DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AQ90

Schedule for Rating Disabilities: The Digestive System

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend the Schedule for Rating Disabilities (VASRD or rating schedule) that addresses the Digestive System. These changes add medical conditions not currently in the rating schedule, revise the rating criteria to reflect medical advances that have occurred since the last revision, clarify existing rating criteria, and update medical terminology. The proposed rule also reflects recommendations from the 2007 report of the National Academy of Sciences, Institute of Medicine, ''A 21st Century System for Evaluating Veterans for Disability Benefits.'' In fashioning this proposed rule, VA considered the most up-to-date medical knowledge and clinical practice of gastroenterology and hepatology specialties.

DATES: VA must receive comments on or before March 14, 2022.

ADDRESSES: Comments may be submitted through *www.regulations.gov* or mailed to, Compensation Service, 21C, 1800 G Street NW, Suite 644A, Washington, DC 20006. Comments should indicate that they are submitted in response to RIN 2900–AQ90—Schedule for Rating Disabilities: The Digestive System. Comments received will be available at *regulations.gov* for public viewing, inspection or copies.

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

SUPPLEMENTARY INFORMATION: Since the last update to the rating schedule section on digestive disorders, important advances in the science and medical care have occurred in the fields of nutrition, gastroenterology, and hepatology. Aware of the impact of these changes, the Veterans Benefits Administration (VBA) collaborated with the Veterans Health Administration (VHA) to update the VASRD. The VHA Office of Specialty Care provided VBA with access to leading authorities in their respective fields to help in this update.

VA proposes to revise 38 CFR 4.110–4.114 pertaining to the digestive system based on the most up-to-date understanding of gastrointestinal disorders and associated functional impairment. The Rome Foundation, a non-profit organization assisting in the diagnosis and treatment of functional gastrointestinal disorders, has introduced a system and classification of the various forms of gastrointestinal dysfunction, known as ''Rome IV.'' See Brian Lacy, ''Bowel Disorders,'' Gastroenterology, 150: 1393–1407 (2016).

In the context of the VASRD, VA has incorporated the concepts and diagnostic criteria outlined by Rome IV in several DCs covering functional digestive disorders, including the revised DC 7319 (Irritable Bowel Syndrome) and new DC 7356 (Gastrointestinal Dysmotility), as discussed below. VA proposes to use these criteria to rate certain other functional gastrointestinal conditions. VA discusses the specific amendments proposed in detail below.

Proposed Deletion of 38 CFR 4.110

Section 4.110 advises rating personnel to consider ulcer location (*e.g.,* gastric, duodenal, marginal) when providing graduated descriptions and evaluations of peptic ulcers. VA proposes to eliminate this instruction as obsolete, along with current DCs 7304, 7305, and 7306, all of which also classify ulcers by location. Modern medicine understands that most peptic ulcers are not due to location but either to infection (*Helicobacter pylori*), or the use of medications, such as aspirin or other non-steroidal anti-inflammatory drugs (NSAIDs). See E. Lew, ''Chapter 15: Peptic Ulcer Disease,'' in ''Current Diagnosis & Treatment: Gastroenterology, Hepatology, & Endoscopy'' (N.J. Greenberger, et al. eds., 2nd ed. 2012). *https://accessmedicine.mhmedical.com/content.aspx?sectionid=105183277&bookid=1621&Resultclick=2.* Thus, VA proposes to delete § 4.110.

Proposed Deletion of 38 CFR 4.111

The current § 4.111 discusses a subset of post-gastrectomy syndromes known as dumping syndrome. However, this section does not accurately reflect this specific clinical condition, nor does it offer specific guidance on rating it. Post-gastrectomy syndromes result from altered form and function of the stomach, which disrupts the stomach's reservoir capacity, mechanical digestion, and gastric emptying. Post-gastrectomy syndromes result in persistent gastrointestinal symptoms such as epigastric pain, nausea, vomiting, early satiety, bloating, diarrhea, or weight loss. Davis J.L., Ripley R.T., Postgastrectomy Syndromes and Nutritional Considerations Following Gastric Surgery, Surg Clin North Am. 2017 Apr;97(2):277–293. (last visited Oct 6, 2021) *https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S0039610916521951?returnurl=https:%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS0039610916521951%3Fshowall%3Dtrue&referrer=https:%2F%2Fwww.ncbi.nlm.nih.gov%2Fpubmed%2F28325187.*

As discussed in more detail below, VA proposes to rate dumping syndrome under new DC 7303, titled ''Chronic complications of upper gastrointestinal surgery,'' which includes operations, including bariatric surgery, performed on the esophagus, stomach, pancreas, and small intestine. Therefore, the material in § 4.111 is unnecessary and, accordingly, VA proposes to remove it.

Proposed Revisions to 38 CFR 4.112

When first published in 1964, § 4.112 discussed issues related to significant weight loss in general terms, referred to as ''appreciable weight loss.'' As part of a 2001 VASRD update, VA introduced and defined the terms ''substantial weight loss'' and ''baseline weight,'' as well as ''minor weight loss'' and ''inability to gain weight.'' 66 FR 29486 (May 31, 2001). VA incorporated these definitions in the VASRD to promote greater uniformity in decision making. Nevertheless, the weight loss requirements among conditions continue to vary. For instance, duodenal ulcer (DC 7305) currently requires weight loss productive of impairment of health, while ulcerative colitis (DC 7323) requires malnutrition.

In accordance with advancements in medicine and the current state of food and nutrition science, VA proposes to update the terms appearing in § 4.112. *See* Jane V. White et al., ''Consensus Statement of the Academy of Nutrition and Dietetics/American Society of Parenteral and Enteral Nutrition Regarding Adult Malnutrition (Undernutrition),'' 112 J. of Academy of Nutritional Dietetics 730–38 (2012). These changes would include modifications to the current definitions of ''substantial weight loss,'' ''minor weight loss,'' ''inability to gain weight,'' and ''baseline weight,'' and would provide alternative methods for obtaining a veteran's baseline weight when this information was not available in the records. All of these proposed changes are discussed in greater detail below.

Currently, 38 CFR 4.112 defines ''baseline weight'' as the average weight for the two-year period preceding the onset of the disease. Weight loss associated with digestive disease prior to military discharge is generally readily ascertainable from an individual's service medical records. However, weight loss associated with digestive disease after military discharge is often less clear, as weight in the military is not always available to physicians afterwards or the onset date of the disease is unknown. As such, VA proposes to redefine ''baseline weight'' (also known as ''usual body weight'') as either documented weight upon discharge from the armed service, if relevant, or the documented average weight for the two-year period preceding the onset of illness. If none of this information is available or is no longer relevant or applicable, VA proposes to estimate the ''baseline weight'' using the Hamwi formula for ideal body weight (IBW) or the Body Mass Index (BMI) table. VA acknowledges that the IBW might provide different results than the BMI tables, depending on the person's body frame and size. Bhumika Shah et al., ''Comparison of Ideal Body Weight Equations and Published Height-Weight Tables With Body Mass Index Tables for Healthy Adults in the United States,'' 21(3) Nutr. Clin. Pract. 312–19 (2006). VA therefore proposes using either method to provide the veteran with the most favorable or advantageous baseline weight under the situations above.

In addition to updating the definition of ''baseline weight,'' VA proposes to clarify the existing requirements regarding degrees of weight loss by including the term ''involuntary'' in reference to the ''weight loss,'' as well as indicating that the weight loss must alter other aspects of health. Moreover, using weight loss to evaluate digestive disorders assumes that it results in some degree of functional impairment. VA proposes to clarify this fact, as it is not clear from the current requirements.

VA also proposes to add the term ''undernutrition'' to § 4.112 to complete a comprehensive definition of weight loss severity. Nutritionists prefer the term ''undernutrition'' over ''malnutrition'' as the latter is more imprecise, denoting either over- or under-nutrition. VA intends to define ''undernutrition'' as a deficiency resulting from involuntary insufficient intake of one or more essential nutrients, or the inability of the body to absorb, utilize, or retain such nutrients. This deficiency results in the failure of the body to maintain normal organ functions and healthy tissues. Jane V. White et al., ''Consensus Statement of the Academy of Nutrition and Dietetics/ American Society of Parenteral and Enteral Nutrition Regarding Adult Malnutrition (Undernutrition),'' 112 J. of Academy of Nutritional Dietetics 730–38 (2012). Signs and symptoms of undernutrition may include edema, loss of subcutaneous tissue, peripheral neuropathy, muscle wasting, weakness, abdominal distention, ascites, and BMI below normal range. Id.

Studies indicate that poor nutritional status, to include severe undernutrition, can lead to severe impairment of function. See F. Romagnoni et al., ''Malnutrition disability evaluation,'' 199 Aging (Milano) 194–99 (June 2011). Severe protein undernutrition can impair multiple organ systems. Id. Meanwhile, gastrointestinal cancer can lead to severe malabsorption, gastrointestinal obstruction, bleeding, chronic diarrhea, and intractable vomiting. Id. Maureen B. Huhmann and David A. August, ''Nutrition in Gastrointestinal Cancer,'' in ''Nutrition and Gastrointestinal Disease,'' 158–68 (Mark DeLegge ed. 2008), *https://link.springer.com/content/pdf/10.1007%2F978-1-59745-320-2.pdf.* Physicians confirm undernutrition by measuring weight, BMI, and laboratory results, including serum albumin, transferrin, total lymphocyte count, and delayed hypersensitivity index. Id. General treatment consists of correcting fluid and electrolyte imbalances, as well as nutritional replenishment. Id.

As certain digestive conditions can lead to severe undernutrition and disability requiring nutritional support, VA proposes rating criteria that provide for higher levels of disability based, among other factors, on the type of nutritional support needed. As discussed in more detail below, VA intends to provide higher ratings for individuals whose digestive conditions may require total parenteral nutrition (TPN) or assisted enteral nutrition. VA proposes to define these terms to assist rating personnel in their application. In brief, TPN involves a special liquid nutritional mixture given into the blood through an intravenous catheter. See ''What Is Parenteral Nutrition?'' The American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) (2012), *http://www.nutritioncare.org/About_Clinical_Nutrition/What_Is_Parenteral_Nutrition/* (last accessed Aug. 29, 2019). Assisted enteral nutrition, on the other hand, involves a special liquid food mixture given through a tube, catheter, or a surgically made hole into the stomach or small bowel. Id. at *http://www.nutritioncare.org/About_Clinical_Nutrition/What_Is_Enteral_Nutrition/* (last accessed Aug. 29, 2019).

Finally, to more accurately describe § 4.112, VA proposes to retitle it as ''Weight loss and nutrition.'' VA intends to reorganize this section into four paragraphs. Paragraph (a) would discuss and define ''substantial weight loss'' and ''minor weight loss;'' paragraph (b) would define ''baseline weight;'' paragraph (c) would define ''undernutrition;'' and paragraph (d) would explain TPN and assisted enteral nutrition.

Proposed Revisions to 38 CFR 4.114

Multiple Ratings Under 38 CFR 4.114

Currently, § 4.114 states that ''[r]atings under diagnostic codes 7301 to 7329, inclusive, 7331, 7342, and 7345 to 7348 inclusive will not be combined with each other. A single evaluation will be assigned under the diagnostic code which reflects the predominant disability picture, with elevation to the next higher evaluation where the severity of the overall disability warrants such elevation.''

As discussed below, VA proposes to add a number of new codes to the digestive system, including gastroesophageal reflux disease (DC 7206), Barrett's esophagus (DC 7207), chronic complications of upper gastrointestinal surgery (DC 7303), liver abscess (DC 7350), pancreas transplant (DC 7352), celiac disease (DC 7355), gastrointestinal dysmotility syndrome (DC 7356), and post pancreatectomy syndrome (DC 7357). VA personnel currently rate these conditions analogous to DCs that VA excludes from combining. VA may combine the new DCs 7206 and 7207, like other esophageal conditions, with other digestive conditions. However, VA proposes to preclude rating personnel

from combining the remaining new codes.

Diagnostic Codes 7200 Through 7202

DC 7200 is currently titled, ''Mouth, injuries of.'' VA proposes to rename it to clarify that it applies to soft tissue injuries that do not include the tongue or lips. Current criteria remain unchanged.

DC 7201 pertains to injuries of the lips; current criteria direct rating personnel to evaluate as disfigurement of the face. VA proposes to specify that it may be rated as either disfigurement of the face (under DC 7800) or as a painful scar (under DC 7804). This is intented to provide greater specificity for raters, and permit a potentially more advantageous rating to claimants based on the facts found by the rater.

DC 7202 is currently titled ''Tongue, loss of whole or part.'' This disability usually occurs in association with treatment for oropharyngeal cancers. The current criteria are based on the amount of tongue removed and degree of speech impairment. However, the criteria pose limitations that prevent the accurate assessment of the disability in this part of the digestive system. First, only the amount of residual tongue and speech impairment are considered. The most salient digestive function, swallowing, is completely excluded. Additionally, the criteria do not account for advances in both medical treatment and rehabilitation that can restore some (if not all) of any swallowing or speech function. See D. Lin, M.D., et al. ''Long-term Functional Outcomes of Total Glossectomy With or Without Total Laryngectomy.'' JAMA Otolaryngol Head Neck Surg, vol 14(9): Pgs 797–803. 2015, *https://jamanetwork.com/journals/jamaotolaryngology/fullarticle/2429579* (last visited Oct. 06, 2021).

The proposed revisions are intended to use criteria specifically focused upon disabilities arising from this part of the digestive system. The criteria would be revised to address swallowing from an anatomic perspective, so the criteria elements must reflect this reality. The 30-percent evaluation level would involve intact oral nutritional intake with permanently impaired swallowing function without prescribed dietary modification (for example, impaired swallowing can present as increased swallowing time or frequent aspiration). The 60-percent evaluation level involves intact oral nutritional intake with permanently impaired swallowing function that requires prescribed dietary modification. The 100-percent evaluation level involves absent oral nutritional intake. VA proposes two notes to accompany this diagnostic code. The first note would direct rating personnel to consider the possibility of awarding special monthly compensation under 38 CFR 3.350. The second note would indicate only a medical provider can prescribe dietary modifications for the purposes of this diagnostic code.

Esophageal Conditions

The proposed changes to esophageal conditions described under proposed DCs 7203 through 7207 reflect the advances in treatment and improved understanding of esophageal disease. The proposed DCs contain more detailed rating criteria involving structural and motility disorders of the esophagus.

