Introduction to Musculoskeletal System VASRD Updates

The following is a glimpse of the changes to the musculoskeletal system rating schedule that are effective February 7, 2021. Diagnostic codes without changes have been omitted from this chart.

Code	Change Description

5001	Bones and joint, tuberculosis of, active or inactive:
	• Updated evaluation criteria to reflect 4.88c instead of 4.88b
	  • 100 –Active disease
	  • Inactive: See §§ 4.88c and 4.89

5002	Multi-joint arthritis (except post-traumatic and gout), 2 or more joints, as an active process
	• Retitled from "Arthritis rheumatoid (atrophic)"
	• Moved "as an active process" from criteria to title
	• Updated existing note and added two new notes:
	  • Note (1): Examples of conditions rated using this diagnostic code include, but are not limited to, rheumatoid arthritis, psoriatic arthritis, and spondyloarthropathies.
	  • Note (2): For chronic residuals, rate under diagnostic code 5003.
	  • Note (3): The ratings for the active process will not be combined with the residual ratings for limitation of motion, ankylosis, or diagnostic code 5003. Instead, assign the higher evaluation.

5003	Degenerative arthritis, other than post-traumatic • Retitled from "Arthritis, degenerative (hypertrophic or osteoarthritis)"

5009	Other specified forms of arthropathy (excluding gout)
	• Retitled from "Arthritis, other types"
	• Evaluation criteria replaced with two notes:
	  • Note (1): Other specified forms of arthropathy include, but are not limited to, Charcot neuropathic, hypertrophic, crystalline, and other autoimmune arthropathies.
	  • Note (2): With the types of arthritis, diagnostic codes 5004 through 5009, rate the acute phase under diagnostic code 5002; rate any chronic residuals under diagnostic code 5003.

5010	Post-traumatic arthritis • Retitled from "Arthritis, due to trauma, substantiated by X-ray findings" • Updated evaluation criteria: • Rate as limitation of motion, dislocation, or other specified instability under the affected joint. If there are 2 or more joints affected, each rating shall be combined in accordance with §4.25.
5011	Decompression illness • Retitled from "Bones, caisson disease of" • Updated evaluation criteria: • Rate manifestations under the appropriate diagnostic code within the affected body system, such as arthritis for musculoskeletal residuals; auditory system for vestibular residuals; respiratory system for pulmonary barotrauma residuals; and neurologic system for cerebrovascular accident residuals.
5012	• Bones, neoplasm, malignant, primary or secondary • Retitled from "Bones, new growths of, malignant" • Updated existing note:

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	• Note: The 100 percent rating will be continued for 1 year following the cessation of surgical, X-ray, antineoplastic chemotherapy or other prescribed therapeutic procedure. If there has been no local recurrence or metastases, rate based on residuals.
5013-5024	• Moved evaluation criteria to top of DC 5013 • Updated evaluation criteria: • Evaluate the diseases under diagnostic codes 5013 through 5024 as degenerative arthritis, based on limitation of motion of affected parts.
5013	Osteoporosis, residuals of • Retitled from "Osteoporosis, with joint manifestations"
5014	Osteomalacia, residuals of • Retitled from "Osteomalacia"
5015	Bones, neoplasm, benign • Retitled from "Bones, new growths of, benign"
5023	Heterotopic ossification • Retitled from "Myositis ossificans"
5024	Tenosynovitis, tendinitis, tendinosis or tendinopathy • Retitled from "Tenosynovitis"

5051-5056 Notes applicable to these DCs	• Existing notes updated and four notes added:
	  • Note (1): When an evaluation is assigned for joint resurfacing or the prosthetic replacement of a joint under diagnostic codes 5051-5056, an additional rating under §4.71a may not also be assigned for that joint, unless otherwise directed.
	  • Note (2): Only evaluate a revision procedure in the same manner as the original procedure under diagnostic codes 5051-5056 if all the original components are replaced.
	  • Note (3): The term "prosthetic replacement" in diagnostic codes 5051-5053 and 5055-5056 means a total replacement of the named joint. However, in DC 5054, "prosthetic replacement" means a total replacement of the head of the femur or of the acetabulum.
	  • Note (4): The 100 percent rating for 1 year following implantation of prosthesis will commence after initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.
	  • Note (5): The 100 percent rating for 4 months following implantation of prosthesis or resurfacing under DCs 5054 and 5055 will commence after the initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.
	  • Note (6): Special monthly compensation is assignable during the 100 percent rating period the earliest date permanent use of crutches is established.

