FOR FURTHER INFORMATION CONTACT:

Mr. Kenneth J. Dyer, Legal Assistant, Social Security Administration, 6401 Security Boulevard, Baltimore, Md. 21235, telephone 301-594-7454.

SUPPLEMENTARY INFORMATION: Services performed as an employee of a religious, charitable, educational, or other organization that is exempt from income taxes under section 501(c)(3) of the Internal Revenue Code of 1954 (IRC), are excluded from social security coverage. However, the employing organization may file a certificate (see sec. 3121(k) of the IRC) waiving its tax exempt status from social security taxes. A study by the General Accounting Office in 1975 revealed that a substantial number of these organizations had not filed waiver certificates with the Internal Revenue Service. The study further showed that these organizations were nevertheless reporting wages and paying social security taxes on them. Pub. L. 94-563, approved on October 19, 1976, made it possible for employees of such organizations to receive social security coverage for the reported wages.

Pub. L. 94-563 amended both the Social Security Act and the IRC. It provides that if the organization failed to file the waiver certificate but paid social security taxes under the Federal Insurance Contribution Act on wages paid its employees for three or more consecutive calendar quarters after 1972, it will be deemed to have filed the certificate. Section 312 of Pub. L. 95-216, further amended only section 3121(k) of the IRC, to change social security tax provisions in light of Pub. L. 94-563.

Public Law 94-563 and Pub. L. 95-216 are discussed only in general terms since the provisions relating to the filing of a waiver certificate, the collection and refund of social security taxes and coverage of organizations and their employees' taxes, are contained in the Internal Revenue Code of 1954 and are the responsibility of the Internal Revenue Service. Consequently, the regulations refer the user to the appropriate IRC provisions. The regulations are being published as final regulations since a notice of proposed rulemaking is unnecessary in that the regulations merely reflect the provisions of statutes already in effect.

Accordingly, the amendments are adopted as set forth below.

(Secs. 205, and 1102 of the Social Security Act, as amended, 53 Stat. 1368, as amended, 49 Stat. 647, as amended, 42 U.S.C. 405 and 1302 as amended.)

(1977 Catalog of Federal Domestic Assistance Program Nos. 13.802, Social Security—Disability Insurance, 13.803, Social Security—Retirement Insurance; 13.804, Social Security—Special Benefits for Persons Age 72 and Over; and 13.805, Social Security—Survivors Insurance.)

Dated: August 15, 1978.

DON WORTMAN,
Acting Commissioner of Social Security.

Approved: September 27, 1978.

JOSEPH A. CALIFANO, Jr.,
Secretary of Health, Education, and Welfare.

Part 404 of title 20 of the Code of Federal Regulations is amended as set forth below:

1. In § 404.1016 the heading and paragraph (a) are revised to read as follows:

§ 404.1016 Election of coverage by religious, charitable, educational, or other organizations exempt from income tax.

(a) *General.* Services performed by an employee in the employ of a religious, charitable, educational, or other organization described in section 501(c)(3) of the Internal Revenue Code of 1954 which is exempt from income tax under section 501(a) of the Internal Revenue Code of 1954 (sec. 101(6) of the Internal Revenue Code of 1939) are excepted from employment. This exception does not apply to services performed during the period for which a form SS-15, Certificate Waiving Exemption From Taxes Under the Federal Insurance Contributions Act, is filed under paragraph (a)(1) of this section, or an organization is deemed to have filed a waiver certificate under paragraph (a)(2) of this section.

(1) *Formal election of coverage—Filing of form SS-15, Certificate Waiving Exemption From Taxes Under the Federal Insurance Contributions Act, and form SS-15a, List of Concurring Employees.* Form SS-15 and form SS-15a, filed under section 3121(k) of the Internal Revenue Code of 1954, have the effect of covering services performed by an employee:

(i) Whose signature appears on the form SS-15a, List of Concurring Employees (or a supplemental list); or

(ii) Who became an employee of the organization after the calendar quarter in which the form SS-15 was filed; or

(iii) Who became a member of a group of employees as described in section 3121(k)(1)(E) of the Internal Revenue Code of 1954 after the calendar quarter in which the form SS-15 was filed with respect to that group.

(2) *No certificate filed—deemed filing of waiver certificate.* Under certain conditions, an organization which has never filed a waiver certificate but has reported wages and paid social security taxes for its employees shall be deemed: (i) To have filed a waiver certificate waiving its social security tax exemption, and (ii) to have elected to cover the services of its employees under social security. Each employee listed on the filed wage reports shall be deemed to have concurred in the filing of the certificate and/or having his or her services covered. The authority and conditions with respect to the deemed filing of a waiver certificate and employee coverage for social security purposes are found in section 3121(k) of the Internal Revenue Code of 1954.

(3) *Coverage of individual employees.* In order for the remuneration for services performed by employees of organizations described in paragraph (a)(2) of this section to be considered wages from covered employment as defined in § 404.1026(a)(2), the employee (or his or her representative) must:

(i) Request that the remuneration be considered wages from covered employment when a deemed filed certificate is not effective for certain periods because of section 3121(k)(4)(C) of the Internal Revenue Code; or

(ii) Request that the remuneration be considered wages from covered employment when, for periods between March 31, 1972, and the date a deemed filed certificate is effective, the remuneration was reported for social security purposes and the employer has obtained a refund or credit for the social security taxes paid on that remuneration.

The request must be in writing and filed with either the Social Security Administration or the Internal Revenue Service on or before April 15, 1980. The written request should identify the employer or employers, the periods in which the services were performed and the approximate amount of wages paid in these periods. The employee must show that he has paid to the Internal Revenue Service his share of the social security taxes due on his wages or that he has made arrangements with the Internal Revenue Service to make the required payment.

[FR Doc. 78-27794 Filed 9-29-78; 8:45 am]

[8320-01]

Title 38—Pensions, Bonuses and Veterans' Relief

CHAPTER I—VETERANS ADMINISTRATION

PART 3—ADJUDICATION

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

RATING CONSIDERATIONS RELATIVE TO SPECIFIC DISEASES

AGENCY: Veterans Administration.

ACTION: Final regulations.

SUMMARY: The Veterans Administration is amending its regulations governing service connection for tuberculosis. The law currently provides that active tuberculosis developing within 3 years from the date of separation from active service may be presumptively service connected. The Veterans Administration, by regulation, added additional presumptive periods of 6 months for minimally advanced tuberculosis, 9 months for moderately advanced tuberculosis, and 12 months for far advanced tuberculosis. This was done on the advice of medical authorities on the theory that those degrees of advancement indicated preexistence of the disease by the specified periods. This theory is no longer tenable. "Diagnostic Standards and Classification of Tuberculosis and Other Mycobacterial Diseases" published by the American Lung Association has discontinued classification of tuberculosis as minimal, moderate, or far advanced and such classifications are no longer taught or used in modern medical practice. The major effect of this change is to remove the regulatory presumptions of 6, 9, and 12 months which are in addition to the 3-year statutory presumption. This brings the regulation into accord with the statute and current medical standards.

EFFECTIVE DATE: September 19, 1978.

FOR FURTHER INFORMATION CONTACT:

T. H. Spindle, 202-389-3005.

SUPPLEMENTARY INFORMATION: On pages 28824-28826 of the FEDERAL REGISTER of July 3, 1978, there was published a notice of proposed regulatory development to amend §§ 3.307, 3.370, 3.371, 3.374, 3.375, and 3.378 relative to abrogating the presumptions that tuberculosis manifest during the fourth year after service may be considered to be service connected.

Interested persons were given 30 days to submit comments, suggestions, or objections to the proposed regulation changes. Four comments were received. The first commentator favored retaining the 4-year presumptive period but offered no evidence or argument to support her position. The second commentator wanted the "change in time limit to also be related to all other diseases * * *" but did not explain what was meant by that comment. The third commentator wanted the 4-year presumptive period extended to 10 years but cited no medical evidence to warrant adoption of his proposal. The fourth commentator suggested that the Veterans Administration use Mantoux skin tests to determine whether a case of tuberculosis was service connected. The procedure would require that the test be given at induction and then 90 days after discharge. This suggestion cannot be adopted because the Mantoux skin test has not been universally given at induction and the Veterans Administration has no authority to require a former service member to report for such a test 90 days after discharge.

The proposed regulatory changes are adopted without amendment.

Approved: September 19, 1978.

By direction of the Administrator.

RUFUS H. WILSON,
Deputy Administrator.

1. In § 3.307, paragraph (c) is revised to read as follows:

§ 3.307 Presumptive service connection for chronic, tropical, or prisoner of war related disease; wartime and service on or after January 1, 1947.

* * * * *

(c) *Prohibition of certain presumptions.* No presumptions may be invoked on the basis of advancement of the disease when first definitely diagnosed for the purpose of showing its existence to a degree of 10 percent within the applicable period. This will not be interpreted as requiring that the disease be diagnosed in the presumptive period, but only that there be then shown by acceptable medical or lay evidence characteristic manifestations of the disease to the required degree, followed without unreasonable time lapse by definite diagnosis. Symptomatology shown in the prescribed period may have no particular significance when first observed, but in the light of subsequent developments it may gain considerable significance. Cases in which a chronic condition is shown to exist within a short time following the applicable presumptive period, but without evidence of manifestations within the period, should be developed to determine whether there was symptomatology which in retrospect may be identified and evaluated as manifestation of the chronic disease to the required 10-percent degree. The consideration of service incurrence provided for chronic diseases will not be interpreted to permit any presumption as to aggravation of a preservice disease or injury after discharge.

* * * * *

2. In § 3.370, paragraph (b) is revised to read as follows:

§ 3.370 Pulmonary tuberculosis shown by X-ray in active service.

* * * * *

(b) *Inactive disease.* Where the veteran was examined at time of entrance into active service but X-ray was not made, or if made, is not available and there was no notation or other evidence of active or inactive reinfection type pulmonary tuberculosis existing prior to such entrance, it will be assumed that the condition occurred during service and direct service connection will be in order for inactive pulmonary tuberculosis shown by X-ray evidence during service in the manner prescribed in paragraph (a) of this section, unless lesions are first shown so soon after entry on active service as to compel the conclusion, on the basis of sound medical principles, that they existed prior to entry on active service.