Several validated studies incorporate swallowing dysfunction (due to stricture) as one of the major manifestations of severity in esophageal disorders. M. Dakkak and J.R. Bennett, ''A New Dysphagia Score With Objective Validation,'' 14(2) J. of Clinical Gastroenterology 99–100 (1992). Thus, the proposed classification and ratings account for this dysfunction, while also taking into account changes in weight, the requirement for nutritional support, complications, and other interventional needs. The proposed higher rating levels are not exclusively based on esophageal stricture-dilatation, but offer alternative descriptors for a more comprehensive evaluation than the current VASRD.

Diagnostic Code 7203

VA proposes to revise the rating criteria for esophageal disorders that manifest as stricture, currently evaluated under DC 7203. Although these conditions have a wide spectrum of causation, the manifestations are similar. As noted above, several validated studies incorporate swallowing dysfunction (due to stricture) as one of the major manifestations of severity in esophageal disorders. Dakkak, supra at 99. Thus, the proposed classification and rating reflects this feature. VA proposes to add Note (3) that provides a non-exhaustive list of the numerous conditions to which DC 7203 applies. These conditions include but are not limited to esophagitis, mechanical or chemical; Mallory Weiss syndrome (bleeding due to tears at the junction of esophagus and stomach) due to caustic ingestion of alkali or acid; drug-induced or infectious esophagitis due to Candida, virus, or other organism; idiopathic eosinophilic or lymphocytic esophagitis; esophagitis, radiation-therapy induced; esophagitis due to peptic stricture; and any esophageal condition that requires treatment with sclerotherapy. See Norton J. Greenberger et al., ''Section 2: Esophageal Diseases'' in ''Current Diagnosis & Treatment: Gastroenterology, Hepatology, & Endoscopy'' (N.J. Greenberger, et al. eds., 2d ed. 2012).

The current criteria focus on the most common symptom, dysphagia (difficulty with swallowing). In its most disabling form, dysphagia can lead to nutritional deficiencies as well as malnutrition in general (either of which can result in loss of earnings capacity). One of the shortcomings with the current criteria is with the subjective nature of terminology such as ''moderate'' and ''severe.'' No concrete, objective definitions exist for these terms as they pertain to dysphagia.

VA proposes to revise the evaluation criteria using the manner and intensity of treatment intervention as the underlying framework. Additionally, VA would take into consideration that the vast majority of esophageal strictures result from peptic disease. See D. J. Patterson, et al. ''Natural History of Benign Esophageal Stricture Treated By Dilatation,'' Gastroenterology, vol 85, pg 347. 1983, *https://www.gastrojournal.org/article/0016-5085(83)90322-0/pdf* (last visited Oct. 06, 2021). While some strictures are managed over a relatively short period of time (*i.e.,* within 24 months), other cases require a long, protracted intervention period. When this occurs, VA would categorize these cases as either recurrent (defined as the inability to maintain target esophageal diameter beyond 4 weeks after the target diameter has been achieved) and refractory (defined as the inability to achieve target esophageal diameter despite receiving no fewer than 5 dilation sessions performed at 2-week intervals). See M. Kochman, et al. ''The refractory and recurrent esophageal stricture: A definition (letter to the editor),'' Gastrointestinal Endoscopy, vol 62(3) pgs 474–475, 2005, *https://www.giejournal.org/article/S0016-5107(05)01917-6/pdf* (last visited Oct. 06, 2021). Once a case progresses to refractory benign esophageal stricture, only 1 in 3 cases ever achieve clinical resolution (defined as maintenance of dysphagia-free status for at least 6 months without the need for further intervention at the end of follow-up). See A. Repici, et al. ''Natural history and management of refractory benign esophageal strictures,'' Gastrointestinal Endoscopy, vol 84(2), pgs 222–228 (223). 2016. When longer and more intensive intervention occurs, more provider encounters are required, leading to a greater loss in earning capacity.

VA proposes a 0-percent evaluation level for a documented history of esophageal stricture(s) without daily symptoms or the requirement for daily medications. VA proposes a 10-percent evaluation for a documented history of esophageal stricture(s) that requires daily medications to control dysphagia that is otherwise asymptomatic. VA proposes a 30-percent evaluation for a documented history of recurrent or refractory esophageal stricture(s) causing dysphagia which requires dilatation no more than 2 times per year. VA proposes a 50-percent evaluation level for a documented history of recurrent or refractory esophageal stricture(s) causing dysphagia which requires at least one of the following: (1) Dilation 3 or more times per year, (2) dilation using steroids at least one time per year, or (3) esophageal stent placement. VA proposes an 80-percent evaluation for a documented history of recurrent or refractory esophageal stricture(s) causing dysphagia where at least one of the following symptoms is present: (1) Aspiration, (2) undernutrition, and/or (3) substantial weight loss as defined by § 4.112(a) and where such dysphagia was treated with either surgical correction or percutaneous esophago-gastrointestinal tube (PEG tube).

VA also proposes to list 5 notes with DC 7203. The first note would require medical findings to be documented by barium swallow, computerized tomography, or esophagogastroduodenoscopy. The second note would require non-gastrointestinal complications of procedures to be rated under the appropriate system. The third note would provide a non-exhaustive list of esophageal conditions to be evaluated under this DC. Note 4 and Note 5 would define recurrent and refractory strictures, respectively.

Diagnostic Code 7204

VA proposes to retitle this DC from ''esophagus, spasm of (cardiospasm)'' to ''esophageal motility disorder.'' The title change would capture several motor disorders of the esophagus—in addition to esophageal spasm—to which VA would apply DC 7204. These disorders include but are not limited to achalasia (cardiospasm), corkscrew and nutcracker esophagus, esophageal rings including Schatzki rings, mucosal webs or folds, and other conditions influencing motility, such as myasthenia gravis, scleroderma, and other neurological conditions.

VA would not substantively change the existing instruction to rate conditions falling under this DC as esophageal stricture (DC 7203). However, VA proposes to delete, as unnecessary, the prior instruction to evaluate an esophageal spasm not amenable to dilation as a stricture, because the proposed rating criteria for esophageal stricture under DC 7203 now consider the frequency of dilatation.

Diagnostic Code 7205

For clarity, VA proposes to add a note with a non-exhaustive list of conditions to which DC 7205, acquired diverticulum of the esophagus, can apply. These conditions include pharyngo-esophageal (Zenker's) diverticulum, as well as mid-esophageal and epiphrenic diverticula. The existing instruction to rate conditions under this DC as esophageal stricture (DC 7203) would remain without substantive change.

New Diagnostic Code 7206

VA proposes to add a new DC for rating gastroesophageal reflux disease (GERD). Historically, VA has rated this condition analogously to hiatal hernia (DC 7346). As discussed below, VA proposes to evaluate hiatal hernia using the revised criteria found in DC 7203 (Esophagus, stricture of) because the medical community now recognizes the close relationship between the majority of symptoms associated with these conditions. See Dakkak, supra. Similarly, VA proposes to evaluate GERD using rating criteria in DC 7203 because these criteria consider symptoms of esophageal obstruction and irritation, which are consistent with the symptoms of GERD. D. Armstrong et al., ''Canadian consensus conference on the management of gastroesophageal reflux disease in adults: Update 2004,'' 19(1) Canadian J. of Gastroenterology, 15–35 (Jan. 2005).

New Diagnostic Code 7207

VA proposes to add Barrett's esophagus to § 4.114 as a relevant medical condition that the VASRD does not presently address. Barrett's esophagus is characterized by the replacement of the normal squamous epithelium of the distal esophagus by dysplastic or aberrant cells (metaplasia), an anomalous cell overgrowth that may eventually become cancerous. ''Barrett's Esophagus'' in National Digestive Diseases Information Clearinghouse, National Institute of Diabetes and Digestive and Kidney Diseases, NIH Publication No. 13–4546 (Feb. 2013), *https://www.niddk.nih.gov/health-information/digestive-diseases/barretts-esophagus* (last visited Oct. 06, 2021). The vast majority of patients with Barrett's esophagus suffer no long-term effects other than the inconvenience of periodic endoscopy to monitor the appearance of adenocarcinoma. Kunal Jajoo, MD and John R. Saltzman, MD, ''Chapter 12: Barret Esophagus,'' in ''Current Diagnosis & Treatment: Gastroenterology, Hepatology, & Endoscopy'' (N.J. Greenberger, et al. eds., 2d ed. 2012), available at *http://accessmedicine.mhmedical.com/content.aspx?bookid=390&Sectionid=39819242* (last visited Oct. 06, 2021). Various medical texts describe periodic surveillance and acid suppression as adequate to manage the disease. Id. This condition is usually a long-term complication of GERD. ''Barrett's Esophagus,'' supra.

If a veteran with Barrett's esophagus also has stricture, VA proposes to evaluate the condition under DC 7203 (Esophagus, stricture of). This is consistent with the prohibition against pyramiding under 38 CFR 4.14. If, however, esophageal stricture is not present, VA proposes to evaluate Barrett's esophagus based on its progression toward cancer. Specifically, VA proposes a 30-percent evaluation for more advanced presentations (known as high-grade dysplasia), documented by pathologic diagnosis. VA proposes a 10-percent evaluation for less advanced presentations (known as low-grade dysplasia). High-degree dysplasia represents a higher risk of disease and requires closer surveillance, such as more frequent endoscopy, biopsy, etc., and in some cases preemptive esophagectomy for adenocarcinoma. See M.S. Dar et al., ''Can extent of high grade dysplasia in Barrett's esophagus predict the presence of adenocarcinoma at esophagectomy?'' 52 Gut 486–89 (2003). Low-degree dysplasia requires at least yearly endoscopy with biopsy. Id. The symptomatology of patients with Barrett's esophagus is indistinguishable from patients with GERD; thus, the rating of 30 percent is more consistent with higher degree of obstruction, while those at 10 percent have mild esophageal discomfort manageable with medications. See Jajoo, supra.

In addition to the above rating criteria, VA proposes to add a note to evaluate any developing malignancies under DC 7343 (Malignant neoplasms of the digestive system, exclusive of skin growths). VA proposes a second note to evaluate any residuals from successful treatment as DC 7203 (Esophagus, stricture of).

Other Digestive Disorders

Diagnostic Code 7301

VA proposes new rating criteria that consider both alimentary support (such

as parenteral nutrition or dietary modification) and recurrent obstruction. Under the present rating criteria, VA assigns ratings of 50, 30, 10, or 0 percent under DC 7301 based on whether peritoneal adhesions are ''severe,'' ''moderately severe,'' ''moderate,'' or ''mild.'' These terms are generic and undefined and may lead to inconsistent evaluations. Further, the rating criteria do not fully address the complexities of this condition, which may require intravenous nutrition and may not be repairable.

The current DC 7301 provides for a maximum 50-percent rating. However, as some adhesions do not respond to treatment or require nutritional support, VA intends to expand DC 7301 to include an 80-percent evaluation. Under the proposed criteria, VA would assign an 80-percent evaluation for persistent (continuous) partial bowel obstruction that is either inoperable and otherwise refractory to treatment or requires TPN for obstructive symptoms.

The 0-percent evaluation is currently described as ''mild'' without additional criteria, explanation, or definition. VA proposes to re-define the 0-percent evaluation by deleting ''mild'' and clarifying the criteria as ''a history of peritoneal adhesions, currently asymptomatic''. VA proposes to amend the 10-percent evaluation, and assign it for symptomatic adhesions, persisting or recurring after surgery, trauma, inflammatory disease process such as chronic cholecystitis or Crohn's disease, or infection, which includes at least one of the symptoms identified in the current VASRD (*e.g.,* abdominal pain, nausea, vomiting, colic, constipation, or diarrhea). VA proposes to amend the 30-percent evaluation, and assign it for documented symptomatic adhesions that meet the criteria for a 10-percent evaluation, but also require medically-directed dietary modification other than TPN. The current rating criteria provide a 50-percent rating for symptomatology warranting inpatient care (*e.g.,* severe peritonitis, ruptured appendix, perforated ulcer, or an operation with drainage). VA proposes to amend the 50-percent evaluation and assign it for documented symptomatic adhesions requiring hospitalization at least once per year, which also require medically-directed dietary modification, other than TPN, and at least one of the following: Diarrhea, constipation, colic, abdominal pain, nausea, or vomiting.

Currently, diagnostic code 7301 includes a note stating that ratings for adhesions only apply with a history of operative, traumatic, or infectious process and in the presence of at least two of the listed symptoms. This note indicates that VA would evaluate peritoneal adhesions caused by surgery, trauma, or infection. However, diagnostic codes 7310 (Stomach, injury of, residuals) and 7317 (Gallbladder, injury of) provide instructions to rate analogously to diagnostic code 7301 in certain cases. VA proposes to delete the current note to clarify that no adhesions are necessary when evaluating stomach or gallbladder injuries under DC 7301. VA would include in the title of diagnostic code 7301 the language indicating that peritoneal adhesions must be due to surgery, trauma, disease, or infection.

New Diagnostic Code 7303

As noted in the discussion regarding current § 4.111, VA proposes to add a DC entitled ''Chronic complications of upper gastrointestinal surgery,'' which includes the need for parenteral or enteral nutrition and the presence of chronic residual pain, motility issues, and dumping syndrome. Existing codes for these conditions (*e.g.,* DCs 7308–7310) would refer rating personnel to the new code, DC 7303, when appropriate. This proposed DC would contain evaluation criteria based on the criteria contained in existing DCs 7308–7310. However, VA is retaining the individual DCs so VA may continue to track specific claims and outcomes.

VA notes that existing DCs relevant to these conditions provide ratings at 20, 40, and 60 percent. As with other DCs, VA assigns these ratings when the disability level is mild, moderate, or severe, respectively. To better accommodate the various complications that arise with upper gastrointestinal surgery, VA proposes to change and expand the disability levels to 0, 10, 30, 50, and 80 percent. This change would not automatically impact any individuals with current disability ratings under existing DCs. If a Veteran's disability rating would be reduced under the amended version of DC 7303, no change in compensation would occur unless the Veteran applied for a change or reevaluation is otherwise warranted and the Veteran's disability is shown to have improved. *See* 38 U.S.C. 1155. If the Veteran's disability rating would increase under the amended version of DC 7303, the Veteran could reapply for that increase.