5054	Hip, resurfacing or replacement (prosthesis) • Retitled from "Hip replacement (prosthesis)" • Convalescent period reduced from 13-months to 5-months for replacement, also applies to resurfacing • Evaluation criteria for resurfacing following convalescence added as note: • At the conclusion of the 100 percent evaluation period, evaluate resurfacing under diagnostic codes 5250 through 5255, there is no minimum evaluation for resurfacing.
5055	Knee, resurfacing or replacement (prosthesis) • Retitled from "Knee replacement (prosthesis)" • Convalescent period reduced from 13-months to 5-months for replacement, also applies to resurfacing • Evaluation criteria for resurfacing following convalescence added as note: • Note: At the conclusion of the 100 percent evaluation period, evaluate resurfacing under diagnostic codes 5256 through 5262; there is no minimum evaluation for resurfacing.

5120	Complete amputation, upper extremity
	• Retitled from "Disarticulation"
	• Updated evaluation criteria:
	  • 100 (major or minor) – Forequarter amputation (involving complete removal of the humerus along with any portion of the scapula, clavicle, and/or ribs)
	  • 90 (major or minor) – Disarticulation (involving complete removal of the humerus only)

5160	Complete amputation, lower extremity
	• Retitled from "Disarticulation, with loss of extrinsic pelvic girdle muscles"
	• Updated evaluation criteria:
	  • 100 – Trans-pelvic amputation (involving complete removal of the femur and intrinsic pelvic musculature along with any portion of the pelvic bones)
	  • 90 – Disarticulation (involving complete removal of the femur and intrinsic pelvic musculature only)
	• Note added:
	  • Note: Separately evaluate residuals involving other body systems (e.g., bowel impairment, bladder impairment) under the appropriate diagnostic code.

5170	Toes, all, amputation of, without metatarsal loss or transmetatarsal, amputation of, with up to half of metatarsal loss • Retitled from "Toes, all, amputation of, without metatarsal loss"

5201	Arm, limitation of motion of
	• Updated evaluation criteria:
	  • 40 major/30 minor – Flexion and/or abduction limited to 25° from side
	  • 30 major/20 minor – Midway between side and shoulder level (flexion and/or abduction limited to 45°)
	  • 20 major or minor – At shoulder level (flexion and/or abduction limited to 90°)

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5202	Humerus, other impairment of • Updated evaluation criteria for "Recurrent dislocation of at scapulohumeral joint" at 20 percent • 20 major or minor – With infrequent episodes, and guarding of movement only at shoulder level (flexion and/or abduction at 90°)
5242	Degenerative arthritis, degenerative disc disease other than intervertebral disc syndrome (also, see either 5003 or 5010) • Retitled from "Degenerative arthritis of the spine (see also diagnostic code 5003)"
5243	Intervertebral disc syndrome • Updated evaluation criteria: • Assign this diagnostic code only when there is disc herniation with compression and/or irritation of the adjacent nerve root; assign diagnostic code 5242 for all other diagnoses.

5244
NEW
	New diagnostic code for "Traumatic paralysis, complete"
	• Evaluation criteria:
	  • Paraplegia: Rate under diagnostic code 5110
	  • Quadriplegia: Rate separately under diagnostic codes 5109 and 5110 and combine in accordance with § 4.25
	  • Note: If traumatic paralysis does not cause loss of use of both hands or both feet, it is incomplete paralysis. Evaluate residuals of incomplete traumatic paralysis under the appropriate diagnostic code (e.g., § 4.124a, Diseases of the Peripheral Nerves).