* * * * *

3. In § 3.371, paragraphs (a) and (c) are revised to read as follows:

§ 3.371 Presumptive service connection for tuberculous disease; wartime and service on or after January 1, 1947.

(a) *Pulmonary tuberculosis.* (1) Evidence of activity on comparative study of X-ray films showing pulmonary tuberculosis within the 3-year presumptive period provided by § 3.307(a)(3) will be taken as establishing service connection for active pulmonary tuberculosis subsequently diagnosed by approved methods but service connection and evaluation may be assigned only from the date of such diagnosis or other evidence of clinical activity.

(2) A notation of inactive tuberculosis of the reinfection type at induction or enlistment definitely prevents the grant of service connection under § 3.307 for active tuberculosis, regardless of the fact that it was shown within the appropriate presumptive period.

* * * * *

(c) *Tuberculous pleurisy and endobronchial tuberculosis.* Tuberculous pleurisy and endobronchial tuberculosis fall within the category of pulmonary tuberculosis for the purpose of service connection on a presumptive basis. Either will be held incurred in service when initially manifested within 36 months after the veteran's

separation from service as determined under § 3.307(a)(2).

* * * * *

4. In § 3.374, paragraph (d) is revoked.

§ 3.374 Effect of diagnosis of active tuberculosis.

* * * * *

(d) [Revoked]

5. In § 3.375, paragraph (a) is revised to read as follows:

§ 3.375 Determination of inactivity (complete arrest) in tuberculosis.

(a) *Pulmonary tuberculosis.* A veteran shown to have had pulmonary tuberculosis will be held to have reached a condition of "complete arrest" when a diagnosis of inactive is made.

* * * * *

6. Section 3.378 is revised to read as follows:

§ 3.378 Changes from activity in pulmonary tuberculosis pension cases.

A permanent and total disability rating in effect during hospitalization will not be discontinued before hospital discharge on the basis of a change in classification from active. At hospital discharge, the permanent and total rating will be discontinued unless (a) the medical evidence does not support a finding of complete arrest (§ 3.375), or (b) where complete arrest is shown but the medical authorities recommend that employment not be resumed or be resumed only for short hours (not more than 4 hours a day for a 5-day week). If either of the two aforementioned conditions is met, discontinuance will be deferred pending examination in 6 months. Although complete arrest may be established upon that examination, the permanent and total rating may be extended for a further period of 6 months provided the veteran's employment is limited to short hours as recommended by the medical authorities (not more than 4 hours a day for a 5-day week). Similar extensions may be granted under the same conditions at the end of 12 and 18 months periods. At the expiration of 24 months after hospitalization, the case will be considered under § 3.321(b) if continued short hours of employment is recommended or if other evidence warrants submission.

[FR Doc. 78-27288 Filed 9-29-78; 8:45 am]

[8320-01]

PART 4—SCHEDULE FOR RATING DISABILITIES

Updating the Schedule for Rating Disabilities

AGENCY: Veterans Administration.

ACTION: Final regulations.

SUMMARY: The Veterans Administration is amending its regulations to provide additional ratings for prosthetic implants to both the upper and lower extremities, to redefine the criteria for the 100-percent evaluation for rheumatic, hypertensive, and arterioschlerotic heart disease and to include a rating for coronary artery bypass. Also, the degrees of advancement of tuberculosis have been eliminated and instructions for continuing the total rating for malignant growths of the brain and spinal cord for 2 years following cessation of treatment have been included. These changes were made to conform to advances in medical science and surgery and to make the evaluations for the various heart diseases more realistic. Also additional charts for rating multiple losses of extremities, and loss of vision due to concentric contraction of field vision have been included. In compliance with Pub. L. 94-168, the "Metric Conversion Act of 1975," all measurements on the rating schedule have been metricated.

EFFECTIVE DATE: September 22, 1978. An amendment to appendix A, table of amendments and effective dates since 1946, is added to include effective dates.

FOR FURTHER INFORMATION CONTACT:

Robert C. Macomber, Chief, Rating Policy Staff, Compensation and Pension Service, Department of Veterans Benefits, Veterans Administration, 810 Vermont Avenue NW., Washington, D.C. 20420, 202-389-2635.

SUPPLEMENTARY INFORMATION: On pages 28826 through 28840 of the FEDERAL REGISTER of July 3, 1978, the Veterans Administration published a notice of proposed regulatory development to amend 38 CFR part 4 to include the additional material summarized above.

Interested persons were given 30 days in which to submit comments, suggestions, or objections regarding the proposed regulations. Three written comments were received. The first commentator requested information relative to the discontinuance of the various degrees of advancement of pulmonary tuberculosis, particularly how this change would affect claims pending adjudication. The inquirer was informed that all claims pending on the effective date of approval of the change will be adjudicated under the criteria in effect prior to the change. Only those claims received after the effective date of this change will be adjudicated under the new criteria; and, all claims adjudicated under the old criteria and properly on the rolls will remain undisturbed insofar as service connection is concerned. The second comment was complimentary in nature, took no exception to the proposed changes but objected to the fact that the Veterans Administration did not grant service connection for his several claimed disabilities. The third comment was received from the American Optometric Association requesting that the requirement of an ophthalmologist to conduct the muscle function test described in § 4.77 of the rating schedule be changed since optometrists are qualified to conduct that examination. We are in agreement with the suggestion and have changed ophthalmologist to examiner.

In conformity with Pub. L. 94-168, the "Metric Conversion Act of 1975," diagnostic code 7802 has been included to metricate the measurement of 1 square foot, which was inadvertently omitted in the proposed change of July 3, 1978. Also the heading immediately preceding codes 6701 through 6724 has been changed to read "Ratings for Pulmonary Tuberculosis Entitled on August 19, 1978," and put in abbreviated language to conform to a similar heading for pulmonary tuberculosis entitled after August 19, 1978.

Approved: September 22, 1978.

MAX CLELAND,

Administrator of Veterans Affairs.

1. Section 4.17 is revised to read as follows:

§ 4.17 Total disability ratings for pension based on unemployability and age of the individual.

All veterans who are basically eligible and who are unable to secure and follow a substantially gainful occupation by reason of disabilities which are likely to be permanent shall be rated as permanently and totally disabled. For the purpose of pension, the permanence of the percentage requirements of § 4.16 is a requisite. The percentage requirements, however, are reduced on the attainment of age 55 to a 60 percent rating for one or more disabilities, with no percentage requirements for any one disability. The requirement at age 60 through 64 will be a 50 percent rating for one or more disabilities. A veteran who has become 65 years of age or older, or became unemployable after age 65, is conclusively presumed to be permanently and totally disabled by statute; hence, rating action for this purpose is unnecessary. When the reduced percentage require-

ments are met, and the disabilities involved are of a permanent nature, a rating of permanent and total disability will be assigned if the veteran is found to be unable to secure and follow substantially gainful employment by reason of such disability. Prior employment or unemployment status is immaterial if in the judgment of the rating board the veteran's disabilities render him or her unemployable. In making such determinations, the following guidelines will be used:

(a) Marginal employment, for example, as a self-employed farmer or other person, while employed in his or her own business, or at odd jobs or while employed at less than half the usual remuneration will not be considered incompatible with a determination of unemployability, if the restriction, as to securing or retaining better employment, is due to disability.

(b) Claims of all veterans who fail to meet the percentage standards but who meet the basic entitlement criteria and are unemployable, will be referred by the rating board to the Adjudication Officer under § 3.321(b)(2) of this chapter.

§ 4.17a [Amended]

2. Section 4.17a is amended by deleting the sentence following paragraph (b).

§ 4.18 [Amended]

3. Section 4.18 is amended by deleting the word "cases" and inserting the word "claims" in the third sentence.

§ 4.19 [Amended]

4. Section 4.19 is amended by adding a semicolon after the word "disability" and deleting the word "cases" and inserting the word "claims" in the first sentence.

5. Section 4.53 is revised to read as follows:

§ 4.53 Muscle patterns.

Every movement calls into action the muscles necessary for that movement constituting a definite muscle pattern which is invariable for that movement. None of the muscles can be left out of action in performing the movement nor can any other muscle be called into play to execute the movement. Every movement requires full efficiency, the full complement of muscles included in its specific pattern. If one, or more, of the group is injured or destroyed the efficiency of the movement is permanently impaired. It is the distortion of the intricate mechanism of muscle structures, the intermuscular binding, the obliteration of fascial planes and welding of aponeurotic sheaths that results in permanent residual disabilities. The typical symptoms associated with severe muscle injuries are: Fatigue rapidly coming on after moderate use of the affected muscle groups; pain occurring shortly after the incidence of fatigue sensations, the type of pain being that which is characteristic of and normally associated with prolonged severe muscular effort (fatigue-pain); inability to make certain movements with the same degree of strength as before injury; uncertainty in making certain movements, particularly when made quickly. When the subjective evidence in an individual claim appears as the natural result of a pathological condition shown objectively, and particularly when consistent from time of first examination, i.e., when obviously not based upon information given to the claimant by previous examiners or relayed to him or her from the claims file, it will be given due weight.

§ 4.54 [Amended]

6. Section 4.54 is amended by adding the words "of disability" after the word "type" in the first, fifth, and sixth sentences.

7. In § 4.55, paragraph (b) is revised to read as follows:

§ 4.55 Principles of combined ratings.

* * * * *

(b) Two or more severe muscle injuries affecting the motion (particularly strength of motion) about a single joint may be combined but not in combination receive more than the rating for ankylosis of that joint at an "intermediate" angle, except that with severe injuries involving the shoulder girdle and arm, the combination may not exceed the rating for unfavorable ankylosis of the scapulohumeral joint. Claims of an unusually severe degree of disability involving the shoulder girdle and arm or the pelvic girdle and thigh muscles wherein the evaluation under the criteria in this section appears inadequate may be submitted to the Director, Compensation and Pension Service for consideration under § 3.321(b)(1) of this chapter.