VA proposes to assign a 0-percent rating for asymptomatic, post-operative status to ensure that rating personnel understand when a noncompensable evaluation is appropriate. VA proposes a 10-percent rating when ongoing medical treatment manages either nausea or vomiting. This new category would allow VA to compensate those individuals whose effective treatment may preclude outward symptoms, but who nevertheless experience mild impairment due to the need for the treatment itself.

Current ratings provide a 20-percent rating when the level of disability is mild. With the proposed addition of the 10-percent disability level, VA proposes to eliminate the 20-percent disability level and instead evaluate individuals with 2 or more of the following symptoms as 30-percent disabled: (1) Vomiting two or more times per week or vomiting not controlled by medical treatment; (2) discomfort or pain within an hour of eating and requiring oral ongoing dietary modification; or (3) three to five watery bowel movements per day every day.

VA proposes to assign the next level of disability, 50-percent, when any of the following continued symptoms exist: (1) Daily vomiting not controlled by oral dietary modification or medication; (2) six or more watery bowel movements per day every day or explosive bowel movements that are difficult to predict or control; (3) post-prandial (meal-induced) light-headedness (syncope) with sweating, the need for medications (such as octreotide) specifically to treat complications of upper gastrointestinal surgery, including dumping syndrome or delayed gastric emptying (requiring promotility agents) following esophageal or stomach surgery.

VA proposes an 80-percent evaluation for complete dependence on TPN (*i.e.,* required continuous total parenteral nutrition) or tube feeding lasting for a period longer than 30 consecutive days in the past 6 months. Although some dependence on nutritional support such as TPN or tube feeding is expected immediately following surgery, a duration lasting longer than 30 consecutive days post-operatively is excessive and reflects a more severe ongoing disability picture. This evaluation is consistent with other disability ratings which require similar levels of nutritional support (*e.g.,* TPN).

Because of its differing presentation, VA proposes to include Note (1), which instructs rating personnel to evaluate complications following intestinal resection under DC 7328 (Intestine, small, resection, dysfunction or malabsorption). VA also proposes to include Note (2), directing that rating personnel evaluate vitamin/mineral deficiencies associated with pancreatic surgery under the appropriate vitamin/mineral deficiency code if a higher evaluation would result. Finally, to further assist rating personnel in accurately applying DC 7303, VA

intends to include Note (3), which indicates that this DC includes operations performed on the esophagus, stomach, pancreas, and small intestine, including bariatric surgery.

Diagnostic Codes 7304 Through 7306

At present, VA evaluates ulcers depending on their location under the following DCs: DC 7304 (Gastric); DC 7305 (Duodenal); and DC 7306 (Marginal gastrojejunal). While ulcers may vary in location, they produce the same array of symptoms and do not differ in functional incapacity. Therefore, VA proposes to eliminate DCs 7305 and 7306 and revise DC 7304, retitled ''Peptic ulcer disease,'' to include all evaluations previously done under current DCs 7304, 7305, 7306.

In 1984, Drs. Barry J. Marshall, and J. Robin Warren reported finding a curved bacillus, initially named *Campylobacter pyloridis,* and subsequently classified as *Helicobacter pylori* (H. pylori), in biopsies taken from patients with gastritis and peptic ulcers. B.J. Marshall and J.R. Warren, ''Unidentified curved bacilli in the stomach of patients with gastritis and peptic ulceration,'' Lancet 1(8390), 1311–15 (June 16, 1984). Drs. Marshall and Warren received the Nobel Prize for Medicine and Physiology in 2005 for their discovery that peptic ulcer disease (PUD) was primarily caused by *H. pylori,* a bacterium with acidic affinity.

Numerous studies have since shown that the eradication of this bacterium reduces ulcer recurrence and complications such as bleeding and cancer. See E. Lew, ''Chapter 15. Peptic Ulcer Disease,'' in ''Current Diagnosis & Treatment: Gastroenterology, Hepatology, & Endoscopy,'' (2d ed. 2012), *http://accessmedicine.mhmedical.com/content.aspx?bookid=390&Sectionid=39819246* (last visited Oct. 06, 2021). Studies have also shown that PUD is primarily related to either *H. pylori* infection or, to a lesser degree, the use of NSAIDS. Id. Other peptic ulcers are residuals of surgery (anastomotic or post-operative gastric). See C. Avunduk, ''Chapter 28. Postgastrectomy Disorders,'' in ''Manual of Gastroenterology: Diagnosis and Therapy,'' The management and outcome of PUD has been drastically changed by the introduction of acid-suppressive and proton pump inhibitor (PPI) therapy. Id. Improved hygiene and antibiotic use have also helped drastically reduced the overall incidence of PUD. Id. VA proposes that this code evaluate *H. pylori,* NSAID, anastomotic, and post-operative gastric ulcers, including treatable conditions.

Currently, VA evaluates ulcers as ''mild,'' ''moderate,'' ''moderately severe,'' ''severe,'' and ''pronounced.'' Although these terms refer to common symptoms such as abdominal pain, vomiting, melena (tarry stools), and weight loss, the criteria remain subjective and vague, which may lead to inconsistent evaluations. For example, under current DC 7305, VA assigns a 40-percent evaluation when the duodenal ulcer is ''Moderately severe; less than severe but with impairment of health manifested by anemia and weight loss; or recurrent incapacitating episodes averaging 10 days or more in duration at least 4 or more times a year.'' What constitutes ''less than severe'' symptomatology or an ''incapacitating episode'' is not defined. To better evaluate peptic ulcers, VA proposes to provide more specific rating criteria which clearly identify the major symptoms associated with PUD and evaluate the level of disability based on the presence of these symptoms, their frequency, and any treatment or outcomes.

VA proposes to assign a 0-percent evaluation for a history of PUD documented by endoscopy or X-ray. VA proposes a 20-percent evaluation for episodes of abdominal pain, nausea, or vomiting lasting for 3 days or more, occurring 3 times or less in the past 12 months, and the symptoms are managed by daily prescribed medication.

Current criteria for a 40-percent evaluation under DC 7305 and 7306 focus on ''recurrent incapacitating episodes,'' or ''intercurrent episodes of pain . . . [and] mild and transient episodes of vomiting or melena.'' As noted above, VA intends to reduce or eliminate ambiguity in its rating criteria by replacing vague terms such as ''recurrent,'' ''transient,'' and ''incapacitating episodes'' with clear, objective criteria. Therefore, VA proposes to assign a 40-percent evaluation for episodes of abdominal pain, nausea, or vomiting lasting for 3 days or more, occurring 4 or more times in the past 12 months.

VA intends to assign a 60-percent evaluation for continuous abdominal pain with intermittent vomiting, recurrent hematemesis (vomiting blood) or melena (tarry stools), and manifestations of anemia which require hospitalization at least once in the past 12 months. The requirement for hospitalization is indicative of severe disabling effects of PUD, which is resistant to treatment and more disabling in its outcome than the symptomatology in the 0-, 20-, and 40-percent evaluation levels.

VA proposes to assign a 100-percent evaluation for 3 months after surgical repair of a perforation or hemorrhage (Fitness for Work, K. Palmer, I. Brown, J. Hobson, Oxford U Press 2013, page 438). According to widely accepted occupational health reference and clinical guidelines, the three-month period for recuperation is recommended in cases of surgical repairs for perforated gastric ulcer or hemorrhage. (T. Palmer, I. Brown, and J. Hobson, Fitness for Work, 5th ed. (2013)). After three months, VA would determine the appropriate rating for residuals using a mandatory VA examination, as stated in the note to DC 7304.

Diagnostic Code 7307

While effective treatment of gastritis requires identification of the specific etiology (origin), the specific etiology has little relevance to functional incapacity, as its symptoms are consistent. Akiva J Marcus et al., ''Chronic Gastritis,'' Medscape (Jun 07, 2019), *http://emedicine.medscape.com/article/176156-overview* (last visited Oct. 06, 2021). Therefore, VA proposes to retitle DC 7307 from ''Gastritis, hypertrophic (identified by gastroscope)'' to the more generalized term of ''Gastritis, chronic.'' VA intends to remove the requirement for endoscopy (*e.g.,* gastroscope) as it is burdensome, unnecessary, or replaced by radiology. See K.R. McQuaid, ''Chapter 15. Gastrointestinal Disorders,'' in ''Current Medical Diagnosis & Treatment 2021,'' (M.A. Papadakis et al. eds. 2021), *https://accessmedicine.mhmedical.com/book.aspx?bookID=2957#249360894* (last visited Oct. 06, 2021). VA also proposes to add a note that lists some of the conditions to which this DC applies to help ensure consistent usage.

The medical community recognizes the symptomatology and functional incapacity associated with chronic gastritis is consistent with PUD. Id. Therefore, VA proposes to remove the existing rating criteria and replace it with a directive to evaluate the condition as a form of PUD under DC 7304.

Diagnostic Code 7308

Postgastrectomy syndromes (DC 7308) are complications of surgery on the stomach. Anatomic and physiological changes introduced by gastric surgery result in changes in the motor functions of the stomach, including disturbances in the gastric reservoir function, the mechanical-digestive function, and the transporting function. See Eagon, J.C., et al. Postgastrectomy syndromes. Surg Clin North Am. 1992 Apr;72(2):445–65.

(last visited Oct. 06, 2021) *https://www.sciencedirect.com/science/article/pii/S0039610916456896?via%3Dihub*. Therefore, VA proposes to remove the current rating criteria and direct rating personnel to use the new criteria of DC 7303 (Chronic complications of upper gastrointestinal surgery).

Diagnostic Code 7309

Currently, DC 7309 (Stomach, stenosis of) directs rating personnel to evaluate it as gastric ulcer, DC 7304. Although this condition is most often a complication of upper gastrointestinal surgery, it less commonly may be a complication of PUD. Jin Hyoung Kim, MD, et al., ''Fluoroscopically Guided Balloon Dilation for Benign Anastomotic Stricture in the Upper Gastrointestinal Tract,'' 9 Korean J. Radiology 4 (2008). As such, VA proposes to direct rating personnel to evaluate this condition under either DC 7303 (Chronic complications of upper gastrointestinal surgery) or DC 7304 (Peptic ulcer disease).

Diagnostic Code 7310

Currently, DC 7310 directs rating personnel to evaluate injuries to the stomach using the criteria of DC 7301 (Peritoneum, adhesion of). However, certain gastrointestinal procedures can also result in injury to the stomach, as well as such neighboring viscera as the pancreas and intestines. Therefore, VA proposes to amend the existing direction to state that rating personnel should continue to evaluate pre-operative injuries to the stomach using the criteria of DC 7301 (Peritoneum, adhesions of, due to surgery, trauma, disease, or infection), while they should evaluate post-operative injuries under the new DC 7303 (Chronic complications of upper gastrointestinal surgery). VA proposes to further amend the instruction for pre-operative injuries to clarify that no adhesions are necessary when evaluating stomach injuries under DC 7301.

Diagnostic Code 7312

The current DC 7312 is entitled ''Cirrhosis of the liver, primary biliary cirrhosis, or cirrhotic phase of sclerosing cholangitis.'' As the two latter conditions are forms of cirrhosis, VA proposes to simplify the title of DC 7312 to ''Cirrhosis of the liver.'' Currently, VA evaluates conditions within the scope of DC 7312 using physical status, functional limitation, laboratory findings, and imaging studies.

Since last modifying this rating criteria, the medical community has increasingly accepted the Model for End-Stage Liver Disease (MELD), a mathematical model developed by the Mayo Clinic to predict survival and outcome in liver disease. P.S. Kamath et al., ''Model for End-Stage Liver Disease (MELD),'' 45 Hepatology 797 (2007); David Wolf, *https://aasldpubs.onlinelibrary.wiley.com/doi/full/10.1002/hep.21563* (last visited Oct. 06, 2021). The MELD score is used throughout the United States to prioritize and stage patients waiting for liver transplants. It also serves as the Social Security Administration's basis for the SSA Chronic Liver Disease (SSA CLD) score used for calculating the severity of chronic liver disease. Disability Evaluation Under Social Security: Blue Book, Chapter 5.00 Digestive System—Adult, section 505: Chronic Liver Disease, Paragraph G, (Sept. 2008). The MELD score is well suited to rating disabilities because of its high correlation with clinical features, including functional status. The MELD also predicts prognosis (disease severity and mortality) in patients with liver cirrhosis and alcoholic hepatitis. F. Botta et al., ''MELD Scoring System in patients with liver cirrhosis and residual liver function,'' 52 Gut 134–39 (2003), *http://gut.bmj.com/content/52/1/134.full.pdf+html* (last visited Oct. 06, 2021). Also, see Milan Sheth et al., ''Utility of the Mayo End-Stage Liver Disease (MELD) score in assessing prognosis of patients with alcoholic hepatitis,'' 2 BMC Gastroenterology 2 (2002), *http://www.biomedcentral.com/content/pdf/1471-230x-2-2.pdf* (last visited Oct. 06, 2021). Therefore, VA is proposing to include it in the rating criteria for cirrhosis alongside analogous clinical signs and symptoms.

The following three values form the MELD score: (1) International normalized ratio (INR) (prothrombin time); (2) serum bilirubin; and (3) serum creatinine. The mathematical equation below uses these values to produce a score between 6 and 40, with 40 indicating a gravely ill person with high risk of mortality.

MELDScore = 10 * ((0.957 * ln(Creatinine)) + (0.378 * ln(Bilirubin)) + (1.12 * ln(INR))) + 6.43

See Wolf, supra at *https://emedicine.medscape.com/article/185856-overview#showall* (last visited Oct. 06, 2021). The scores from 6 to 15 correlate best with expected survival. Id. VA intends the rating criteria to list ranges of MELD scores that correspond to various levels of liver impairment correlated with clinical findings.

As the MELD score may not always be available, VA also proposes to include alternative means of determining functional impairment using clinical findings pertaining to physical status, functional incapacity, laboratory findings, and imaging studies.

VA intends to assign a 0-percent evaluation for a history of liver disease without current symptoms. Consistent with the current evaluation under DC 7312, VA would assign a 10-percent evaluation for either a MELD score greater than 6 but less than 10, or evidence of weakness, anorexia, abdominal pain, or malaise.