5255	Femur, impairment of • Updated evaluation criteria for malunion of: • Evaluate under diagnostic codes 5256, 5257, 5260, or 5261 for the knee, or 5250-5254 for the hip, whichever results in the highest evaluation

5257	Knee, other impairment of
	• Updated evaluation criteria:
	  • Recurrent subluxation or instability
	  • 30 – Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes both an assistive device (e.g., cane(s), crutch(es), walker) and bracing for ambulation
	  • 20 – One of the following:
	  • a) Sprain, incomplete ligament tear, or repaired complete ligament tear causing persistent instability, and a medical provider prescribes a brace and/or assistive device (e.g., cane(s), crutch(es), walker) for ambulation
	  • b) Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes either an assistive device (e.g., cane(s), crutch(es), or a walker) or bracing for ambulation
	  • 10 – Sprain, incomplete ligament tear, or complete ligament tear (repaired, unrepaired, or failed repair) causing persistent instability, without a prescription from a medical provider for an assistive device (e.g., cane(s), crutch(es), walker) or bracing for ambulation.
	  • Patellar instability:
	  • 30 – A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription for a brace and either a cane or walker

	• 20 – A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription by a medical provider for one of the following: a brace, cane, or walker • 10 – A diagnosed condition involving the patellofemoral complex with recurrent instability (with or without history of surgical repair) that does not require a prescription from a medical provider for a brace, cane, or walker • Notes added: • Note (1): For patellar instability, the patellofemoral complex consists of the quadriceps tendon, the patella, and the patellar tendon. • Note (2): A surgical procedure that does not involve repair of one or more patellofemoral components that contribute to the underlying instability shall not qualify as surgical repair for patellar instability (including, but not limited to, arthroscopy to remove loose bodies and joint aspiration).
5262	Tibia and fibula, impairment of • Updated evaluation criteria for malunion of: • Evaluate under diagnostic codes 5256, 5257, 5260, or 5261 for the knee, or 5270 or 5271 for the ankle, whichever results in the highest evaluation. • Added evaluation criteria for medial tibial stress syndrome (MTSS), or shin splints • 30 – Requiring treatment for no less than 12 consecutive months, and unresponsive to surgery and either shoe orthotics or other conservative treatment, both lower extremities • 20 – Requiring treatment for no less than 12 consecutive months, and unresponsive to surgery and either shoe orthotics, other conservative treatment, one lower extremity • 10 – Requiring treatment for no less than 12 consecutive months, and unresponsive to either shoe orthotics or other conservative treatment, one or both lower extremities • 0 – Treatment less than 12 consecutive months, one or both lower extremities
5271	Ankle, limited motion of • Updated evaluation criteria: • 20 – Marked (less than 5 degrees dorsiflexion or less than 10 degrees plantar flexion) • 10 – Moderate (less than 15 degrees dorsiflexion or less than 30 degrees plantar flexion)
5269 NEW	New diagnostic code for “Plantar fasciitis” • Evaluation criteria: • 30 – No relief from both non-surgical and surgical treatment, bilateral • 20 – No relief from both non-surgical and surgical treatment, unilateral • 10 – Otherwise, unilateral or bilateral • Note (1): With actual loss of use of the foot, rate 40 percent. • Note (2): If a veteran has been recommended for surgical intervention, but is not a surgical candidate, evaluate under the 20 percent or 30 percent criteria, whichever is applicable.
§ 4.73	Muscle injuries • New note added to top of rating schedule (first note unchanged):

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

5330
NEW
	New diagnostic code for "Rhabdomyolysis, residuals of"
	• Evaluation criteria:
	  • Rate each affected muscle group separately and combine in accordance with § 4.25.
	  • Note: Separately evaluate any chronic renal complications within the appropriate body system.

5331 NEW	New diagnostic code for "Compartment syndrome" • Evaluation criteria: • Rate each affected muscle group separately and combine in accordance with § 4.25.

Diagnostic codes that were removed	5018, 5020, 5022

Important considerations –

- Changes to the Musculoskeletal System Rating Schedule are effective February 7, 2021.
- Consider whether historical or new criteria applies based on the date the claim was received, as well as your effective date for the issue.
- General effective date rules should be used, as the change in rating schedule is **NOT** considered liberalizing legislation (38 CFR 3.114 does not apply).
- Review the DBQ and other pertinent evidence. Consider potential entitlement to an earlier effective date (38 CFR 3.400(o)) when processing a claim for increase, but remember you cannot grant an evaluation based on the new schedule prior to February 7, 2021. Remember to make your decision based on the totality of the evidence.
- Historical rating schedule can be found in the e-CFR, accessed through the Knowledge Management Portal; Regulation Citator through Jobs Aids; Medical EPSS; or the e-CFR accessed through the Compensation Service Intranet.