* * * * *

8. Section 4.56 is amended as follows:

(a) By amending "History and complaint" in paragraph (c) as set forth below:

(b) By deleting the word "Faradism" and inserting "faradic current" in the sixth sentence of "Objective findings" in paragraph (d).

§ 4.56 Factors to be considered in the evaluation of disabilities residual to healed wounds involving muscle groups due to gunshot or other trauma.

* * * * *

(c) *Moderately severe disability of muscles.*

* * * * * *

History and complaint. Service department record or other sufficient evidence showing hospitalization for a prolonged period in service for treatment of wound of severe grade. Record in the file of consistent complaint of cardinal symptoms of muscle wounds. Evidence of unemployability because of inability to keep up with work requirements is to be considered, if present.

* * * * *

§ 4.60 [Revoked]

9. Section 4.60 is revoked.

§ 4.63 [Amended]

10. Section 4.63 is amended by adding "(8.9 cms.)" after "3½ inches" in paragraph (a).

§ 4.71 [Amended]

11. Section 4.71 is amended by adding "(See Plate III)" after the word "joints" and deleting the word "inches" and inserting "centimeters" in the last sentence.

12. In § 4.71a, the following revisions and additions are made to read as follows:

(a) Diagnostic code 5003 is revised;

(b) A new center title, Prosthetic Implants, and diagnostic codes 5051, 5052, 5053, 5054, 5055, and 5056 are added;

(c) Following diagnostic code 5111, a new Table II is added;

(d) Under "Amputations: Lower Extremity," diagnostic code 5166 is revised and diagnostic code 5174 is revoked;

(e) Under "The Elbow and Forearm," diagnostic codes 5211 and 5212 are revised;

(f) Under "The Wrist," the NOTE following diagnostic code 5214 is revised;

(g) Under "Multiple Fingers: Unfavorable Ankylosis", subparagraph (3) preceding diagnostic code 5216 and paragraph (b) following diagnostic code 5219 are revised;

(h) Under "Multiple Fingers: Favorable Ankylosis", subparagraph (3) preceding diagnostic code 5220 and paragraph (a) following diagnostic code 5223 are revised;

(i) Under "Ankylosis of Individual Fingers", the NOTE following diagnostic code 5227 is revised;

(j) Under "The Knee and Leg", diagnostic code 5264 is revoked; and

(k) Under "Shortening of the Lower Extremity", diagnostic code 5275 is revised.

§ 4.71a Schedule of ratings—musculoskeletal system.

ACUTE, SUBACUTE, OR CHRONIC DISEASES

* * * * *

	Rating
5003 Arthritis, degenerative (hypertrophic or osteoarthritis).	
Degenerative arthritis established by X-ray findings will be rated on the basis of limitation of motion under the appropriate diagnostic codes for the specific joint or joints involved (DC 5200 etc.). When however, the limitation of motion of the specific joint or joints involved is noncompensable under the appropriate diagnostic codes, a rating of 10 pct is for application for each such major joint or group of minor joints affected by limitation of motion, to be combined, not added under diagnostic code 5003. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion. In the absence of limitation of motion, rate as below:	
With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups, with occasional incapacitating exacerbations	20
With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups	10

NOTE (1). The 20 pct and 10 pct ratings based on X-ray findings, above, will not be combined with ratings based on limitation of motion.

NOTE (2). The 20 pct and 10 pct ratings based on X-ray findings, above, will not be utilized in rating conditions listed under diagnostic codes 5013 to 5024, inclusive.

* * * * *

PROSTHETIC IMPLANTS

	Rating	
	Major	Minor
5051 Shoulder replacement (prosthesis).		
Prosthetic replacement of the shoulder joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe, painful motion or weakness in the affected extremity	60	50
With intermediate degrees of residual weakness, pain or limitation of motion, rate by analogy to diagnostic codes 5200 and 5203		
Minimum rating	30	20
5052 Elbow replacement (prosthesis).		
Prosthetic replacement of the elbow joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe painful motion or weakness in the affected extremity	50	40

PROSTHETIC IMPLANTS—Continued

	Rating	
	Major	Minor
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5205 through 5208.		
Minimum evaluation	30	20
5053 Wrist replacement (prosthesis).		
Prosthetic replacement of wrist joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe, painful motion or weakness in the affected extremity	40	30
With intermediate degrees of residual weakness, pain or limitation of motion, rate by analogy to diagnostic code 5214.		
Minimum rating	20	20

NOTE.—The 100 pct rating for 1 year following implantation of prosthesis will commence after initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.

	Rating
5054 Hip replacement (prosthesis).	
Prosthetic replacement of the head of the femur or of the acetabulum:	
For 1 year following implantation of prosthesis	100
Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches	[1]90
Markedly severe residual weakness, pain or limitation of motion following implantation of prosthesis	70
Moderately severe residuals of weakness, pain or limitation of motion	50
Minimum rating	30
5055 Knee replacement (prosthesis).	
Prosthetic replacement of knee joint:	
For 1 year following implantation of prosthesis	100
With chronic residuals consisting of severe painful motion or weakness in the affected extremity	60
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5256, 5261, or 5262.	
Minimum rating	30
5056 Ankle replacement (prosthesis).	
Prosthetic replacement of ankle joint:	
For 1 year following implantation of prosthesis	100
With chronic residuals consisting of severe painful motion or weakness	40
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to 5270 or 5271.	
Minimum rating	20

[1] Also entitled to special monthly compensation.

NOTE (1). The 100 pct rating for 1 year following implantation of prosthesis will commence after initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.

NOTE (2). Special monthly compensation is assignable during the 100 pct rating period the earliest date permanent use of crutches is established.

TABLE II

RATINGS FOR MULTIPLE LOSSES OF EXTREMITIES
WITH DICTATOR'S RATING CODE AND VA REGULATION

IMPAIRMENT OF ONE EXTREMITY	IMPAIRMENT OF OTHER EXTREMITY					
	ANAT. LOSS OR LOSS OF USE BELOW ELBOW	ANAT. LOSS OR LOSS OF USE BELOW KNEE	ANAT. LOSS OR LOSS OF USE ABOVE ELBOW (PREVENTING USE OF PROSTHESIS)	ANAT. LOSS OR LOSS OF USE ABOVE KNEE (PREVENTING USE OF PROSTHESIS)	ANAT. LOSS NEAR SHOULDER PREVENTING USE OF PROSTHESIS	ANAT. LOSS NEAR HIP PREVENTING USE OF PROSTHESIS
ANAT. LOSS OR LOSS OF USE BELOW ELBOW	L CODES L-1 a b or c VAR 1350 (B) (38 CFR 3.350 (b))	L CODES L-1 g h i or j VAR 1350 (B) (38 CFR 3.350 (b))	L½ CODE L-2 a VAR 1350 (F)(1)(a) (38 CFR 3.350 (f)(1)(i))	L½ CODE L-2 b or d VAR 1350 (F)(1)(a) (38 CFR 3.350 (f)(1)(i))	M CODE M-3 a VAR 1350 (F)(1)(b) (38 CFR 3.350 (f)(1)(ii))	M CODE M-3 c VAR 1350 (F)(1)(b) (38 CFR 3.350 (f)(1)(ii))
ANAT. LOSS OR LOSS OF USE BELOW KNEE	L CODES L-1 g h i or j VAR 1350 (B) (38 CFR 3.350 (b))	L CODES L-1 d e or f VAR 1350 (B) (38 CFR 3.350 (b))	L½ CODE L-2 b or d VAR 1350 (F)(1)(a) (38 CFR 3.350 (f)(1)(i))	L½ CODE L-2 c VAR 1350 (F)(1)(a) (38 CFR 3.350 (f)(1)(i))	M CODE M-3 c VAR 1350 (F)(1)(b) (38 CFR 3.350 (f)(1)(ii))	M CODE M-3 b VAR 1350 (F)(1)(b) (38 CFR 3.350 (f)(1)(ii))
ANAT. LOSS OR LOSS OF USE ABOVE ELBOW (PREVENTING USE OF PROSTHESIS)	L½ CODE L-2 a VAR 1350 (F)(1)(a) (38 CFR 3.350 (f)(1)(i))	L½ CODE L-2 b or d VAR 1350 (F)(1)(a) (38 CFR 3.350 (f)(1)(i))	M CODE M-1 a VAR 1350 (C) (38 CFR 3.350 (c))	M CODE M-2 a or b VAR 1350 (C) (38 CFR 3.350 (c))	M½ CODE M-4 a VAR 1350 (F)(1)(c) (38 CFR 3.350 (f)(1)(iii))	M½ CODE M-4 c or d VAR 1350 (F)(1)(c) (38 CFR 3.350 (f)(1)(iii))
ANAT. LOSS OR LOSS OF USE ABOVE KNEE (PREVENTING USE OF PROSTHESIS)	L½ CODE L-2 b or d VAR 1350 (F)(1)(a) (38 CFR 3.350 (f)(1)(i))	L½ CODE L-2 c VAR 1350 (F)(1)(a) (38 CFR 3.350 (f)(1)(i))	M CODE M-2 a or b VAR 1350 (C) (38 CFR 3.350 (c))	M CODE M-1 b VAR 1350 (C) (38 CFR 3.350 (c))	M½ CODE M-4 c or d VAR 1350 (F)(1)(c) (38 CFR 3.350 (f)(1)(iii))	M½ CODE M-4 b VAR 1350 (F)(1)(c) (38 CFR 3.350 (f)(1)(iii))
ANAT. LOSS NEAR SHOULDER PREVENTING USE OF PROSTHESIS	M CODE M-3 a VAR 1350 (F)(1)(b) (38 CFR 3.350 (f)(1)(ii))	M CODE M-3 c VAR 1350 (F)(1)(b) (38 CFR 3.350 (f)(1)(ii))	M½ CODE M-4 a VAR 1350 (F)(1)(c) (38 CFR 3.350 (f)(1)(iii))	M½ CODE M-4 c or d VAR 1350 (F)(1)(c) (38 CFR 3.350 (f)(1)(iii))	N CODE N-1 VAR 1350 (D) (38 CFR 3.350 (d))	N CODE N-2 VAR 1350 (D) (38 CFR 3.350 (d))
ANAT. LOSS NEAR HIP PREVENTING USE OF PROSTHESIS	M CODE M-3 c VAR 1350 (F)(1)(b) (38 CFR 3.350 (f)(1)(ii))	M CODE M-3 b VAR 1350 (F)(1)(b) (38 CFR 3.350 (f)(1)(ii))	M½ CODE M-4 c or d VAR 1350 (F)(1)(c) (38 CFR 3.350 (f)(1)(iii))	M½ CODE M-4 b VAR 1350 (F)(1)(c) (38 CFR 3.350 (f)(1)(iii))	N CODE N-2 VAR 1350 (D) (38 CFR 3.350 (d))	N CODE N-1 VAR 1350 (D) (38 CFR 3.350 (d))

NOTE: Need for aid and attendance or permanently bedridden qualifies for subpar. L. Code L-1 k or L - VAR 1350 (B) (38 CFR 3.350 (b)). Paraplegia with loss of use of both lower extremities and loss of anal and bladder sphincter control qualifies for subpar. O. Code O-1 VAR 1350 (E) (38 CFR 3.350 (e)). Any of the above plus additional disabilities rated 50% or 100% qualifies for the next intermediate or full rate Code P-1 or Code P-2 respectively - VAR 1350 (F)(3) and (4) (38 CFR 3.350 (f)(3) and (4)).