VA currently assigns a 30-percent evaluation for portal hypertension and splenomegaly, with weakness, anorexia, abdominal pain, malaise, and at least minor weight loss. VA proposes to eliminate the reference to ''minor weight loss'' and assign a 30-percent evaluation for either a MELD score of 10 or 11, or; portal hypertension (splenomegaly or ascites) with weakness, anorexia, abdominal pain, or malaise, which would fully reflect the severity of the disability.

The current DC 7312 assigns either a 50- or 70-percent evaluation depending on the number of episodes of ascites, hepatic encephalopathy, or hemorrhage from varices or portal gastropathy (erosive gastritis). VA proposes to eliminate the 50- and 70-percent levels of evaluation and assign a 60-percent evaluation for a MELD score greater than 11 but less than 15, or daily fatigue with at least 1 episode in the last year of variceal hemorrhage, portal gastropathy, or hepatic encephalopathy. This proposal would ensure VA rates individuals for chronic symptomatology, as well as episodic flare-ups.

VA proposes a 100-percent evaluation for either a MELD score of at least 15, or constant daily debilitating symptoms and generalized weakness with at least one of the following: Ascites (fluid in the abdomen), a history of spontaneous bacterial peritonitis, encephalopathy, variceal hemorrhage, coagulopathy, portal gastropathy, hepatopulmonary or hepatorenal syndrome.

In addition to the above rating criteria, VA proposes to add three notes. Note 1 would instruct rating personnel to evaluate hepatocellular carcinoma occurring with cirrhosis under DC 7343 (Malignant neoplasms of the digestive system, exclusive of skin growths) rather than cirrhosis. Note 2 would indicate that biochemical studies, imaging studies, or biopsies must confirm liver dysfunction, including hyponatremia, thrombocytopenia, and/or coagulopathy in order to receive an evaluation under DC 7312. Note 3 would instruct rating personnel to

evaluate the condition based on symptomatology where the evidence does not contain a MELD score.

Diagnostic Code 7314

DC 7314 is currently titled ''Cholecystitis, chronic,'' which is a persistent swelling and irritation of the gallbladder. The gallbladder is a sac adjacent to the liver that stores bile, a substance the liver makes and the intestines use to digest fats. See ''Gallstones,'' National Digestive Diseases Information Clearing House, NIH Publication No. 13–2897 (November 2017), *https://www.niddk.nih.gov/health-information/digestive-diseases/gallstones* (last visited Oct. 06, 2021). The symptoms of chronic cholecystitis are similar to other diseases of the biliary tract (the name for the liver and gallbladder ducts, which are related to the production, storage, and use of bile). See G. Paumgartner and N.J. Greenberger, ''Chapter 53. Gallstone Disease,'' in ''Current Diagnosis & Treatment: Gastroenterology, Hepatology, & Endoscopy,'' (N.J. Greenberger, et al. eds., 2d ed. 2012), *http://accessmedicine.mhmedical.com/content.aspx?bookid=390&Sectionid=39819290* (last visited Oct. 06, 2021). Therefore, VA proposes to expand this DC to cover all chronic diseases of the biliary tract by retitling it ''Chronic biliary tract disease.''

Currently, DC 7314 provides 30-, 10-, and 0-percent evaluations. VA assigns a 30-percent evaluation if the condition is severe, with frequent attacks of gallbladder colic. VA assigns a 10-percent evaluation if the condition is moderate, with gallbladder dyspepsia, confirmed by X-ray, and with infrequent attacks (not over 2 or 3 a year) of gallbladder colic, with or without jaundice. VA assigns a 0-percent evaluation if the condition is mild.

VA proposes to eliminate the subjective terms in the existing criteria as a way of reducing inconsistent evaluations, but continue rating these conditions on the frequency of ''attacks.'' To provide more objectivity to the rating process, VA proposes to specify the number of episodes and associated symptoms required for each level of disability.

VA proposes to assign a 30-percent evaluation for 3 or more clinically documented attacks of right upper quadrant pain with nausea and vomiting in the past 12 months; or when biliary tract strictures require dilatation at least once in the past 12 months. VA would assign a 10-percent evaluation for 1 or 2 clinically documented attacks of right upper quadrant pain with nausea and vomiting in the past 12 months. Under this proposal, VA would assign a 0-percent evaluation when the condition is asymptomatic and there is no history of a clinically documented attack of right upper quadrant pain with nausea and vomiting in the past 12 months.

In addition to the above criteria, VA proposes to note the following non-exhaustive list of conditions to which this DC applies: Cholangitis, biliary strictures, Sphincter of Oddi dysfunction, bile duct injury, and choledochal cyst. This note would also direct evaluating primary sclerosing cholangitis under the renamed DC 7345 (Chronic liver disease without cirrhosis), due to shared symptomatology.

Diagnostic Code 7315

DC 7315, Chronic choleslithiasis, currently directs rating personnel to evaluate this condition under DC 7314 (Cholecystitis, chronic). VA does not propose any changes other than amending the instruction to reflect the retitling of DC 7314.

Diagnostic Code 7316

DC 7316, chronic cholangitis, is one of several related conditions currently evaluated under DC 7314 (Cholecystitis, chronic). VA proposes to track this disability under DC 7314, so it proposes to eliminate DC 7316. This removal would not, in and of itself, alter existing evaluations or grants of service connection. Rather, VA would modify the individual's record to reflect the grant of service connection under DC 7314 instead of DC 7316.

Diagnostic Code 7317

Currently, VA directs rating personnel to rate gallbladder injuries under DC 7301 (Peritoneum, adhesions of). However, that code does not address all likely effects of injuries to the gallbladder. Therefore, VA proposes to evaluate this condition under whichever of the following DCs most effectively demonstrates the level of functional limitation: 7301 (Peritoneal adhesions), or 7314 (Chronic gallbladder and biliary tract disease), or 7318 (Cholecystectomy (gallbladder removal) complications of (such as strictures and biliary leaks)). VA also proposes to correct a typographical error, changing the title from ''Gall bladder, injury of,'' to ''Gallbladder, injury of.''

Further, VA proposes to add a note to DC 7317, clarifying that no adhesions are necessary when evaluating gallbladder injuries under DC 7301.

Diagnostic Code 7318

Currently, DC 7318 is titled, ''Gall bladder, removal of.'' As with DC 7317, VA is correcting the spelling to ''Gallbladder.'' However, the current title does not fully express the scope of complications of gallbladder removal. Also, the medical term for gallbladder removal is cholecystectomy. As rating personnel may encounter either term in medical records, VA proposes to retitle this DC as ''Cholecystectomy (gallbladder removal), complications of (such as strictures and biliary leaks).''

VA currently assigns a 30-percent evaluation for severe symptoms, a 10-percent evaluation for mild symptoms, and 0-percent evaluation if the condition is asymptomatic. Using subjective terms ''severe'' and ''mild'' without indicating specific symptoms may contribute to inconsistent evaluations.

Therefore, VA proposes new criteria that enumerate the complications and symptoms, to include abdominal pain and diarrhea, resulting from the removal of the gallbladder. See Steen W. Jensen, MD, ''Postcholecystectomy Syndrome,'' Medscape Reference (Jul 24, 2020), *http://emedicine.medscape.com/article/192761-overview* (last visited Oct. 06, 2021). Specifically, VA proposes to assign a 0-percent evaluation for a cholecystectomy without symptoms. VA proposes a 10-percent evaluation for intermittent (stopping and starting at intervals) abdominal pain and diarrhea characterized by one to two watery bowel movements per day. VA proposes a 30-percent evaluation for recurrent abdominal pain most often occurring after a meal (post-prandial) or at night time (nocturnal) and chronic diarrhea characterized by three or more watery bowel movements per day.

Diagnostic Code 7319

DC 7319 is currently titled ''Irritable colon syndrome (spastic colitis, mucous colitis, etc.).'' However, the medical community now refers to ''irritable colon syndrome'' as ''irritable bowel syndrome.'' Therefore, VA proposes to retitle this code ''Irritable Bowel Syndrome (IBS)'' to more accurately describe the condition to which it applies.

The current evaluation levels under this DC are 30, 10, and 0-percent. VA assigns a 30-percent evaluation if the condition is severe, ''with diarrhea or alternating diarrhea and constipation, with more or less constant abdominal distress.'' VA assigns a 10-percent evaluation if the condition is moderate, with ''frequent episodes of bowel disturbance with abdominal distress.'' VA assigns a 0-percent evaluation if the condition is mild, with ''disturbances of bowel function with occasional episodes of abdominal distress.''

VA proposes to replace current criteria with more objective criteria derived from the Rome IV criteria for IBS. See Brian Lacy, ''Bowel Disorders,'' Gastroenterology, 150: 1393–1407 (2016).

Specifically, VA proposes to assign a 10-percent evaluation when an individual has abdominal pain related to defecation at least once during the previous 3 months. In addition, this person must have had two or more of the following: Change in stool frequency, change in stool form, altered stool passage (straining and/or urgency), mucorrhea, abdominal bloating, or subjective distension.

VA proposes to assign a 20 percent evaluation when an individual has abdominal pain for at least 3 days per month during the previous 3 months. Additionally, this individual must have had two or more of the following: Change in stool frequency, change in stool form, altered stool passage (straining and/or urgency), mucorrhea, abdominal bloating, or subjective distension.

VA proposes a 30-percent evaluation when an individual has at least one episode per week of abdominal pain associated with defecation during the previous 3 months. Further, the individual must have exhibited two or more of the following: Change in stool frequency, change in stool form, altered stool passage (straining and/or urgency), mucorrhea, abdominal bloating, or subjective distension.

VA also proposes to add one note to DC 7319 to assist rating personnel in applying these criteria. This note would clarify that this DC pertains to functional digestive disorders (38 CFR 3.317), such as dyspepsia, functional bloating and constipation, and diarrhea. Rating personnel may evaluate other symptoms of functional digestive disorders not found under this code using new DC 7356 (gastrointestinal dysmotility syndrome), following the general principles of §§ 4.14 and 4.114.

Proposed Elimination of DC 7321, Amebiasis, DC 7322, Dysentery, Bacillary, and DC 7324, Distomiasis, Intestinal or Hepatic

All three diagnostic codes refer to conditions that are infectious in nature. There are two main types of dysentery: (1) Bacillary dysentery or shigellosis that is caused by shigella bacteria, and (2) amebic dysentery or amebiasis that is caused by an ameba (single-celled parasite) called Entamoeba histolytica. DC 7324 is currently titled ''Distomiasis, intestinal or hepatic'' and refers to the early 20th century medical texts that used this now outdated term when referring to an intestinal parasitosis caused by trematodes or flukes (Fasciola hepatica).

VA published a final rule in the **Federal Register** at 84 FR 28227 on June 18, 2019, to amend 38 CFR 4.88a and 4.88b, the portion of the VASRD dealing with infectious diseases, immune disorders, and nutritional deficiencies. In this final rule, VA introduced two new diagnostic codes, DC 6334 (Shigella infections) and 6320 (Parasitic diseases) otherwise not specified. DC 6334 addresses conditions previously covered under DC 7322 and DC 6320 addresses conditions previously covered under DC 7321 and DC 7324. Therefore, VA proposes to delete DC 7321 (Amebiasis), DC 7322 (Dysentery, bacillary), and DC 7324 (Distomiasis, intestinal or hepatic) from the portion of the rating schedule that addresses the digestive system.

This removal would not, in and of itself, alter existing evaluations or grants of service connection. Rather, VA would modify the individual's record to reflect the grant of service connection under the appropriate diagnostic code.

Diagnostic Code 7323

VA currently evaluates ulcerative colitis (DC 7323) at 100, 60, 30, or 10 percent. VA assigns a 100-percent evaluation if the condition is pronounced, resulting in marked malnutrition, anemia, and general debility, or if there are serious complications, such as liver abscess. A severe condition, consisting of numerous attacks yearly and malnutrition, with health only fair during remissions, warrants a 60-percent evaluation. VA assigns a 30-percent evaluation if the condition is moderately severe, with frequent exacerbations. A moderate condition, with infrequent exacerbations, warrants a 10-percent evaluation.

Ulcerative colitis is one of the primary forms of inflammatory bowel disease. While specific inflammatory bowel diseases merit different treatment, they share many common symptoms and resulting functional impairments. ''Ulcerative Colitis,'' University of Maryland Medical Center, Inflammatory Bowel Disease Center (Apr. 23, 2013), *http://www.umm.edu/programs/ibd/services/colitis* (last visited Oct. 06, 2021). Therefore, VA proposes to remove the existing criteria and replace it with an instruction to rate the condition using the criteria proposed for the newly created DC 7326, Crohn's disease, another form of inflammatory bowel disease.

Diagnostic Code 7325

Currently, VA evaluates chronic enteritis using the criteria under DC 7319 (Irritable colon syndrome). However, this process may not account for the most likely or most disabling of symptoms. Therefore, VA proposes to direct rating personnel to rate these conditions under either the revised DC 7319 (Irritable bowel syndrome) or DC 7326 (Crohn's disease), whichever is most appropriate.

Diagnostic Code 7326

Currently, DC 7326 is titled ''Enterocolitis, chronic.'' VA proposes to retitle it, ''Crohn's disease or undifferentiated form of inflammatory bowel disease'' to account for the array of inflammatory intestinal conditions that have similar symptoms and functional outcomes.

Currently, VA directs rating personnel to evaluate this condition using the criteria provided under DC 7319 (Irritable colon syndrome). However, the medical community has determined that inflammatory bowel conditions are distinct from irritable bowel conditions (see DC 7319) and are characterized by inflammation of unknown etiology that can affect any portion of the gastrointestinal tract from the mouth to the perianal area. See ''IBS and IBD: Two Very Different Disorders,'' Crohn's & Colitis Foundation of America (Oct. 2019), *https://www.crohnscolitisfoundation.org/what-is-ibd/ibs-vs-ibd* (last visited Oct. 06, 2021). See also ''What Is Crohn's Disease?'' Crohn's & Colitis Foundation of America, *http://www.crohnscolitisfoundation.org/what-are-crohns-and-colitis/what-is-crohns-disease/* (last visited Oct. 06, 2021). Transmural inflammation, coupled with the number of potentially affected organs, produces various signs and symptoms and corresponding functional outcomes.

