: All submissions received must include the Docket ID No. for this