AMPUTATIONS: LOWER EXTREMITY

* * * * *

	Rating
5166 Forefoot, amputation proximal to metatarsal bones (more than one-half of metatarsal loss)	[3]40

[3] Also entitled to special monthly compensation.

* * * * *

5174 [Revoked.]

THE ELBOW AND FOREARM

* * * * *

	Rating	
	Major	Minor
5211 Ulna, impairment of.		
Nonunion in upper half, with false movement:		
With loss of bone substance (1 inch (2.5 cms.) or more) and marked deformity	40	30
Without loss of bone substance or deformity	30	20
Nonunion in lower half	20	20
Malunion of, with bad alignment	10	10
5212 Radius, impairment of.		
Nonunion in lower half, with false movement:		
With loss of bone substance (1 inch (2.5 cms.) or more) and marked deformity	40	30
Without loss of bone substance or deformity	30	20
Nonunion in upper half	20	20
Malunion of, with bad alignment	10	10

* * * * *

THE WRIST

5214 Wrist, ankylosis of

* * * * *

NOTE.—Extremely unfavorable ankylosis will be rated as loss of use of hands under diagnostic code 5125.

* * * * *

MULTIPLE FINGERS: UNFAVORABLE ANKYLOSIS

* * * * *

(3) With only one joint of a digit ankylosed or limited in its motion, the determination will be made on the basis of whether motion is possible to within 2 inches (5.1 cms.) of the median transverse fold of the palm; when so possible, the rating will be for favorable ankylosis, otherwise unfavorable.

* * * * *

5219 * * *

(b) The ratings for codes 5216 through 5219 apply to unfavorable ankylosis or limited motion preventing flexion of tips to within 2 inches (5.1 cms.) of median transverse fold of the palm.

* * * * *

MULTIPLE FINGERS: FAVORABLE ANKYLOSIS

* * * * *

(3) With only one joint of a digit ankylosed or limited in its motion, the determination will be made on the basis of whether motion is possible to within 2 inches (5.1 cms.) of the median transverse fold of the palm; when so possible, the rating will be for favorable ankylosis, otherwise unfavorable.

* * * * *

5223 * * *

(a) The ratings for codes 5220 through 5223 apply to favorable ankylosis or limited motion permitting flexion of the tips to within 2 inches (5.1 cms.) of the transverse fold of the palm. Limitation of motion of less than 1 inch (2.5 cms.) in either direction is not considered disabling.

* * * * *

ANKYLOSIS OF INDIVIDUAL FINGERS

* * * * *

5227 * * *

NOTE.—Extremely unfavorable ankylosis will be rated as amputation under diagnostic codes 5152 through 5156.

THE KNEE AND LEG

* * * * *

5264 [Revoked]

SHORTENING OF THE LOWER EXTREMITY

	Rating
5275 Bones, of the lower extremity, shortening of:	
Over 4 inches (10.2 cms.)	[3]60
3½ to 4 inches (8.9 cms. to 10.2 cms.)	[3]50
3 to 3½ inches (7.6 cms. to 8.9 cms.)	40
2½ to 3 inches (6.4 cms. to 7.6 cms.)	30
2 to 2½ inches (5.1 cms. to 6.4 cms.)	20
1¼ to 2 inches (3.2 cms. to 5.1 cms.)	10

[3] Also entitled to special monthly compensation.

NOTE.—Measure both lower extremities from anterior superior spine of the ilium to the internal malleolus of the tibia. Not to be combined with other ratings for fracture or faulty union in the same extremity.

§ 4.73 [Amended]

13. Section 4.73 is amended as follows:

(a) The spelling of the word "Maissiat's" is corrected in diagnostic codes 5314 and 5317.

(b) The spelling of the word "iliacus" is corrected in diagnostic code 5316.

(c) Footnote 4 in diagnostic code 5317 is revised to read: "[4] If bilateral, see § 4.64 for consideration of special monthly compensation for loss of use of buttocks."

14. Section 4.76 is revised and § 4.76a, Table III, Figure 1 and example of computation of concentric contraction are added so that the revised and added material reads as follows:

§ 4.76 Examination of field vision.

Measurement of the visual field will be made when there is disease of the optic nerve or when otherwise indicated. The usual perimetric methods will be employed, using a standard perimeter and 3 mm. white test object. At least 16 meridians 22½ degrees apart will be charted for each eye. (See Figure 1. For the 8 principal meridians, see Table III.) The charts will be made a part of the report of examination. Not less than 2 recordings, and when possible, 3 will be made. The minimum limit for this function is established as a concentric central contraction of the visual field to 5°. This type of contraction of the visual field reduces the visual efficiency to zero. Where available the examination for form field should be supplemented, when indicated, by the use of target screen or campimeter. This last test is especially valuable in detection of scotoma.

§ 4.76a Computation of average concentric contraction of visual fields.

The extent of contraction of visual field in each eye is determined by recording the extent of the remaining visual fields in each of the eight 45 degree principal meridians. The number of degrees lost is determined at each meridian by subtracting the remaining degrees from the normal visual fields given in Table III. The degrees lost are then added together to determine total degrees lost. This is subtracted from 500. The difference represents the total remaining degrees of visual field. The difference divided by eight represents the average contraction for rating purposes.

TABLE III.—*Normal visual field extent at 8 principal meridians*

Meridian:	*Normal degrees*
Temporally	85
Down temporally	85
Down	65
Down nasally	50
Nasally	60
Up nasally	55
Up	45
Up temporally	55
Total	500

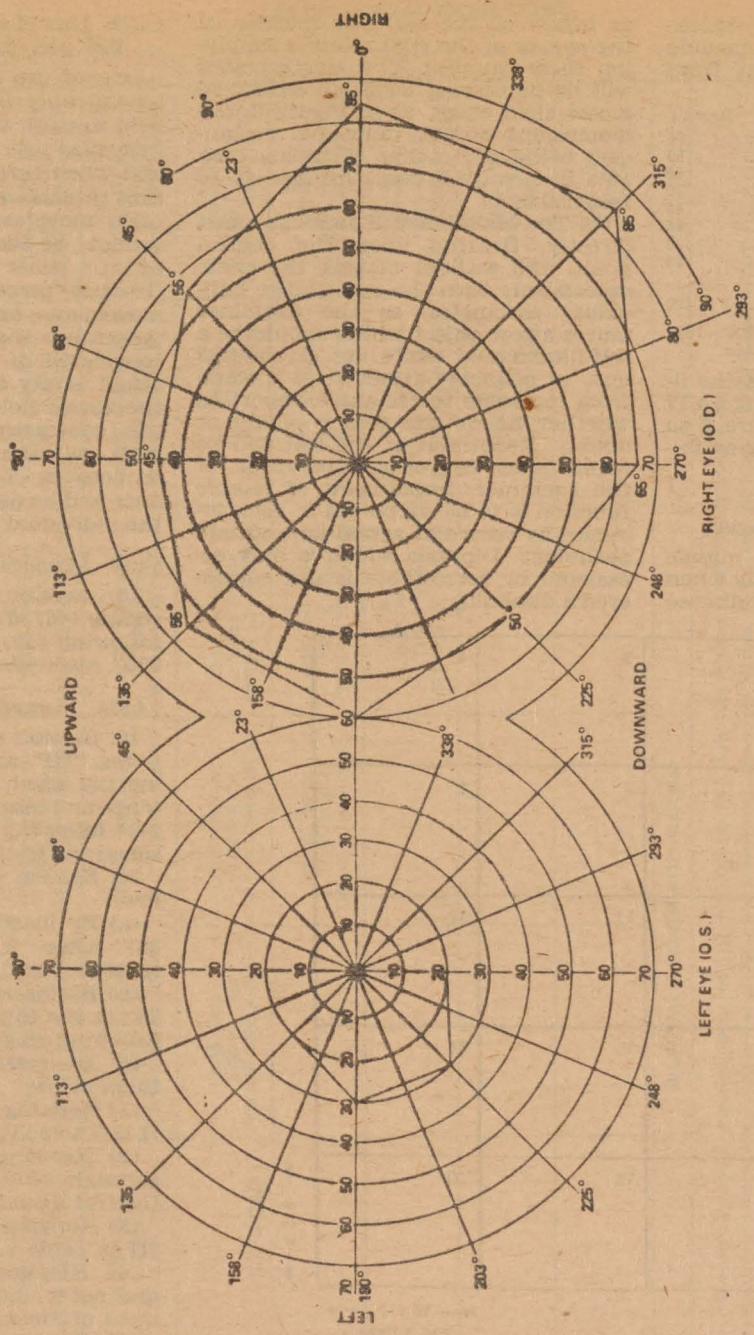


Figure 1. Chart of visual field showing normal field right eye and abnormal contraction visual field left eye.