Therefore, VA proposes new rating criteria based on the Truelove and Witts criteria for inflammatory bowel disease, to include Crohn's disease and ulcerative colitis (DC 7323). A. Kornbluth and D. Sachar, ''The Practice Guidelines for Ulcerative Colitis of the American College of Gastroenterology,'' 105 a.m. J. Gastroenterology, 501–23 (2010). These criteria focus on the frequency and severity of the hallmark clinical symptom, bloody diarrhea with rectal urgency. Id. In addition to these criteria, VA proposes to evaluate the severity of the disease based on the number and frequency of exacerbations, as well as the level of treatment used to control the disease.

According to the Truelove and Witts criteria, mild symptomatology involves fewer than four bowel movements per day with infrequent rectal bleeding; severe symptomatology involves six or more bowel movements per day with frequent rectal bleeding. VA therefore proposes to assign a 10-percent evaluation for minimal or mild symptomatic disease that is managed with oral or topical agents (other than immunosuppressants or other biologic agents) and is characterized by recurrent abdominal pain with 3 or less daily episodes of diarrhea and no signs of systemic toxicity.

VA proposes a 30-percent evaluation for mild to moderate disease, with recurrent abdominal pain, with 3 or less episodes of diarrhea per day, minimal signs of toxicity (fever, tachycardia, or anemia), and symptoms managed with topical or oral agents.

VA proposes to assign a 60-percent evaluation for moderate disease with recurrent abdominal pain, 4 to 5 daily episodes of diarrhea, and intermittent signs of toxicity (such as fever, tachycardia, or anemia), and requiring immunosuppressants or other biologic agents on an outpatient basis.

VA proposes a 100-percent evaluation for all cases of severe inflammatory bowel disease that are unresponsive to treatment, require hospitalization at least annually, and result in either an inability to work or are characterized by recurrent abdominal pain associated with at least 2 of the following features: 6 or more episodes per day of diarrhea, 6 or more episodes per day of rectal bleeding, recurrent episodes of rectal incontinence, or recurrent abdominal distention. VA also proposes to include three notes to assist rating personnel in applying DC 7326. The first note would direct that, following colectomy or colostomy with persistent or recurrent residuals, rating personnel should evaluate the condition under DC 7326 or DC 7329 (Intestine, large, resection of), whichever DC provides the highest rating. The second note would state that endoscopy or radiologic studies must confirm the diagnosis of IBD for VA rating purposes to ensure the proper application of this code. William A. Rowe et al., ''Inflammatory bowel disease,'' Medscape Reference (Apr 10, 2020), *http://emedicine.medscape.com/article/179037-overview* (last visited Oct. 06, 2021). Finally, the third note would inform personnel that inflammatory bowel disease may affect any segment of the gastrointestinal tract from the mouth to the anus.

VA acknowledges that, generally, the use of the terms ''minimal,'' ''mild,'' ''moderate,'' and ''severe'' may lead to inconsistent evaluations due to their subjectivity. However, VA proposes to provide more clarity in the assignment of ratings by defining these terms by the characteristics and criteria listed for each level under DC 7326.

Diagnostic Code 7327

Currently, DC 7327 is titled ''Diverticulitis.'' VA proposes to retitle it as ''Diverticulitis and diverticulosis'' to account for other conditions that rating personnel presently evaluate analogously under this code.

In its present form, DC 7327 does not provide specific criteria for diverticulitis but instead directs rating personnel to evaluate it as irritable colon syndrome (DC 7319), peritoneal adhesions (DC 7301), or ulcerative colitis (DC 7323), depending on the predominant disability picture. However, these criteria do not sufficiently capture its functional impairment. Therefore, VA proposes criteria specific to diverticulitis, such as fever, abdominal pain, elevated white cell count, the frequency of disabling episodes, the development of abdominal complications, intestinal bleeding, and hospitalizations. According to the National Institute of Diabetes and Digestive and Kidney Disease, diverticulosis is quite common, especially in the aging population. Survey data suggests while only about 35 percent of U.S. adults age 50 years or younger have diverticulosis, individuals older than age 60 are affected at a higher rate (58 percent). Furthermore, research suggests that less than 5 percent of people with diverticulosis would develop diverticulitis, but most people with diverticulosis will never develop symptoms or problems. See ''Diverticular Disease,'' National Digestive Diseases Information Clearing House, NIH Publication No. 13–1163 (May 2016), *https://www.niddk.nih.gov/health-information/digestive-diseases/diverticulosis-diverticulitis/definition-facts* (last visited Oct. 06, 2021).

Specifically, VA proposes assigning a 0-percent evaluation for asymptomatic diverticulitis or diverticulosis; or a symptomatic diverticulitis or diverticulosis that is managed by diet and medication. VA proposes a 20-percent evaluation for diverticular disease requiring hospitalization one or more times per year for abdominal distress, fever, and leukocytosis (elevated white blood cells) without associated hemorrhage, obstruction, abscess, peritonitis, or perforation. VA proposes a 30-percent evaluation for diverticular disease requiring hospitalization for abdominal distress, fever, and leukocytosis one or more times the past 12 months, with at least 1 of the following complications: Hemorrhage, obstruction, abscess, peritonitis, or perforation. VA also proposes to include one note to clarify that rating personnel should evaluate colectomy or colostomy under either this DC or DC 7329 (Intestine, large, resection of), whichever DC results in the highest evaluation.

Diagnostic Code 7328

VA currently evaluates resection of the small intestine as follows: A 60-percent evaluation if the condition shows ''marked interference with absorption and nutrition, manifested by severe impairment of health objectively supported by examination findings, including material weight loss;'' a 40-percent evaluation if the condition produces ''definite interference with absorption and nutrition, manifested by impairment of health objectively supported by examination findings, including definite weight loss;'' and a 20-percent evaluation if the condition is ''symptomatic, with diarrhea, anemia, and inability to gain weight.''

These criteria contain vague terms, such as ''material,'' ''definite,'' and ''marked.'' Also, the current criteria, based partly on weight loss or the inability to gain weight, are no longer appropriate because the availability of parenteral and supplemental nutrition will ordinarily allow patients to maintain body weight.

Therefore, VA proposes to provide rating criteria that are both more objective and more characteristic of the disabling effects of resection of the small intestine in light of modern medicine. The new criteria would consider the need for oral dietary supplementation or parenteral nutrition and the presence of diarrhea and other symptoms.

Based on the current clinical guidelines and reflective of functional outcomes of small intestine resection described below, VA proposes to assign a 0-percent evaluation for asymptomatic individuals with a history of resection of the small intestine. VA would assign a 20-percent evaluation for an individual who is status post intestinal resection and experiences 4 or more episodes of diarrhea per day. VA proposes a 40-percent evaluation when there is evidence of 4 or more episodes of diarrhea per day resulting in undernutrition and anemia, and the individual requires prescribed oral dietary supplementation and continuous medication. VA proposes a 60-percent evaluation for manifestations of undernutrition and anemia and

requiring prescribed oral dietary supplementation, continuous medication and intermittent total parental nutrition (TPN). VA proposes an 80-percent evaluation for manifestations of undernutrition and anemia that require total parenteral nutrition.

Additionally, VA proposes to include an explanatory note stating that this condition includes short bowel syndrome, mesenteric ischemic thrombosis, and post-bariatric surgery complications with instructions to consider a higher rating for short bowel syndrome with high-output syndrome (including high-output stoma) under DC 7329 ''Intestine, large, resection of.''

The average length of the adult human small intestine is approximately 600 cm (236.22 in), as calculated from studies performed on cadavers. According to Lennard-Jones and to Weser, the range extends from 260 (102.4 in) to 800 cm (315 in).[1] Any disease, traumatic injury, vascular accident, or other pathology that leaves less than 200 cm (78.7 in) of viable small bowel or results in a loss of 50 percent or more of the small intestine places the patient at risk for developing short-bowel syndrome. Short-bowel syndrome is a disorder clinically defined by malabsorption, diarrhea, steatorrhea (fatty stool), fluid and electrolyte disturbances, and malnutrition. The common etiologic factor in all causes of short-bowel syndrome is the functional or anatomic loss of extensive segments of small intestine so that absorptive capacity is severely compromised. Burt Cagir, M.D., FACS, ''Short Bowel Syndrome,'' Medscape Reference (May 22, 2019), *https://emedicine.medscape.com/article/193391-overview#showall* (last viewed Oct. 10, 2019). In some cases, short bowel syndrome can result in high-output syndrome (including high-output stoma), in which the increased elimination and reduced absorption in the colon produce an imbalance in certain electrolytes. Therefore, VA intends to direct rating personnel to consider whether they may assign a higher evaluation under proposed DC 7329 (Intestine, large, resection of), where VA provides for a 100-percent evaluation when a high-output syndrome has resulted in more than 2 episodes of dehydration requiring intravenous hydration in the past 12 months.

Diagnostic Code 7329

VA currently evaluates resection of the large intestine (DC 7329) based on undefined criteria of whether symptoms are ''severe'' (40 percent), ''moderate'' (20 percent), or ''slight'' (10 percent). VA proposes new rating criteria that replace these subjective terms with more objective indicators based on the amount/level of resection, the need for chronic intravenous hydration following surgery, and other surgical outcomes, such as colostomy and ileostomy.

Specifically, VA proposes evaluations at the 10, 20, and 40 percent levels for partial colectomy (resection of only part of the large intestines). VA proposes a 10-percent evaluation for a partial colectomy with reanastomosis (reconnection of the intestinal tube). VA proposes a 20-percent evaluation for a similar level of resection (partial colectomy), but loss of the ileocecal valve, which prevents the flow of bacteria from the large intestine to the small intestine, and with subsequent recurrent diarrhea of more than 3 times per day. See ''Short Bowel Syndrome and Crohn's Disease,'' Crohn's & Colitis Foundation of America, 3 (March 2018), *https://www.crohnscolitisfoundation.org/sites/default/files/legacy/assets/pdfs/short-bowel-disease-crohns.pdf* (last visited Oct. 06, 2021). Without the ileocecal valve, individuals may develop small-growth bacteria, which manifest as diarrhea, bloating, nausea, and vomiting. Id.

VA proposes a 40-percent evaluation for a partial colectomy with permanent colostomy (an opening in the abdominal wall that is made during surgery). Individuals with colostomies must live with small bags attached to their abdomen. These bags collect stool and individuals must empty them. See ''Colostomy,'' in ''A.D.A.M. Medical Encyclopedia,'' PubMed Health, U.S. National Library of Medicine (Oct. 05, 2021), *http://www.nlm.nih.gov/medlineplus/ency/article/002942.htm* (last visited Oct. 06, 2021).

Additionally, VA proposes higher ratings, 60 and 100 percent, for veterans with total colectomies, or complete removal of the large intestines (colon). Total colectomy is a procedure most commonly done to treat many diseases of the colon such as colon cancer, Crohn's disease, ulcerative colitis, or massive abdominal trauma. One of the major functions of the intact large intestine is to absorb water, electrolytes, and vitamins. Following total colectomies, increased amount of fluid may be excreted, resulting in a chronic salt and water depletion, which can result in a number of metabolic changes. Christl SU and Scheppach W., Metabolic consequences of total colectomy. Scand J Gastroenterol Suppl. 1997;222:20–4. (last visited Oct. 06, 2021) In some cases, total colectomy is performed in conjunction with ileostomy surgery (small intestine known as the ileum). Permanent ileostomies are created when the large intestine (colon) is damaged and needs removing. Occasionally, and most frequently seen in cases with ileostomies, individuals may experience ''high-output syndrome,'' in which the high intestinal output increases the risk of dehydration and fluid-electrolyte abnormalities, and seriously impairs the quality of life. K. McDoniel et al., ''Use of clonidine to decrease intestinal fluid losses in patients with high-output short bowel syndrome,'' 28 J. of Parenteral Enteral Nutrition 4: 265–68 (July–Aug. 2004). *https://www.ncbi.nlm.nih.gov/pubmed/15291409* (last visited Oct. 06, 2021)

To adequately compensate veterans with total colectomies, VA proposes a 60-percent evaluation for a total colectomy without high output syndrome. VA proposes a 100-percent evaluation for a total colectomy with formation of ileostomy (permanent opening), high-output syndrome, and more than 2 episodes of dehydration requiring intravenous hydration in the past 12 months.

Diagnostic Code 7330

DC 7330 is currently titled ''Intestine, fistula of, persistent, or after attempt at operative closure.'' However, this title does not address the full range of intestinal fistulas. Therefore, VA proposes to retitle this code as ''Intestinal fistulous disease, external,'' and include a note explaining that this code applies to external fistulas that have developed as a consequence of abdominal trauma, surgery, radiation, malignancy, infection, or ischemia. David E. Stein, MD, et al., ''Intestinal Fistulas Treatment and Management,'' Medscape Reference (Mar 08, 2018), *http://emedicine.medscape.com/article/179444-overview* (last visited Oct 06, 2021).

Currently, the amount and frequency of fecal discharge determines the evaluation under DC 7330. VA assigns a 100-percent evaluation if fecal discharge is ''copious and frequent;'' a 60-percent evaluation for discharge that is ''constant or frequent;'' and a 30-percent evaluation for ''slight'' and ''infrequent.'' VA evaluates healed fistulas as peritoneal adhesions. As previously noted, terms such as ''frequent'' and ''slight'' are too vague to allow for consistent evaluations. Through this update, VA proposes to replace such references with more specific and objective criteria.

Therefore, VA proposes new rating criteria which would account for the

quantity of drainage from the fistula, as well as any need for nutritional support. Specifically, VA proposes a 30-percent evaluation for intermittent fecal discharge with persistent drainage that lasts longer than 3 months in the past 12 months. VA proposes a 60-percent evaluation for mandatory enteral nutritional support along with at least one of the following: Daily drainage equivalent to 3 or less standard ostomy bags (sized 130 cubic centimeters); or requiring fewer than 10 pad changes per days; or a Body Mass Index (BMI) between 16 and 18 with persistent drainage of any amount for more than 2 months in the past 12 months. VA proposes a 100-percent evaluation for mandatory total parenteral nutrition; or enteral nutrition along with at least one of the following: Daily discharge equivalent to 4 or more standard ostomy bags (sized 130 cubic centimeters); or requiring 10 or more pad changes per days; or both a BMI less than 16 and persistent draining for more than 1 month during the past 12 months.

Diagnostic Code 7332

Current DC 7332 applies to impairment of sphincter control of the rectum and anus. VA proposes to include a note to ensure that rating personnel understand that such control may include either the inability to retain or the inability to expel stool at an appropriate time and place.

Currently, VA assigns: A 100-percent evaluation if the loss of sphincter control is complete; a 60-percent evaluation if there is ''extensive leakage and fairly frequent involuntary bowel movements;'' a 30-percent evaluation for occasional involuntary bowel movements, such that changing a pad is necessary; a 10-percent evaluation for constant slight, or occasional moderate, leakage; and a 0-percent evaluation if the condition is healed or slight, without leakage. These criteria contain numerous indefinite terms, such as ''extensive,'' ''frequent,'' ''occasional,'' and ''slight,'' which are open to interpretation.

Therefore, VA proposes to use the widely-recognized Cleveland Clinic Incontinence Scale (CCIS), a standardized, evidence-based measure that accounts for difficulties with retention and expulsion of stool. This scale determines the severity of sphincter impairment by assigning a score between 0 (absent) and 4 (daily) in each of the following 5 categories: Incontinence to gas, incontinence to liquid, incontinence to solid, need to change a pad, and lifestyle changes. A.M. Kaiser, ''The McGraw-Hill Manual of Colorectal Surgery,'' 743 (2009).

VA's proposed rating criteria provide descriptive criteria that track the CCIS and objective means of determining functional impairment, such as a degree of stool incontinence, a need to change a pad, and lifestyle changes.

Specifically, VA proposes a 0-percent evaluation for a history of impairment of sphincter control, but without current symptoms. VA proposes a 10-percent evaluation when a veteran has incontinence or retention that is fully responsive to a physician-prescribed bowel program and requires either medication or special diet. Alternatively, VA may assign a 10-percent evaluation with incontinence to solids and/or liquids at least once every 6 months, and which requires wearing a pad at least once every 6 months.

VA proposes a 30-percent evaluation when a veteran has incontinence or retention that is fully responsive to a physician-prescribed bowel program and requires digital stimulation, medication (beyond laxative use), and special diet. Alternatively, a 30-percent evaluation is proposed with incontinence to solids and/or liquids 2 or more times per month, which requires changing a pad 2 or more times per month.

VA proposes a 60-percent evaluation when an individual has complete or partial loss of sphincter control characterized by incontinence or retention that is partially responsive to a physician-prescribed bowel program, which requires either surgery or digital stimulation, as well as prescribed medication (beyond laxative use) and special diet. Alternatively, VA may assign a 60-percent evaluation for incontinence to solids and/or liquids 2 or more times per week, which requires changing of a pad 2 or more times per week.

VA proposes a 100-percent evaluation when a veteran has complete loss of sphincter control characterized by incontinence or retention that is not responsive to a physician-prescribed bowel program and that requires either surgery or digital stimulation, with medication and diet. Alternatively, VA may assign a 100-percent evaluation for incontinence to solids and/or liquids 2 or more times per day, which requires changing a pad 2 or more times per day.

Diagnostic Code 7333

The current rating criteria for DC 7333, stricture of the rectum and anus, include: ''requiring colostomy'' for a 100-percent evaluation; ''great reduction of lumen, or extensive leakage'' for a 50-percent evaluation; and ''moderate reduction of lumen, or moderate constant leakage'' for a 30-percent evaluation. VA notes that this proposed rulemaking includes a separate DC, DC 7329, which adequately evaluates colostomy and ileostomy. As such, there is no longer a need to include colostomy in the rating criteria for DC 7333. Instead, VA proposes to add a Note (2), directing rating personnel to evaluate an ostomy as DC 7329 (Intestine, large, resection of).

Further, VA proposes to remove from the rating criteria the indefinite terms, such as ''great,'' ''extensive,'' and ''moderate,'' and instead replace them with objective criteria on the extent of reduction of the lumen (or the opening of the anal canal). Brisinda, G., et al., Surgical treatment of anal stenosis, World J Gastroenterol. 2009 Apr 28; 15(16): 1921–1928 (last visited Oct 06, 2021) *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2675080/*. Specifically, VA proposes: A 10-percent evaluation for luminal narrowing with or without straining during defecation, which is managed by dietary intervention; a 30-percent evaluation for reduction of the lumen by less than 50 percent, with straining during defecation; a 60-percent evaluation for the reduction of the lumen by at least 50 percent, with pain and straining during defecation; and a 100-percent evaluation for the inability to open the anus accompanied by the inability to expel solid feces. Carrington, Emma V., at al., Advances in the evaluation of anorectal function, Nat Rev Gastroenterol Hepatol. 2018 May; 15(5): 309–323., (last visited Oct. 06, 2021) *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6028941/*.

VA also advises in Note (1) that rating personnel may use this code to evaluate such conditions as dyssynergic defecation (levator ani) and anismus (functional constipation).

Diagnostic Code 7334

DC 7334, Prolapse of the rectum, currently provides the following evaluations: 50 percent for ''severe (or complete), persistent'' rectal prolapse; 30 percent for ''moderate, persistent or frequently recurring'' rectal prolapse; and 10 percent for mild rectal prolapse ''with constant slight or occasional moderate leakage.'' These criteria, employing such terms as ''mild,'' ''moderate,'' ''severe,'' or ''frequently recurring,'' are vague and subjective and may lead to inconsistent decisions.

VA proposes to remove the subjective language and apply new rating criteria based on precipitating factors, whether or not prolapse can be reduced, along with whether or not surgical repair can be performed. These elements are easily measured and represent accurate

proxies for occupational impairment. Seenivasagam, T., et al., Irreducible Rectal Prolapse: Emergency Surgical Management of Eight Cases and A Review of the Literature Med J Malaysia Vol 66 No 2 June 2011 (last visited Oct. 06, 2021) *http://www.e-mjm.org/2011/v66n2/Rectal_Prolapse.pdf*.

Specifically, VA proposes a 10-percent evaluation for spontaneously reducible prolapse that is not repairable. VA proposes a 30-percent evaluation for manually reducible prolapse of the rectum that is not repairable and occurs only after bowel movements, exertion, or performing the Valsalva maneuver. VA proposes a 50-percent evaluation for manually reducible prolapse that is not repairable and occurs at times other than bowel movements, exertion, or while performing the Valsalva maneuver. VA proposes to add a 100-percent evaluation for persistent prolapse of the rectum that is irreducible, regardless of whether it is repairable. A note would continue a 100-percent evaluation for 2 months following any repair and provide that VA would then evaluate the residual condition and apply 38 CFR 3.105(e) to any change.

VA also proposes a second note instructing rating personnel to provide a single evaluation under DC 7332 (Rectum and anus, impairment of sphincter control) when sphincter control is the predominant disability.

Diagnostic Code 7335

''Fistula-in-ano'' (DC 7335) is also known as ''anorectal fistula.'' The criteria in this DC also apply to anorectal abscesses. Therefore, VA proposes to add these names to the title to help rating personnel correctly apply the criteria.

Currently, VA evaluates this condition analogously to DC 7332 (Rectum and anus, impairment of sphincter control). VA assigns evaluations of 0, 10, 30, 60, or 100 percent based on loss of sphincter control and involuntary bowel movements. However, the current rating criteria for impairment of sphincter control does not consider the primary disabling effects of fistulas, which are abscesses, pain, and drainage. See J.L. Poggio, ''Fistula-in-Ano,'' Medscape Reference (Mar. 27, 2020), *http://emedicine.medscape.com/article/190234-overview#showall* (last visited Oct. 06, 2021). Therefore, VA proposes the following rating criteria to address the specific disabling effects of fistula-in-ano: A 10-percent evaluation for a single fistula with pain and discharge, but which is not accompanied by abscess; a 20-percent evaluation for 2 or more simultaneous fistulas with some drainage and pain, but not accompanied by abscess; a 40-percent evaluation for 1 or 2 simultaneous fistulas accompanied by abscess, drainage, and pain; and a 60-percent evaluation for more than 2 constant or near-constant fistulas with abscess, drainage, and pain, which are refractory to medical and surgical treatment.

Diagnostic Code 7336

VA currently evaluates hemorrhoids (DC 7336) by assigning: A 20-percent evaluation for ''persistent bleeding and with secondary anemia, or for fissures;'' a 10-percent evaluation for hemorrhoids that are ''large or thrombotic, irreducible, with excessive redundant tissue, evidencing frequent recurrences;'' and a 0-percent evaluation if they are ''mild or moderate.''

Current medical understanding recognizes there are differences in the expected presentations, exam findings, and treatment approaches between internal hemorrhoids and external hemorrhoids. See Scott C. Thornton,''Hemorrhoids'' Medscape Reference Sep. 24, 2019. *https://emedicine.medscape.com/article/775407-overview* (last visited Oct. 06, 2021). However, the current rating criteria do not differentiate between internal and external hemorrhoids. As such, VA proposes to include location in the rating criteria, as well as remove subjective terms such as ''mild,'' ''moderate,'' ''excessive,'' and ''frequent,'' which may lead to inconsistent evaluations. VA would replace them with more objective criteria that apply, in part, to any type of hemorrhoid and, in part, only to either internal or external hemorrhoids.

VA therefore proposes to assign a 10-percent evaluation for prolapsed internal hemorrhoids with 2 or less episodes per year of thrombosis, or for external hemorrhoids with three or more episodes per year of thrombosis. VA proposes a 20-percent evaluation for either of the following: Internal or external hemorrhoids with persistent bleeding and anemia, or continuously prolapsed internal hemorrhoids with 3 or more episodes per year of thrombosis.

Diagnostic Code 7337

Pruritis ani (DC 7337) is an itching and a compelling need to scratch the area around the anus. Therefore, for clarity, VA proposes to add ''anal itching'' to the title of this code.

This condition is generally a symptom of another condition, such as a skin disorder or hemorrhoids. Currently, VA directs rating personnel to evaluate pruritis ani under the criteria provided for the underlying condition. However, in many cases, this practice does not account for the actual itching. Therefore, VA proposes to associate specific rating criteria to better evaluate it, in addition to the underlying condition.

Specifically, VA proposes to assign a 0-percent evaluation for anal itching without bleeding or excoriation (tearing of the skin). VA proposes to assign a maximum 10-percent evaluation if the condition is associated with bleeding or excoriation.

Diagnostic Codes 7338, 7339 and 7340

Currently DC 7338 is titled as ''Hernia, inguinal,'' DC 7339 is titled ''Hernia, ventral, postoperative,'' and DC 7340 is titled ''Hernia, femoral.'' For the reasons set forth below, VA proposes to combine these three diagnostic codes into one diagnostic code, titled ''Hernia, including femoral, inguinal, umbilical, ventral, incisional, and other (but not including hiatal).'' These different types of hernia have similar functional impairments that arise from the weakness and/or defects of the abdominal wall and associated pain. Even though the location of the hernia may differ, this functional impairment results in disabilities that can be quantified using similar elements, permitting development of universally applicable evaluation criteria. The elements for the proposed evaluation criteria are both objective and measurable, which in turn ensures greater consistency of adjudication process (inter-rater reliability).

A hernia is defined as a protrusion, bulge, or projection of an organ or a part of an organ through the body wall that normally contains it. There are a lot of different types of hernias to include groin hernias (inguinal and femoral), umbilical, ventral, incisional, hiatal, and other less common types such as epigastric, giant abdominal, and spigelian. See WebMD Medical Reference, Medically Reviewed by Neha Pathak, MD on September 21, 2020, What Are the Types of Hernias? (last visited Oct. 06, 2021) *https://www.webmd.com/digestive-disorders/types-of-hernias#1*. Most of the hernias, with exception of hiatal hernias, share common features of functional impairment due to abdominal wall defect, surgical approaches, and treatment prognosis (functional outcomes). Hiatal hernias are different from the other hernias because they involve a diaphragm, an internal muscle that separates the chest from the abdominal cavity. With a hiatal hernia there is no visible protrusion, but symptoms may include heartburn, chest

pain, and a bad taste in the mouth, which are due to the upward flow of stomach acid, air, or bile. Hiatal hernia is rated under DC 7346.

VA proposes to combine evaluations currently done under DCs 7338, 7339, and 7340 under new retitled DC 7338, ''Hernia, including femoral, inguinal, umbilical, ventral, incisional, and other (but not including hiatal).'' VA takes into consideration pain or discomfort somewhere on the surface of the abdomen or in the groin area; however, a hernia can also be painless and only appear as a bulge. VA proposes to base its evaluation of disability due to new or recurrent hernia that is present for 12 months or more on: (1) The size of the abdominal wall defect, (2) the ability to surgically repair or reduce hernia (repairable versus irreparable), and (3) the degree of postoperative functional impairment.

VA proposes to evaluate the size of the abdominal wall defect using the concept of ''loss of domain'' (LOD). LOD expresses the relationship between the size of a hernia and abdominal volume (contents of the abdominal cavity) where herniated contents of the abdominal cavity permanently inhabit the hernia sac. See Parker, S. G., et al., What Exactly is Meant by ''Loss of Domain'' for Ventral Hernia? Systematic Review of Definitions. World J Surg. 2019; 43(2): 396–404. (last visited Oct. 06, 2021) *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6329734/*. LOD is widely used to predict operative difficulty and success, which in turn is indicative of any future functional impairment and associated disability. See E. Tanaka ''A computerized tomography scan method for calculating the hernia sac and abdominal cavity volume in complex large incisional hernia with loss of domain.'' Hernia, vol. 14, Pg 64. 2010. (last visited Oct. 06, 2021) *https://link.springer.com/article/10.1007%2Fs10029-009-0560-8*. Multiple sources identify the ''cut-off'' threshold or percentage proportion above which LOD becomes clinically significant (*i.e.* the point at which closing an abdominal defect becomes very difficult and development of complications is more likely), when a hernia's size is equal to 15 cm or greater in one dimension. See Buenafe A. A., Lee-Ong, A., Lateral release in the repair of large ventral hernia. Ann Laparosc Endosc Surg 2019; 4:24 (last visited Oct. 06, 2021) *http://ales.amegroups.com/article/view/5038/html*.