Example of computation of concentric contraction under the schedule with abnormal findings taken from Figure 1.

Loss:	*Degrees*
Temporally	55
Down temporally	55
Down	45
Down nasally	30
Nasally	40
Up nasally	35
Up	25
Up temporally	35
Total loss	320

Remaining field 500° minus 320°=180°. 180°÷8=22½° average concentric contraction.

15. Section 4.77 is revised and the illustration immediately following § 4.77 is revised and designated Figure 2 so that the revised material reads as follows:

§ 4.77 Examination of muscle function.

(a) The measurement of muscle function will be undertaken only when the history and findings reflect disease or injury of the extrinsic muscles of the eye, or of the motor nerves supplying these muscles. The measurement will be performed using an industrial motor field chart, as in Figure 2, the dimensions of the individual rectangles being 8⅜ inches (21.3 cms.) by 10½ inches (26.7 cms.) for use at 10 feet (3.0 m.).

(b) The claimant will face the chart directly, fixating upon the central point, and without moving the head, successively turn the eyes to the individual rectangles, as the examiner moves a test object which should be a self-illuminated white dot of about 3 mm. in diameter attached to a wand from rectangle to rectangle, reporting whether he or she sees it singly or doubly. Repetition of the test will be made under the close supervision of the examiner. Impairment of muscle function is to be supported in each instance by record of actual appropriate pathology. Diplopia which is only occasional or correctable is not considered a disability.

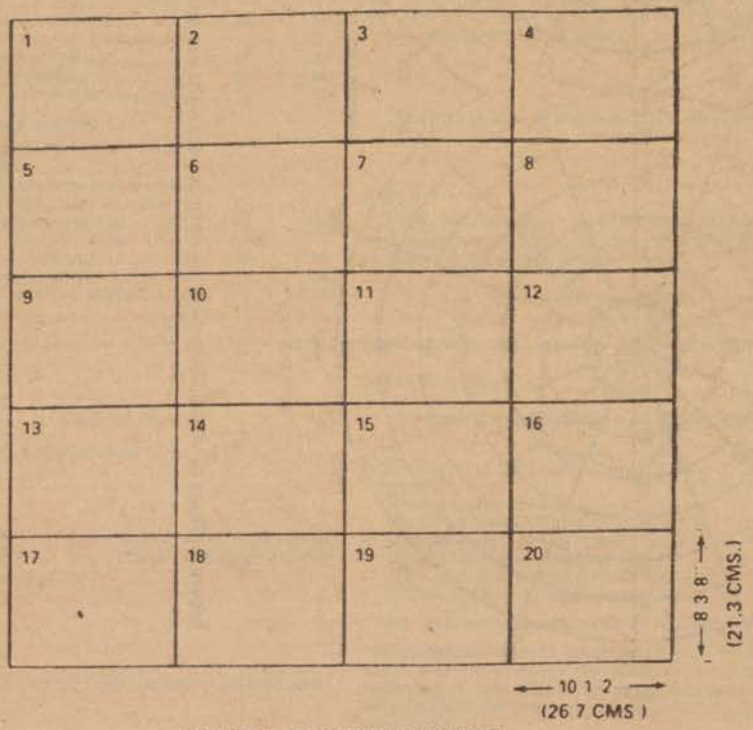


FIGURE 2 MOTOR FIELD CHART

§ 4.78 [Amended]

16. Section 4.78 is amended by deleting "38 U.S.C. 360" and inserting "§ 3.383(a) of this chapter" in the last line.

17. Section 4.79 is revised to read as follows:

§ 4.79 Loss of use of one eye, having only light perception.

Loss of use or blindness of one eye, having only light perception, will be held to exist when there is inability to recognize test letters at 1 foot (.30m.) and when further examination of the eyes reveals that perception of objects, hand movements or counting fingers cannot be accomplished at 3 feet (.91m.), lesser extents of visions, particularly perception of objects, hand movements, or counting fingers at distances less than 3 feet (.91 m.), being considered of negligible utility. With visual acuity 5/200 (1.5/60) or less or the visual field reduced to 5° concentric contraction, in either event in both eyes, the question of entitlement on account of regular aid and attendance will be determined on the facts in the individual case.

§ 4.83 [Amended]

18. Section 4.83 is amended by adding "(6/30)", "(6/21)" and "(6/30)" following "20/100", "20/70", and "20/100" respectively in the last sentence.

§ 4.83a [Amended]

19. Section 4.83a is amended by deleting "III" and inserting "V" following the word "table" in the first sentence and inserting "(1.5/60)" and "(6/21)" following "5/200" and "20/70" respectively in the second sentence.

20. Section 4.84a is amended as follows:

(a) By inserting "(1.5/60)" and "(6/30)" after "5/200" and "20/100" respectively in diagnostic code 6019.

(b) By inserting "(6/21)": after "20/70" in the fourth sentence of the note following diagnostic code 6029.

(c) By making the changes as set forth below:

(1) Revising and redesignating Table II as Table IV.

(2) Revising diagnostic codes 6061 through 6079 under "Impairment of Central Visual Acuity."

(3) Revising and redesignating Table III as Table V.

(4) Revising diagnostic code 6080 and notes under "Ratings for Impairment of Field Vision."

(5) Revising diagnostic code 6090 and notes under "ratings for Impairment of Muscle Function."

§ 4.84a Schedule of ratings — eye.

* * * * *

TABLE IV

TABLE FOR RATING BILATERAL BLINDNESS
WITH DICTATOR'S RATING CODE AND VA REGULATION

VISION ONE EYE	VISION OTHER EYE						
	5/200 (1.5/60) OR LESS	LIGHT PERCEPTION ONLY	NO LIGHT PERCEPTION PLUS PHTHISIS BULBI	NO LIGHT PERCEPTION PLUS DEFORMITY	NO LIGHT PERCEPTION PLUS DISFIGUREMENT	NO LIGHT PERCEPTIONS PLUS EVISCERATION	ANATOMICAL LOSS
5/200 (1.5/60) OR LESS	L* CODE LB 1 1350 (B)(2) (38 CFR 3.350 (b) (2))	L+½* CODE LB 2 1350 (F)(2)(a) (38 CFR 3.350 (f)(2)(i))	M CODE MB 2 b (1) 1350 (F)(2)(b) (38 CFR 3.350 (f)(2)(ii))	M CODE MB 2 b (3) 1350 (F)(2)(b) (38 CFR 3.350 (f)(2)(ii))	M CODE MB 2 b (4) 1350 (F)(2)(b) (38 CFR 3.350 (f)(2)(ii))	M CODE MB 2 b (2) 1350 (F)(2)(b) (38 CFR 3.350 (f)(2)(ii))	M CODE MB 2 (a) 1350 (F)(2)(b) (38 CFR 3.350 (f)(2)(ii))
LIGHT PERCEPTION ONLY		M CODE MB 1 a 1350 (C) (38 CFR 3.350 (c))	M+½ CODE MB 3 b (1) 1350 (F)(2)(c) (38 CFR 3.350 (f)(2)(iii))	M+½ CODE MB 3 b (3) 1350 (F)(2)(c) (38 CFR 3.350 (f)(2)(iii))	M+½ CODE MB 3 b (4) 1350 (F)(2)(c) (38 CFR 3.350 (f)(2)(iii))	M+ CODE MB 3 b (2) 1350 (F)(2)(c) (38 CFR 3.350 (f)(2)(iii))	M+½ CODE MB 3 a 1350 (F)(2)(c) (38 CFR 3.350 (f)(2)(iii))
NO LIGHT PERCEPTION PLUS PHTHISIS BULBI			N CODE NB 2 a 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))	N CODE NB 2 a&c 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))	N CODE NB 2 a&d 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))	N CODE NB 2 a&b 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))	N SEE NOTE 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))
NO LIGHT PERCEPTION PLUS DEFORMITY				N CODE NB 2 c 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))	N CODE NB 2 c&d 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))	N CODE NB 2 b&c 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))	N SEE NOTE 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))
NO LIGHT PERCEPTION PLUS DISFIGUREMENT					N CODE NB 2 d 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))	N CODE NB 2 b&d 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))	N SEE NOTE 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))
NO LIGHT PERCEPTION PLUS EVISCERATION						N CODE NB 2 d 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))	N SEE NOTE 1350 (F)(2)(d) (38 CFR 3.350 (f)(2)(iv))
ANATOMICAL LOSS							N CODE NB 1 1350 (D) (38 CFR 3.350 (d))
BILATERAL BLINDNESS WITH DEAFNESS							
Any of the above plus service connected total deafness one ear add ½ rate (limit O) code PB 1 VAR 1350 (F)(2)(e) 1 (38 CFR 3.350 (f)(2)(v)(a)). Any of the above plus bilateral deafness, 40% or more, at least one ear service connected add full step (limit O) code PB 2 VAR 1350 (F)(2)(e) (38 CFR 3.350(f)(2)(v)). Any of the above plus service connected deafness, 60% or more, at least one ear service connected qualifies for Subpar O code OB VAR 1350 (E) (38 CFR 3.350(e)).							

* With need for aid and attendant qualifies for Subpar M code MB-1-b VAR 1350 (C). (38CFR3.350 (c)).

NOTE No specific dictators rating code provided, code NB 2 should be modified to fit the conditions shown.

IMPAIRMENT OF CENTRAL VISUAL ACUITY

		Rating
6061	Anatomical loss both eyes	[5]100
6062	Blindness in both eyes having only light perception	[5]100
	Anatomical loss of 1 eye:	
6063	In the other eye 5/200 (1.5/60)	[5]100
6064	In the other eye 10/200 (3/60)	[5]90
6064	In the other eye 15/200 (4.5/60)	[5]80
6064	In the other eye 20/200 (6/60)	[5]70
6065	In the other eye 20/100 (6/30)	[5]60
6065	In the other eye 20/70 (6/21)	[5]60
6065	In the other eye 20/50 (6/15)	[5]50
6066	In the other eye 20/40 (6/12)	[5]40
	Blindness in 1 eye, having only light perception:	
6067	In the other eye 5/200 (1.5/60)	[5]100
6068	In the other eye 10/200 (3/60)	[5]90
6068	In the other eye 15/200 (4.5/60)	[5]80
6068	In the other eye 20/200 (6/60)	[5]70
6069	In the other eye 20/100 (6/30)	[5]60
6069	In the other eye 20/70 (6/21)	[5]50
6069	In the other eye 20/50 (6/15)	[5]40
6070	In the other eye 20/40 (6/12)	[5]30
	Vision in 1 eye 5/200 (1.5/60):	
6071	In the other eye 5/200 (1.5/60)	[5]100
6072	In the other eye 10/200 (3/60)	90
6072	In the other eye 15/200 (4.5/60)	80
6072	In the other eye 20/200 (6/60)	70
6073	In the other eye 20/100 (6/30)	60
6073	In the other eye 20/70 (6/21)	50
6073	In the other eye 20/50 (6/15)	40
6074	In the other eye 20/40 (6/12)	30
	Vision in 1 eye 10/200 (3/60):	
6075	In the other eye 10/200 (3/60)	90
6075	In the other eye 15/200 (4.5/60)	80
6075	In the other eye 20/200 (6/60)	70
6076	In the other eye 20/100 (6/30)	60
6076	In the other eye 20/70 (6/21)	50
6076	In the other eye 20/50 (6/15)	40
6077	In the other eye 20/40 (6/12)	30
	Vision in 1 eye 15/200 (4.5/60):	
6075	In the other eye 15/200 (4.5/60)	80
6075	In the other eye 20/200 (6/60)	70
6076	In the other eye 20/100 (6/30)	60
6076	In the other eye 20/70 (6/21)	40
6076	In the other eye 20/50 (6/15)	30
6077	In the other eye 20/40 (6/12)	20
	Vision in 1 eye 20/200 (6/60):	
6075	In the other eye 20/200 (6/60)	70
6076	In the other eye 20/100 (6/30)	60
6076	In the other eye 20/70 (6/21)	40
6076	In the other eye 20/50 (6/15)	30
6077	In the other eye 20/40 (6/12)	20
	Vision in 1 eye 20/100 (6/30):	
6078	In the other eye 20/100 (6/30)	50
6078	In the other eye 20/70 (6/21)	30
6078	In the other eye 20/50 (6/15)	20
6079	In the other eye 20/40 (6/12)	10
	Vision in 1 eye 20/70 (6/21):	
6078	In the other eye 20/70 (6/21)	30
6078	In the other eye 20/50 (6/15)	20
6079	In the other eye 20/40 (6/12)	10
	Vision in 1 eye 20/50 (6/15):	
6078	In the other eye 20/50 (6/15)	10
6079	In the other eye 20/40 (6/12)	10
	Vision in 1 eye 20/40 (6/12):	
	In the other eye 20/40 (6/12)	0

[5] Also entitled to special monthly compensation.
[6] Add 10% if artificial eye cannot be worn; also entitled to special monthly compensation.

TABLE V

RATINGS FOR CENTRAL VISUAL ACUITY IMPAIRMENT

(With Diagnostic Code)

VISION IN ONE EYE			VISION IN OTHER EYE						
	20/40 (6/12)	20/50 (6/15)	20/70 (6/21)	20/100 (6/30)	20/200 (6/60)	15/200 (4.5/60)	10/200 (3/60)	5/200 (1 5/60)	LIGHT PERCEPTION ONLY ANATOMICAL LOSS
20/40 (6/12)	0								
20/50 (6/15)	10 (6079)	10 (6078)							
20/70 (6/21)	10 (6079)	20 (6078)	(6078)						
20/100 (6/30)	10 (6079)	20 (6078)	30 (6078)	50 (6078)					
20/200 (6/60)	20 (6077)	30 (6076)	40 (6076)	60 (6076)	70 (6075)				
15/200 (4 5/60)	20 (6077)	30 (6076)	40 (6076)	60 (6076)	70 (6075)	80 (6075)			
10/200 (3/60)	30 (6077)	40 (6076)	50 (6076)	60 (6076)	70 (6075)	80 (6075)	90 (6075)		
5/200 (1 5/60)	30 (6074)	40 (6073)	50 (6073)	60 (6073)	70 (6072)	80 (6072)	90 (6072)	[5]100 (6071)	
LIGHT PERCEPTION ONLY	[5]30 (6070)	[5]40 (6069)	[5]50 (6069)	[5]60 (6069)	[5]70 (6068)	[5]80 (6068)	[5]90 (6068)	[5]100 (6067)	[5]100 (6062)
ANATOMICAL LOSS OF ONE EYE	[6]40 (6066)	[6]50 (6065)	[6]60 (6065)	[6]60 (6065)	[6]70 (6064)	[6]80 (6064)	[6]90 (6064)	[5]100 (6063)	[5]100 (6061)

5 ALSO ENTITLED TO SPECIAL MONTHLY COMPENSATION

6 ADD 10 PERCENT IF ARTIFICIAL EYE CANNOT BE WORN ALSO ENTITLED TO SPECIAL MONTHLY COMPENSATION

RATINGS FOR IMPAIRMENT OF FIELD VISION

	Rating
6080 Field vision, impairment of:	
Homonymous hemianopsia	30
Field, visual, loss of temporal half:	
Bilateral	30
Unilateral	10
Or rate as 20/70 (6/21).	
Field, visual, loss of nasal half:	
Bilateral	20
Unilateral	10
Or rate as 20/50 (6/15).	
Field, visual, concentric contraction of:	
To 5°:	
Bilateral	100
Unilateral	30
Or rate as 5/200 (1.5/60).	
To 15° but not to 5°:	
Bilateral	70
Unilateral	20
Or rate as 20/200 (6/60)	
To 30° but not to 15°:	
Bilateral	50
Unilateral	10
Or rate as 20/100 (6/30)	
To 45° but not to 30°:	
Bilateral	30
Unilateral	10
Or rate as 20/70 (6/21):	
To 60° but not to 45°:	
Bilateral	20
Unilateral	10
Or rate as 20/50 (6/15).	

NOTE (1). Correct diagnosis reflecting disease or injury should be cited.

NOTE (2). Demonstrable pathology commensurate with the functional loss will be required. The concentric contraction ratings require contraction within the stated degrees, temporally; the nasal contraction may be less. The alternative ratings are to be employed when there is ratable defect of visual acuity, or a different impairment of the visual field in the other eye. Concentric contraction resulting from demonstrable pathology to 5 degrees or less will be considered on a parity with reduction of central visual acuity to 5/200 (1.5/60) or less for all purposes including entitlement under § 3.350(b)(2) of this chapter; not however, for the purpose of § 3.350(a) of this chapter. Entitlement on account of blindness requiring regular aid and attendance, § 3.350(c) of this chapter, will continue to be determined on the facts in the individual case.

* * * * *

RATINGS FOR IMPAIRMENT OF MUSCLE FUNCTION

	Rating
6090 Muscle function, ocular, impairment of:	
Producing diplopia in 19-20 rectangles. Rate as 5/200 (1.5/60).	
Producing diplopia in 17-18 rectangles. Rate as 10/200 (3/60).	
Producing diplopia in 14-16 rectangles. Rate as 15/200 (4.5/60).	
Producing diplopia in 12-13 rectangles. Rate as 20/200 (6/60).	
Producing diplopia in 9-11 rectangles... Rate as 20/100 (6/30).	
Producing diplopia in 6-8 rectangles..... Rate as 20/70 (6/21).	
Producing diplopia in 3-5 rectangles..... Rate as 20/50 (6/15).	
Producing diplopia in 0-2 rectangles..... Rate as 20/40 (6/12).	

NOTE (1). Correct diagnosis reflecting disease or injury should be cited.

NOTE (2). The ratings under diagnostic code 6090 are to be applied only to the poorer eye if both have ratable impairment of visual acuity or visual field; if only one eye has a ratable impairment, to that eye, but not in combination with any other eye rating.

* * * * *

21. Section 4.85 is revised to read as follows:

§ 4.85 Hearing impairments reported as a result of regional office or authorized audiology clinic examinations.

(a) If the results of controlled speech reception tests are used, the letter, A through F, designating the impairment in efficiency of each ear separately, will be ascertained from table VI. Table VI indicates six areas of impairment in efficiency. The literal designation of impaired efficiency (A, B, C, D, E, or F) will be determined by intersecting the horizontal row appropriate for percentage of discrimination and the vertical column appropriate to the speech reception decibel loss; thus, with a speech reception decibel loss of 62 db and a percentage discrimination of 72 percent the literal designation is "D"; if the speech reception decibel loss is 62 db and the percentage discrimination is 70 percent, the literal designation is "E".

(b) The percentage evaluation will be found from table VII by intersecting the horizontal row appropriate for the literal designation for the ear having the better hearing and the vertical column appropriate to the literal designation for the ear having the poorer hearing. For example, if the better ear has a literal designation of "B" and the poorer ear has a literal designation of "C", the percentage evaluation is in the second horizontal row from the bottom and in the third vertical column from the right and is 10 percent and the diagnostic code is 6293.

(c) If the results of pure tone audiometry are used, the equivalent literal designation for each ear, separately, will be ascertained from table VII, and the percentage evaluation determined in the same manner as for speech reception impairment in paragraph (b) of this section. For example, if the average pure tone decibel loss for the frequencies 500, 1,000 and 2,000 is not more than 57 db and there is no loss more than 70 db for any of these three frequencies, the equivalent literal designation is "C"; if in the other ear, the average is not more than 79 db, and there is no loss more than 90 db, the equivalent literal designation is "D". The percentage evaluation is therefore found in the horizontal row opposite "C", and in the vertical column under "D", and is 20 percent and the diagnostic code is 6289. Note that if in the first instance any of the 3 frequencies has a loss of more than 70 db, or in the second instance more than 90 db, the literal designation will be higher, i.e., further from "A" in the alphabetical series.