VA proposes to evaluate the degree of postoperative functional impairment based on the Carolinas Comfort Scale (CCS). CCS is a validated, disease-specific, quality of life (QOL) questionnaire developed for patients undergoing hernia repair, which takes into consideration an individual's ability to (1) bend over, (2) perform activities of daily living (ADLs), (3) walk, and (4) climb stairs in the presence or absence of postoperative pain. The presence of pain during these activities increases the odds that a patient will not return to work. See B. T. Heniford, ''Carolinas Comfort Scale as a Measure of Hernia Repair Quality of Life,'' Annals of Surgery, vol 267(1), Pg. 175. January 2018. (last visited Oct. 06, 2021) *https://insights.ovid.com/pubmed?pmid=27655239*. Furthermore, pain is the most common symptom associated with hernia repair and can severely affect an individual's functional status. See L. Chung, et. al., ''Pain and its effects on physical activity and quality of life before operation in patients undergoing elective inguinal and ventral hernia repair,'' Am J Surg vol 208(3), Pg. 406–411. 2014. The CCS questionnaire proved to be a reliable instrument for assessing quality of life and functional impairment after hernia repair and has become a predominant outcome measure in this discipline of surgery.

VA proposes a 100-percent evaluation for new or recurrent irreparable hernia, which is present for 12 months or more, and with both of the following features and symptoms that are present for 12 months or more: (1) Hernia size equal to 15 cm or greater in one dimension; and (2) pain is present when performing at least three of the following activities: Bending over, ADLs, walking, and climbing stairs. In similar cases where pain is present when performing two of the aforementioned activities, VA proposes a 60-percent disability evaluation.

VA proposes a 30-percent evaluation for new or recurrent irreparable hernia, which is present for 12 months or more, and with both of the following features and symptoms that are present for 12 months or more: (1) Size is equal to 3 cm or greater but less than 15 cm in one dimension; and (2) pain is present when performing at least two of the aformentioned activities. In similar cases where pain is present when performing one of the aforementioned activities, VA proposes a 20-percent disability evaluation.

VA proposes a 10-percent disability evaluation for new or recurrent irreparable hernia, which is present for 12 months or more and with hernia size smaller than 3 cm. VA proposes a 0-percent evaluation for asymptomatic hernia, which is either present and repairable, or was repaired.

Diagnostic Code 7344

VA proposes to add a note to DC 7344 clarifying that the conditions evaluated under DC 7344 ''Benign neoplasms, exclusive of skin growths'' include lipoma, leiomyoma, colon polyps, and villous adenoma. VA would not substantively change the instruction to evaluate the predominant disability or the specific residuals after treatment under an appropriate DC.

Diagnostic Code 7345

Currently, DC 7345 is titled ''Chronic liver disease without cirrhosis (including Hepatitis B, chronic active hepatitis, autoimmune hepatitis, hemochromatosis, drug-induced hepatitis, etc., but excluding bile duct disorders and Hepatitis C).'' VA proposes to simplify this title to ''Chronic liver disease without cirrhosis,'' which would be consistent with current medical terminology.

The current rating criteria for DC 7345 assigns evaluations as follows: A 100-percent evaluation for ''near-constant debilitating symptoms (such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain);'' a 60-percent evaluation for ''daily fatigue, malaise, and anorexia with substantial weight loss (or other indication of undernutrition), and hepatomegaly; or incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least 6 weeks during the past 12-month period, but not occurring constantly;'' a 40-percent evaluation for ''daily fatigue, malaise, and anorexia, with minor weight loss and hepatomegaly, or incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least 4 weeks, but less than 6 weeks, during the past 12-month period;'' a 20-percent evaluation for ''daily fatigue, malaise, and anorexia (without weight loss or hepatomegaly) requiring dietary restriction or continuous medication; or incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least 2 weeks, but less than 4 weeks, during the past 12-month period;'' a 10-percent evaluation for ''intermittent fatigue, malaise, and anorexia, or incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least

1 week, but less than 2 weeks, during the past 12-month period;'' and a 0-percent evaluation if the condition is not symptomatic.

Current rating criteria contain numerous references to subjective factors, such as what constitutes an ''incapacitating episode'' and how long it lasts, which may contribute to inconsistent adjudication decisions. Similarly, the difference between ''minor'' versus ''substantial'' weight loss is ambiguous. Therefore, VA proposes to include more objective factors, such as required medication and laboratory evidence of liver damage. VA also intends to reduce the number of disability levels from six (0, 10, 20, 40, 60, and 100) to five (0, 20, 40, 60, and 100) because using more objective evidence-based factors requires clearer distinctions between disability levels. Veterans currently rated under DC 7345 would not see their disability evaluations change solely because of these proposed revisions. Additionally, VA takes into consideration significant advances in the treatment and management of patients with viral hepatitis which occurred during the last decade. Two major classes of antiviral therapeutics have been adopted to treat the infection: Drugs that directly interfere with virus replication (direct antiviral agents) and drugs that modulate antiviral immune response (immunomodulatory drugs). As a result, people experience better outcomes, fewer side effects and shorter treatment times. For example, with the use of new antiviral drugs, hepatitis C has become a curable disease in more that 95 percent of the treated patients. See Roderburg, C. et al., Antiviral Therapy in Patients with Viral Hepatitis and Hepatocellular Carcinoma: Indications and Prognosis. Visc Med. 2016 Apr; 32(2): 121–126. (last visited Oct. 06, 2021) *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4926886/.*

VA recognizes that occupationally relevant symptoms, such as fever, nausea, muscle aches and soreness, joint pain, and profound fatigue, are common during hepatitis treatment. In some instances, headache, insomnia, weight loss, or difficulties with memory or concentration, can also occur. Bertoletti, A. and Le Bert, N., Immunotherapy for Chronic Hepatitis B Virus Infection, Gut Liver. 2018 Sep; 12(5): 497–507. (last visited Oct. 06, 2021) *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6143456/, https://pubmed.ncbi.nlm.nih.gov/29316747/.* Furthermore, treatment total effectiveness (''cure'') or sustained off-treatment control (''functional cure'') of hepatitis infection is determined by the inability to detect virus load for 6 months after discontinuing therapy. VA proposes to maintain a 100-percent evaluation during treatment with both parenteral (infusion) direct antiviral agents (such as entecavir, lamivudine, tenofovir, telbivudine, and other) and parenteral immunomodulatory drugs (such as interferon and other). In a new Note (1), VA proposes to continue a 100-percent evaluation for six months following discontinuance of treatment (parenteral antiviral therapy and parenteral immunomodulatory drugs). Thereafter, six months after discontinuance of parenteral antiviral therapy and parenteral immunomodulatory drugs, VA proposes to determine the appropriate disability rating by mandatory VA exam. Lastly, VA proposes to apply the provisions of § 3.105(e) to any change in evaluation based upon that or any subsequent examination.

VA proposes a 60-percent evaluation for progressive chronic liver disease that requires continuous medication and causes substantial weight loss and at least two of the following symptoms: Daily fatigue, malaise (feeling ill), anorexia (loss of appetite), hepatomegaly (enlarged liver), pruritus (itch), and arthralgia (joint pain). VA proposes a 40-percent evaluation for progressive chronic liver disease that requires continuous medication and causes minor weight loss and at least two of the following symptoms: Daily fatigue, malaise, anorexia, hepatomegaly, pruritus, and arthralgia. VA proposes a 20-percent evaluation for chronic liver disease accompanied by at least one of the following symptoms: Intermittent fatigue, malaise, anorexia, hepatomegaly, or pruritus. VA proposes to assign a 0-percent evaluation for a history of liver disease without current symptoms.

VA proposes to retain existing Note (1) but re-designate it as Note (4). VA recognizes that some individuals may not be able to receive parenteral (infusion) antiviral or immunomodulatory therapy or a second oral antiviral medication, despite physician recommendation, because the use of such medications may be contraindicated in their specific case. Therefore, VA proposes Note (2) that instructs rating personnel to evaluate such cases under DC 7312 ''Cirrhosis of the liver.'' To further assist VA adjudicators in delivering consistent rating decisions, VA proposes an explanatory Note (3), which provides a list of the disorders to be evaluated underusing this diagnostic code: Hepatitis B, Primary Biliary Cirrhosis (PBC), Primary Sclerosing Cholangitis (PSC), autoimmune liver disease, Wilson's disease, Alpha-1-antitrypsin deficiency, hemochromatosis, drug-induced hepatitis, and non-alcoholic steatohepatitis (NASH). The proposed Note (3) would also contain the information discussed in current Note (3), namely, that serologic testing must confirm Hepatitis B. Additionally, Note (3) would clarify that while VA would evaluate Hepatitis C using the criteria under DC 7345, rating personnel should code it under DC 7354 ''Hepatitis C (or non-A, non-B hepatitis)'' so VA can track the claims and decisions regarding Hepatitis C in the veterans' population.

Diagnostic Code 7346

Hiatal hernias occur when part of the stomach protrudes upwards through the diaphragm (the muscle across the bottom of the rib cage that helps control breathing). Symptoms are rare, but when present are due to the upward flow of stomach acid, air, or bile. See ''Hiatal Hernia,'' in ''A.D.A.M. Medical Encyclopedia,'' PubMed Health, U.S. National Library of Medicine (April 24, 2017), *https://medlineplus.gov/ency/article/001137.htm* (last accessed Nov. 6, 2018). Therefore, VA proposes to retitle this DC as ''Hiatal hernia and paraesophageal hernia'' to more accurately reflect the conditions VA is likely to evaluate under this code.

VA currently assigns evaluations for hiatal hernias as follows: A 60-percent evaluation for symptoms of ''pain, vomiting, material weight loss, and hematemesis or melena with moderate anemia, or other symptom combinations productive of severe impairment of health;'' a 30-percent evaluation for ''persistently recurrent epigastric distress with dysphagia, pyrosis, and regurgitation, accompanied by substernal or arm or shoulder pain, productive of considerable impairment of health;'' and a 10-percent evaluation for 2 or more of the same symptoms as for the 30 percent evaluation, but of less severity.

However, as discussed above, the medical community now recognizes that impairment of the esophageal sphincter creates the majority of symptoms. See Dakkak, supra. As such, VA proposes to delete the existing rating criteria and instead instruct rating personnel to evaluate this condition under DC 7203 (Esophagus, stricture of).

Diagnostic Code 7347

Currently, DC 7347 is titled ''Pancreatitis.'' Acute pancreatitis can be a very serious, even life threatening, condition but most individuals can expect complete recovery. Nevertheless, acute pancreatitis can become chronic if

pancreatic tissue sustains irreversible damage and develops scarring (fibrosis). Therefore, VA proposes to retitle this DC as ''Pancreatitis, chronic'' to more adequately reflect long-term functional impairment of this condition.

The pancreas is the organ that produces enzymes necessary for digestion. The inflammation from chronic pancreatitis disrupts the production of necessary digestive enzymes, creating pancreatic insufficiency. Etemad, B. and Whitcomb, D.C., Chronic pancreatitis: Diagnosis, classification, and new genetic developments. Gastroenterology 2001: Diagnostics & Therapeutics. Gastroenterology, Volume 120, Issue 3, February 2001, Pages 682–707 (last visited Oct. 06, 2021) *https://www.sciencedirect.com/science/article/pii/S001650850100796X?via%3Dihub*. Abdominal pain, with intermittent attacks of severe pain, is the most prevalent symptom in individuals with chronic pancreatitis. Other symptoms associated with chronic pancreatitis include diarrhea and weight loss. Chronic pancreatitis is a severe progressive debilitating illness that can worsen over time, leading to permanent impairment. The clinical picture is complex, involving multiple systems with occasional extreme debility and confinement.

The current criteria for assigning evaluations are as follows: A 100-percent evaluation for frequently recurring disabling attacks of abdominal pain with few pain-free intermissions and with steatorrhea (excess fat in the stools), malabsorption, diarrhea, and severe malnutrition; a 60-percent evaluation for frequent attacks of abdominal pain, loss of normal body weight, and other findings showing continuous pancreatic insufficiency between acute attacks; a 30-percent evaluation for a moderately severe condition, with at least 4–7 typical attacks of abdominal pain per year with good remission between attacks; and a 10-percent evaluation for at least 1 recurring attack of typical severe abdominal pain in the past year.

VA proposes new rating criteria that incorporate medical advances in pain management, digestive enzyme replacement, and assisted nutrition (tube enteral feeding). Additionally, the new rating criteria accounts for complications resulting from pancreatic insufficiency, the number of annual episodes, pain management, and hospitalizations.

VA proposes to remove the current 10-percent disability level, which accounts for a single attack of abdominal pain in the past year, which does not require any treatment or cause any long-term complications. This level of functional impairment would have minimal to no impact on earning capacity. VA proposes a 30-percent disability evaluation for confirmed diagnosis of pancreatitis with at least one episode per year of abdominal or mid-back pain that requires an ongoing outpatient medical treatment for pain, digestive problems, or management of related complications such as cyst or pseudocyst, intestinal obstruction, or ascites. VA proposes a 60-percent evaluation for three or more episodes of abdominal or mid-back pain per year, with at least one episode per year requiring hospitalization for management of complications related to abdominal pain or requiring enteral feeding. VA proposes a 100-percent evaluation for daily episodes of abdominal or mid-back pain requiring 3 or more hospitalizations per year, as well as pain management by a physician, with maldigestion and malabsorption requiring dietary restriction and pancreatic enzyme supplementation.

In addition to the revised rating criteria, VA proposes to make nonsubstantive changes to the existing Note (1) requiring laboratory evidence or clinical studies confirming pancreatitis as the cause of abdominal pain, as many other causes for such pain may exist. VA proposes to delete the current Note (2). A newly proposed code, DC 7357 (Post-pancreatectomy syndrome), eliminates the need to instruct personnel to rate total or partial pancreatectomy a minimum of 30 percent.

VA proposes replacing the current Note (2) with a note instructing personnel to separately rate diabetes due to pancreatic insufficiency under DC 7913 (Diabetes mellitus).

Diagnostic Code 7348

DC 7348, Vagotomy with pyloroplasty or gastroenterostomy, evaluates complications that may occur following certain abdominal surgeries. At one time, physicians commonly used these procedures to treat gastric ulcer disease. See R.A. Hejazi et al., ''Postsurgical Gastroparesis,'' in ''Gastroparesis: Pathophysiology, Presentation, and Treatment,'' 194 (Henry P. Parkman and Richard W. McCallum eds. 2012). However, medication now treats the majority of gastric ulcer disease. Today, vagotomy most often follows lung transplant surgery. Id. Therefore, VA proposes to remove the current reference to ''recurrent ulcer'' in the criteria for a 20-percent evaluation, so it would then read simply ''with incomplete vagotomy.'' VA would not change the remainder of the criteria.