§ 4.86a [Amended]

22. Section 4.86a is amended.

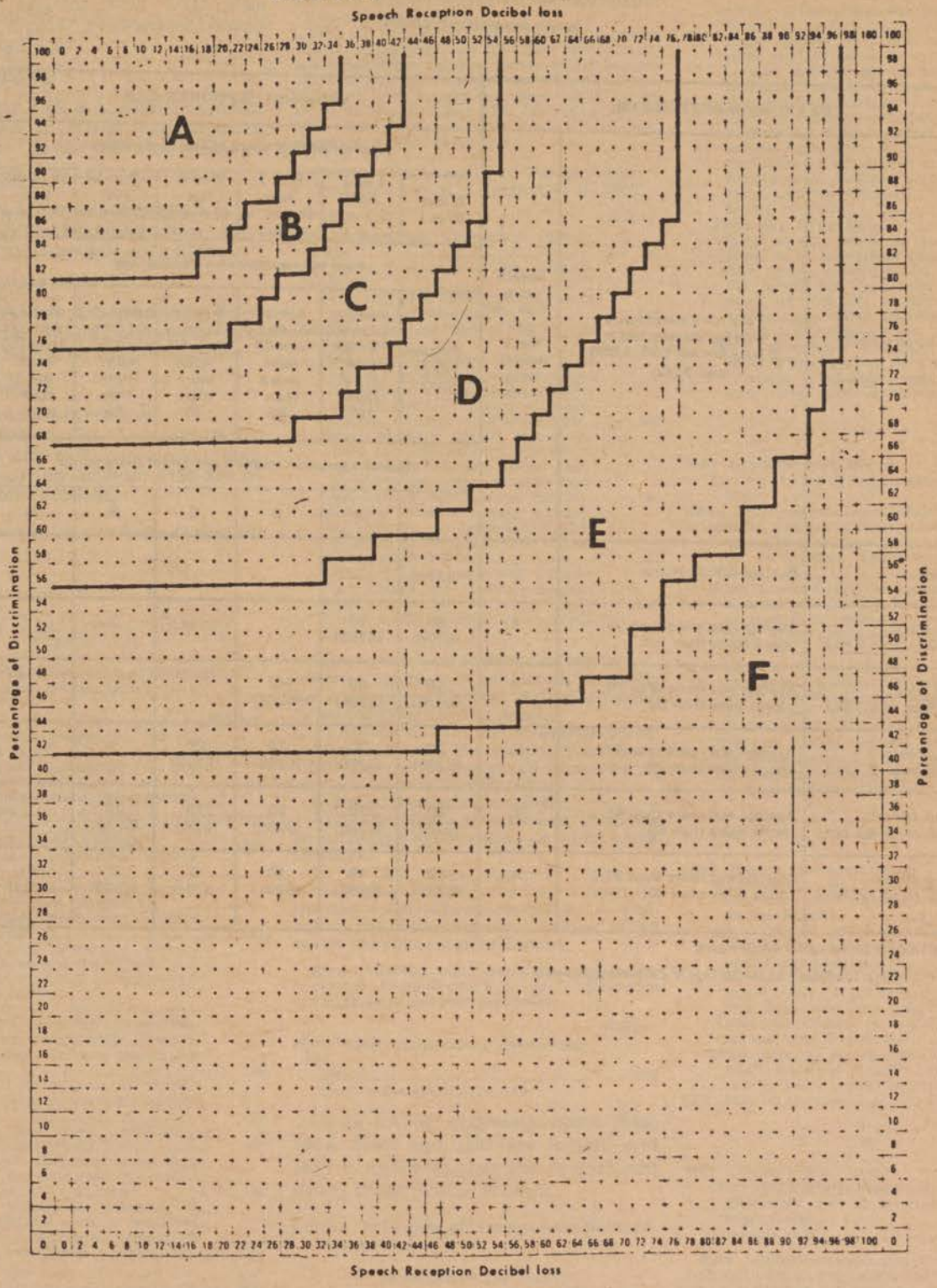
(a) By adding "(meters)" after the word "feet" in the first sentence;

(b) By adding "(metric)" after the word "footage" and deleting "V" and inserting "VII" in the third sentence.

23. Following § 4.87, Tables IV and V are revised and redesignated Tables VI and VII respectively as follows:

TABLE VI

Literal Designation of Hearing Impairment



(This chart showing the literal designation of hearing loss is based on the ANSI norm.)

TABLE VII

RATINGS FOR HEARING IMPAIRMENT

(with diagnostic code)

HEARING IN BETTER EAR			HEARING IN POORER EAR					
			Conversational voice in feet and meters					
			0 feet (0 m.)	1 to 4 feet (0.3 m. to 1.2 m.)	5 to 7 feet (1.5 m. to 2.1 m.)	8 to 9 feet (2.4 m. to 2.7 m.)	10 to 14 feet (3.0 m. to 4.3 m.)	15 to 40 feet (4.6 m. to 12.2 m.)
			Pure tone audiometry decibel loss					
Conversational	Pure tone audiometry average decible loss at 3 frequencies 500, 1,000 and 2,000	Speech reception impairment literal designation	Average 100 or more	Average not more than 99, none more than 105	Average not more than 79, none more than 90	Average not more than 57, none more than 70	Average not more than 45, none more than 55	Average not more than 37, none more than 45
			Speech reception impairment literal designation					
			F	E	D	C	B	A
0 feet (0 m.)	Average 100 or more	F	[7] 80 (6277)					
1 to 4 feet (0.3 m. to 1.2 m.)	Average not more than 99, none more than 105	E	60 (6278)	60 (6283)				
5 to 7 feet (1.5 m. to 2.1 m.)	Average not more than 79, none more than 90	D	40 (6279)	40 (6284)	40 (6288)			
8 to 9 feet (2.4 m. to 2.7 m.)	Average not more than 57, none more than 70	C	30 (6280)	30 (6285)	20 (6289)	20 (6292)		
10 to 14 feet (3.0 m. to 4.3 m.)	Average not more than 45, none more than 55	B	20 (6281)	20 (6286)	20 (6290)	10 (6293)	10 (6295)	
15 to 40 feet (4.6 m. to 12.2 m.)	Average not more than 37, none more than 45	A	10 (6282)	10 (6287)	10 (6291)	0 (6294)	0 (6296)	0 (6297)

This chart is based upon ANSI norm.

[7] ENTITLED TO SPECIAL MONTHLY COMPENSATION

§ 4.87a [Amended]

24. Section 4.87a is amended by deleting "V" and inserting "VII" after the word "Table" in diagnostic codes 6277 through 6297.

§ 4.88 [Amended]

25. Section 4.88 is amended by deleting "quinine or other" and inserting "medication" in the last sentence.

§ 4.88a [Amended]

26. Section 4.88a is amended by inserting "(Hansen's Disease)" after "Leprosy" in diagnostic code 6302.

§ 4.89 [Amended]

27. Section 4.89 is amended by deleting the word "NOTE" preceding "Pub. L. 90-493" following the section title.

§ 4.94 [Revoked]

28. section 4.94 is revoked.

29. In § 4.97 under "Diseases of the Lungs and Pleura-Tuberculosis," diagnostic codes 6701 through 6732 are revised to read as follows:

§ 4.97 Schedule of ratings—respiratory system.

* * * * *

DISEASES OF THE LUNGS AND PLEURA—TUBERCULOSIS

RATINGS FOR PULMONARY TUBERCULOSIS ENTITLED ON AUGUST 19, 1978

	Rating
6701 Tuberculosis, pulmonary, chronic, far advanced, active	
6702 Tuberculosis, pulmonary, chronic, moderately advanced, active	
6703 Tuberculosis, pulmonary, chronic, minimal, active	
6704 Tuberculosis, pulmonary, chronic, active, advancement unspecified	100
6721 Tuberculosis, pulmonary, chronic, far advanced, inactive	
6722 Tuberculosis, pulmonary, chronic, moderately advanced, inactive	
6723 Tuberculosis, pulmonary, chronic, minimal, inactive	
6724 Tuberculosis, pulmonary, chronic, inactive, advancement unspecified	
General Rating Formula for Inactive Pulmonary Tuberculosis:	
For 2 years after date of inactivity, following active pulmonary tuberculosis, which was clinically identified during active service, or subsequently	100
Thereafter, for 4 years, or in any event, to 6 years after date of inactivity	50
Thereafter, for 5 years, or to 11 years after date of inactivity	30
Following far advanced lesions diagnosed at any time while the disease process was active, minimum	30
Following moderately advanced lesions, provided there is continued disability, emphysema, dyspnea on exertion, impairment of health, etc	20
Otherwise	0

NOTE (1). The 100 pct rating under codes 6701 through 6724 is not subject to a requirement of precedent hospital treatment. It will be reduced to 50 percent for failure to submit to examination or to follow prescribed treatment upon report to that effect from the medical authorities. When a veteran is placed on the 100 pct rating for inactive tuberculosis, the medical authorities will be appropriately notified of the fact, and of the necessity under 38 U.S.C. 356 to notify the Adjudication Division in the event of failure to submit to examination or to follow prescribed treatment.

NOTE (2). The graduated 50 pct and 30 pct ratings and the permanent 30 pct and 20 pct ratings for inactive pulmonary tuberculosis are not to be combined with ratings for other respiratory disabilities. Following thoracoplasty the rating will be for removal of ribs combined with the rating for collapsed lung. Resection of ribs incident to thoracoplasty will be rated as removal.

RATINGS FOR PULMONARY TUBERCULOSIS INITIALLY ENTITLED AFTER AUG. 19, 1968

	Rating
6730 Tuberculosis, pulmonary, chronic, active	100
6731 Tuberculosis, pulmonary, chronic, inactive:	
For 1 year after date of attainment of inactivity of tuberculosis	100
Thereafter, rate residuals attributable to tuberculosis:	
Pronounced: Advanced fibrosis with severe ventilatory deficit manifested by dyspnea at rest, marked restriction of chest expansion, with pronounced impairment of bodily vigor	100
Severe; extensive fibrosis, severe dyspnea on slight exertion with corresponding ventilatory deficit confirmed by pulmonary function tests with marked impairment of health	60
Moderate; with considerable pulmonary fibrosis and moderate dyspnea on slight exertion, confirmed by pulmonary function tests	30
Definitely symptomatic with pulmonary fibrosis and moderate dyspnea on extended exertion	10
Healed lesions, minimal or no symptoms	0

Active pulmonary tuberculosis will be considered permanently and totally disabling for non-service-connected pension purposes in the following circumstances:

(a) Associated with active tuberculosis involving other than the respiratory system.

(b) With severe associated symptoms or with extensive cavity formation.

(c) Reactivated cases, generally.

(d) With definite advancement of lesions on successive examinations or while under treatment.

(e) Without retrogression of lesions or other evidence of material improvement at the end of 6 months hospitalization or without change of diagnosis from "active" at the end of 12 months hospitalization.

NOTE.—"Material improvement" means lessening or absence of clinical symptoms, and X-ray findings of a stationary or retrogressive lesion.

	Rating
6732 Pleurisy, tuberculous, active or inactive:	
Active	100
Inactive: See §§ 4.88b and 4.89.	

30. In § 4.104, diagnostic codes 7000, 7004, 7005, and 7007 are revised and 7017 is added so that the revised and added codes read as follows:

§ 4.104 Schedule of ratings—cardiovascular system.

DISEASES OF THE HEART

	Rating
7000 Rheumatic heart disease:	
As active disease and, with ascertainable cardiac manifestation, for a period of 6 months	100
Inactive:	
Definite enlargement of the heart confirmed by roentgenogram and clinically; dyspnea on slight exertion; rales, pretibial pitting at end of day or other definite signs of beginning congestive failure; more than sedentary employment is precluded	100
The heart definitely enlarged; severe dyspnea on exertion, elevation of systolic blood pressure, or such arrhythmias as paroxysmal auricular fibrillation or flutter or paroxysmal tachycardia; more than light manual labor is precluded	60
From the termination of an established service episode of rheumatic fever, or its subsequent recurrence, with cardiac manifestations, during the episode or recurrence, for 3 years, or diastolic murmur with characteristic EKG manifestations or definitely enlarged heart	30
With identifiable valvular lesion, slight, if any dyspnea, the heart not enlarged; following established active rheumatic heart disease	10

* * * * *

7004 Syphilitic heart disease:	
Rate as rheumatic heart disease, inactive.	
7005 Arteriosclerotic heart disease:	
During and for 6 months following acute illness from coronary occlusion or thrombosis, with circulatory shock, etc	100
After 6 months, with chronic residual findings of congestive heart failure or angina on moderate exertion or more than sedentary employment precluded	100
Following typical history of acute coronary occlusion or thrombosis as above, or with history of substantiated repeated anginal attacks, more than light manual labor not feasible	60
Following typical coronary occlusion or thrombosis, or with history of substantiated anginal attack, ordinary manual labor feasible	30

* * * * *

7007 Hypertensive heart disease:	
With definite signs of congestive failure, more than sedentary employment precluded	100
With marked enlargement of the heart, confirmed by roentgenogram, or the apex beat beyond midclavicular line, sustained disastolic hypertension, diastolic 120 or more, which may later have been reduced, dyspnea on exertion, more than light manual labor is precluded	60
With definite enlargement of the heart, sustained diastolic hypertension of 100 or more, moderate dyspnea on exertion	30

* * * * *

7017 Coronary artery bypass:	
For 1 year following bypass surgery	100
Thereafter, rate as arteriosclerotic heart disease.	
Minimum rating	30

NOTE.—Authentic myocardial insufficiency with arteriosclerosis may be substituted for occlusion.

NOTE.—The 100 pct rating for 1 year following bypass surgery will commence after the initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.

31. In § 4.118, diagnostic code 7801 and 7802 are revised to read as follows:

§ 4.118 Schedule of ratings—skin.

* * * * *

	Rating
7801 Scars, burns, third degree:	
Area or areas exceeding 1 square foot (0.1 m.²)	40
Area or areas exceeding one-half square foot (0.05 m.²)	30
Area or areas exceeding 12 square inches (77.4 cm.²)	20
Area or areas exceeding 6 square inches (38.7 cm.²)	10

NOTE (1). Actual third degree residual involvement required to the extent shown under 7801.

NOTE (2). Ratings for widely separated areas, as on two or more extremities or on anterior and posterior surfaces of extremities or trunk, will be separately rated and combined.

* * * * *

	Rating
7802 Scars, burns, second degree:	
Area or areas approximating 1 square foot (0.1 m.²)	10

NOTE.—See NOTE (2) under diagnostic code 7801.

* * * * *

32. In § 4.124a, following diagnostic codes 8002 and 8021 a note is added to read as follows:

§ 4.124a Schedule of ratings—neurological conditions and convulsive disorders.

* * * * *

	Rating
Brain, new growth of:	
8002 Malignant	100
NOTE.—The rating in code 8002 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. Minimum rating	30

* * * * *

Spinal cord, new growths of:	
8021 Malignant	100
NOTE.—The rating in code 8021 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. Minimum rating	30

* * * * *

33. In § 4.150, diagnostic codes 9900 and 9905 are revised to read as follows:

§ 4.150 Schedule of ratings—dental and oral conditions.

	Rating
9900 Maxilla or mandible, osteomyelitis of, chronic:	
Rate as osteomyelitis, chronic under diagnostic code 5000	

* * * * *

9905 Temporomandibular articulation, limited motion of:	
Motion limited to ¼ inch (6.3 mm.)	40
Motion limited to ½ inch (12.7 mm.)	20
Any definite limitation, interfering with mastication or speech	10

* * * * *

APPENDIX A.—TABLE OF AMENDMENTS AND EFFECTIVE DATES SINCE 1946

1. Section 4.71a is revised to read as follows:

Sec.
4.71a Diagnostic Code 5000—60 percent; February 1, 1962.
Diagnostic Code 5000 NOTE (2):
First three sentences; July 10, 1956.
Last sentence; July 6, 1950.
Diagnostic Code 5002—100 percent, 60 percent, 40 percent, 20 percent; March 1, 1963.
Diagnostic Code 5003; July 6, 1950.
Diagnostic Code 5012—NOTE; March 10, 1976.
In sentence following DC 5024: "except gout which will be rated under 5002"; March 1, 1963.
Diagnostic Code 5051;
Diagnostic Code 5052;
Diagnostic Code 5053;
Diagnostic Code 5054; September 9, 1975.
Diagnostic Code 5055; September 9, 1975.
Diagnostic Code 5056;
Diagnostic Code 5164—60 percent; June 9, 1952.
Diagnostic Code 5172; July 6, 1950.
Diagnostic Code 5173; June 9, 1952.
Diagnostic Code 5255 "or hip"; July 6, 1950.
Diagnostic Code 5257—Evaluation; July 6, 1950.
Diagnostic Code 5297—(Removal of one rib) "or resection of 2 or more"; August 23, 1948.
Diagnostic Code 5297—NOTE (2): Reference to lobectomy; pneumonectomy and graduated ratings; February 1, 1962.
Diagnostic Code 5298; August 23, 1948.
4.94 [Revoked]

2. Section 4.94 is revoked;

3. Section 4.104 is revised to read as follows:

4.104 Diagnostic Code 7000—30 percent; July 6, 1950.
Diagnostic Code 7000—100 percent inactive "with signs of congestive failure upon any exertion beyond rest in bed" revoked;
Diagnostic Code 7005—80 percent revoked;
Diagnostic Code 7007—80 percent revoked;
Diagnostic Code 7015—100 percent Evaluation. Criteria for All Evaluations and NOTES (1) and (2); September 9, 1975.
Diagnostic Code 7016; September 9, 1975.
Diagnostic Code 7017;
Diagnostic Code 7100—20 percent; July 6, 1950.
Diagnostic Code 7101 "or more"; September 1, 1960.
Diagnostic Code 7101—NOTE (2); September 9, 1975.
Diagnostic Code 7110—Criteria for 100 percent, NOTE and 60 percent and 20 percent Evaluations; September 9, 1975.
Diagnostic Code 7111—NOTE; September 9, 1975.
Diagnostic Codes 7114, 7115, 7116, and NOTE; June 9, 1952.
Diagnostic Code 7117 and NOTE; June 9, 1952.
NOTE following Diagnostic Code 7120; July 6, 1950.
Diagnostic Code 7121—100 percent Criterion and Evaluation and 60 percent Criterion; March 10, 1976. Criteria for 30 percent and 10 percent and NOTE; July 6, 1950.
Last sentence of NOTE following Diagnostic Code 7122; July 6, 1950.

4. Section 4.124a is revised to read as follows:

4.124a Diagnostic Code 8002, NOTE;
Diagnostic Code 8021, NOTE;
Diagnostic Code 8045; October 1, 1961.
Diagnostic Code 8046; October 1, 1961.
Diagnostic Code 8100—Evaluations; June 9, 1953.
Diagnostic Codes 8910 through 8914; October 1, 1961.
Diagnostic Codes 8910 through 8914 General Rating Formula—Criteria and Evaluations; September 9, 1975.

[FR Doc. 78-27287 Filed 9-29-78; 8:45 am]

[6560-01]

Title 40—Protection of Environment

CHAPTER I—ENVIRONMENTAL PROTECTION AGENCY

[FRL 980-1; PP 6F1782, 7F1984, 7F1986, and 7F1987/R171]

SUBCHAPTER E—PESTICIDE PROGRAMS

PART 180—TOLERANCES AND EXEMPTIONS FROM TOLERANCES FOR PESTICIDE CHEMICALS IN OR ON RAW AGRICULTURAL COMMODITIES

Methidathion

AGENCY: Office of Pesticide Programs, Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This rule establishes tolerances for residues of the insecticide methidathion on various raw agricultural commodities. The regulation was requested by Ciba-Geigy Corp. This rule establishes maximum permissible levels for residues of methidathion on various raw agricultural commodities.

EFFECTIVE DATE: October 2, 1978.

FOR FURTHER INFORMATION CONTACT:

Mr. James Rea, Product Manager (PM) 12, Registration Division (TS-767), Office of Pesticide Programs, EPA, 401 M Street SW., Washington D.C. 20460, 202-755-9315.

SUPPLEMENTARY INFORMATION: On July 6, 1976, August 23, 1977, and