Rating personnel are likely to continue to encounter veterans who experienced permanent complications after surgeries to treat gastric ulcers. Therefore, VA would retain the existing note on evaluating recurrent gastric ulcer following complete vagotomy. However, to maintain consistency with the overall amendments, the note would refer rating personnel to the revised DC 7304 (Peptic ulcer disease), which VA is proposing to expand to include all ulcer disease, rather than DC 7305 (Ulcer, duodenal), which VA is proposing to discontinue.

The current note under DC 7348 also instructs rating personnel to evaluate dumping syndrome under DC 7308. As explained above in DC 7308, VA believes that the most appropriate criteria for evaluating postgastrectomy syndromes are in the new DC 7303, and proposes to update the current note accordingly.

New Diagnostic Code 7350

A liver abscess is an infection of the liver that generally produces symptoms of fever, chills, right upper quadrant pain, loss of appetite, and a general feeling of poor health. Effective treatment generally involves drainage of the abscess followed by antibiotics, although prolonged antibiotic treatment may be used exclusively if the individual is too ill to tolerate the drainage procedure. Ruben Peralta, MD et al., ''Liver Abscess,'' Medscape Reference (Mar. 27, 2020) *http://emedicine.medscape.com/article/188802* (last visited Oct. 06, 2021). Without treatment, liver abscess results in death. Id.

Liver abscess is relevant to veterans because it is associated with travel to developing countries. M.P. Sharma et al., ''Amoebic Liver Abscess,'' 4 J. of Indian Acad. of Clinical Med., 107 (Apr. 2003). VA proposes a new DC for the three major types of liver abscess, including pyogenic (infectious), amebic (due to Entamoeba hystolytica), and fungal (related to Candida albicans and others). VA proposes a new note under DC 7350 to inform rating personnel of the various types of abscesses considered under the code.

VA proposes to assign a 100-percent evaluation for six months from the onset of this condition (date of initial diagnosis) followed by a mandatory VA examination to determine the appropriate evaluation based on any residuals. VA would apply the provisions of § 3.105(e) to any reduction in evaluation. Furthermore, despite the availability of anti-microbial agents,

modern antibiotics, and recent drainage techniques, liver abscesses can still lead to severe debilitation and systemic manifestations of anemia, infection, and liver function abnormalities that generally resolve after a convalescence period lasting anywhere from 6 to 12 months. Therefore, VA proposes to rate the condition based on chronic residuals under the appropriate body system.

Diagnostic Code 7351

VA proposes to maintain the existing criteria for liver transplant (DC 7351), but intends to add a minimum 60-percent evaluation for those awaiting retransplantation. Complications, such as side effects of necessary medications, from an earlier transplant can contribute significantly to functional impairment. Johnny C. Hong, MD, FACS et al., ''Predictive Index for Long-Term Survival After Retransplantation of the Liver in Adult Recipients: Analysis of a 26-Year Experience in a Single Center'', 254 Annals of Surgery, 444 (Sept. 2011).

VA also proposes to amend the existing note to direct rating personnel to evaluate the residuals of any recurrence of the underlying liver disease under the appropriate DC, and combine that evaluation with other post-transplant residuals under the appropriate body system(s), subject to the provisions of § 4.14 and 4.114.

New Diagnostic Code 7352

VA proposes to add a DC for pancreatic transplant. VA published its existing rating schedule before surgeons first performed the procedure. They now perform it with sufficient frequency to warrant inclusion. Dixon B Kaufman MD, Ph.D., ''Pancreas Transplantation'', Medscape Reference (Jul. 12, 2021), *http://emedicine.medscape.com/article/429408* (last visited Oct. 06, 2021).

VA proposes to assign a 100-percent evaluation beginning on the day of hospital admission for transplant surgery. In addition, a note would require a VA examination one year following hospital discharge to determine the appropriate evaluation based on residuals, subject to the provisions of § 3.105(e). VA would assign a minimum 30-percent evaluation for residuals of the necessary long-term immunosuppressive medication. This practice conforms to the concept of horizontal equity in other systems, such as a minimum 30 percent for cardiac transplantation. In addition to the reference above by Kaufman, see ''Outcomes of Recipients With Pancreatic Transplant Alone Who Develop End-Stage Renal Disease: S.K. Singh; S.J. Kim et. al. Am. Journal of Transplantation 2016: 16(2):535–540.

Diagnostic Code 7354

The current rating criteria for Hepatitis C (or non-A, non-B hepatitis) are identical to that for DC 7345 (Chronic liver disease without cirrhosis). VA does not intend to apply different criteria for Hepatitis C than for other types of hepatitis. For simplicity, VA proposes to delete the existing rating criteria associated with this code and replace it with a statement to evaluate Hepatitis C as DC 7345 (Chronic liver disease without cirrhosis). As noted above, VA would retain the separate DC for Hepatitis C for purposes of tracking information about claims and rating decisions.

New Diagnostic Code 7355

Celiac disease, also known as gluten-sensitive enteropathy, is a chronic autoimmune disorder with gastrointestinal and extraintestinal (systemic) manifestations. Individuals with celiac disease cannot tolerate gluten (a protein commonly found in wheat, rye, and barley) and experience symptoms that interfere with the digestion and absorption of food nutrients. Gastrointestinal symptoms include chronic diarrhea, abdominal bloating and pain, vomiting, constipation, flatulence, and pale, foul-smelling, or fatty stool (steatorrhea). The prognosis for patients with correctly diagnosed and treated celiac disease is excellent. However, the prognosis for patients with celiac disease who are not responding to gluten withdrawal and corticosteroid treatment is generally poor. Furthermore, celiac disease with poor response to the treatment has significant and often debilitating maldigestive and malabsorption syndrome that affects multiple organ systems. See ''Celiac Disease,'' in National Digestive Diseases Information Clearinghouse, National Institute of Diabetes and Digestive and Kidney Diseases, NIH Publication No. 08–4269 (Oct 2020), *https://www.niddk.nih.gov/health-information/digestive-diseases/celiac-disease/definition-facts* (last visited Oct. 06, 2021). The main systemic (extraintestinal) manifestations of celiac disease are based on malabsorption syndrome. Malabsorption refers to the impaired absorption of nutrients and includes defects that occur both during the digestion and absorption of food nutrients in the gastrointestinal tract. Sometimes, absorption of a single nutrient component may be impaired (such as lactose intolerance due to lactase deficiency). However, in the case of systemic diseases such as celiac disease or Crohn's disease (which affects the whole intestine), the absorption of almost all nutrients is impaired. In severe cases, malabsorption causes significant weight loss, anemia, hypocalcemia (low level of calcium in the blood), osteopenia and osteoporosis (loss of calcium from bones), Vitamin B deficiency, dermatitis herpetiformis (a skin rash), lymph node enlargement, hormonal disorders (amenorrhea and infertility in women and impotence and infertility in men), and a three-fold increased risk for development of intestinal T cell-non Hodgkin's lymphoma, and other gastrointestinal cancers such as adenocarcinoma of the small intestine and pharynx. C. Catassi et al., ''Risk of Non-Hodgkin's Lymphoma in Celiac Disease,'' 287(11) J. of the Am. Med. Asscn., 1413–19 (2002).

In its new rating criteria, VA proposes to account for both systemic (extraintestinal) and digestive manifestations of the disease. VA proposes a 30-percent evaluation for malabsorption syndrome with chronic diarrhea that is managed by medically-prescribed dietary intervention such as a prescribed gluten-free diet, and without nutritional deficiencies. VA proposes a 50-percent evaluation for individuals with malabsorption syndrome that causes chronic diarrhea managed by medically-prescribed dietary intervention, such as a prescribed gluten-free diet, with present nutritional deficiencies due to lactase and pancreatic insufficiency; and with systemic manifestations including but not limited to, weakness and fatigue, dermatitis, lymph node enlargement, hypocalcemia, low vitamin levels, or atrophy of the inner intestinal lining shown on biopsy. VA proposes an 80-percent evaluation for individuals with malabsorption syndrome that causes weakness which interferes with ADLs. Additionally, these individuals exhibit weight loss, which results in wasting and nutritional deficiencies, and systemic manifestations of the disease including, but not limited to, weakness and fatigue, dermatitis, lymph node enlargement, hypocalcemia, low vitamin levels, anemia related to malabsorption, and episodes of abdominal pain and diarrhea due to lactase deficiency or pancreatic insufficiency. In addition to these rating criteria, VA proposes to include a Note (1) directing that appropriate serum antibody testing or endoscopy with biopsy (intestinal) must confirm the diagnosis of celiac disease. For evaluation of celiac disease with the

predominant disability of malabsorption (inability to absorb nutrients from a diet), VA proposes to add a second note directing rating personnel to select the greater evaluation between the rating criteria under DC 7328 and the criteria under new DC 7355.

New Diagnostic Code 7356

VA proposes a new code to evaluate and track a group of gastrointestinal conditions characterized by chronic or recurrent symptoms that are unexplained by any structural, endoscopic, laboratory, or other objective signs of injury or disease. In the American veterans population, these gastrointestinal conditions are often associated with service in the Southwest Asia theater of operations during the Persian Gulf War. Gastrointestinal dysmotility syndrome is a broad term which is used to cover a spectrum of gastrointestinal disorders with abnormal intestinal contractions (spasms or intestinal paralysis). Coordinated movements of the esophagus, stomach, and intestines are required to digest and move intestinal contents along the digestive tract. See Paine. P., et al., Review article: The assessment and management of chronic severe gastrointestinal dysmotility in adults. (last visited Oct. 06, 2021) *https://onlinelibrary.wiley.com/doi/full/10.1111/apt.12496*. These digestive disorders occur in the absence of tissue damage in the gastrointestinal tract and are functional, rather than structural, in nature. At the request of Congress, the Institute of Medicine (IOM) extensively studied conditions resulting from deployment during the 1991 Persian Gulf War. Institute of Medicine (US) Committee on Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009. Washington (DC): National Academies Press (US); 2010. (last visited Oct. 06, 2021) *https://www.ncbi.nlm.nih.gov/books/NBK220118/*. In its reports, the IOM determined that Gulf War service causes, ''post-traumatic stress disorder (PTSD) and that service is associated with multisymptom illness; gastrointestinal disorders such as irritable bowel syndrome; alcohol and other substance abuse; and anxiety disorders and other psychiatric disorders.'' The IOM report identified and validated functional digestive disorders as disabling and provided the basis for VA to presume their relationship to military service. ''Presumptive Service Connection for Diseases Associated with Service in the Southwest Asia Theater of Operations in the Persian Gulf War: Functional Gastrointestinal Disorders,'' 76 FR 41696 (July 15, 2011). Therefore, VA proposes a new diagnostic code 7356, Gastrointestinal dysmotility syndrome, to evaluate a group of these functional digestive disorders.

VA proposes evaluation of gastrointestinal motility disorders based on the most common presentations, including but not limited to, abdominal pain, bloating, feeling of epigastric fullness, dyspepsia, nausea and vomiting, regurgitation, constipation, diarrhea, episodes of intestinal obstruction and pseudo-obstruction (absence of mechanical obstruction), and poor gastric emptying. Additionally, VA would take into consideration the presence of nutritional compromise (*i.e.,* requirement for assisted parental nutrition (tube feeding) and/or total parental nutrition (TPN)) and response to treatment (*i.e.,* requirement for ambulatory and/or inpatient care). See Mia L Manabat ''Intestinal Motility Disorders,'' Medscape Reference, (Sep. 16, 2020). *https://emedicine.medscape.com/article/179937-overview* (last visited Oct. 06, 2021). This evaluation is consistent with other disability ratings which require similar levels of nutritional support such as TPN or tube feeding.

Specifically, VA proposes a 10-percent evaluation for intermittent abdominal pain with epigastric fullness associated with bloating, and without evidence of a structural gastrointestinal disease. VA proposes a 30-percent evaluation for symptoms of pseudo-obstruction (CIPO) as well as symptoms of intestinal motility disorder such as abdominal pain, bloating, feeling of epigastric fullness, dyspepsia, nausea and vomiting, regurgitation, constipation, and diarrhea, managed by ambulatory care and requiring prescribed dietary management or manipulation. VA proposes a 50-percent evaluation where intermittent tube feeding is required and the individual has recurrent emergency treatment for episodes of intestinal obstruction or regurgitation due to poor gastric emptying, abdominal pain, recurrent nausea, or vomiting. VA proposes an 80-percent evaluation for complete dependence on total parenteral nutrition (TPN) or continuous tube feeding for nutritional support. VA proposes to add a note that this DC is applicable to illnesses associated with 38 CFR 3.317(a)(2)(i)(B)(3) (medically unexplained chronic multisymptom illness involving functional gastrointestinal disorders in Persian Gulf veterans), other than those which can be evaluated under DC 7319.

New Diagnostic Code 7357

As noted above, VA proposes to add a DC to § 4.114 to evaluate veterans that have post-pancreatectomy syndromes, which follow therapeutic pancreatectomies either to remove cancers or to treat complications of chronic pancreatitis. The post-pancreatectomy condition resulting from the removal of the pancreas can vary in degrees of severity, but is generally less severe than prior to surgery. See Lewis Rashid and Vic Velanovich, ''Symptomatic change and gastrointestinal quality of life after pancreatectomy,'' 14(1) HPB 9, 11 (Jan. 2012), *http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3252985/pdf/hpb0014-0009.pdf* (last visited Oct. 06, 2021). See also D.G. Heidt et al., ''Total Pancreatectomy: Indications, Technique, Sequelae,'' 11 J. of Gastrointestinal Surgery 209 (2007).

VA proposes to rate this condition based on the highest evaluation under either DC 7347 (Pancreatitis, chronic), DC 7303 (Chronic complications of upper gastrointestinal surgery, including operations performed on the esophagus, stomach, pancreas, and small intestine, including bariatric surgery), or residuals, such as malabsorption (DC 7328), diarrhea (DC 7319 or 7326), diabetes (DC 7913), or chronic pancreatitis pain (DC 7347). Consistent with the current rating schedule, VA would assign a minimum rating of 30 percent if no higher evaluation is warranted under this or other DCs.

Executive Orders 12866 and 13563

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

Regulatory Flexibility Act

The Secretary hereby certifies that this rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601–612). The certification is based on the fact that small entities or businesses are not affected by revisions to the VASRD. 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 given year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

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

Catalog of Federal Domestic Assistance Numbers and Titles

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

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on July 6, 2021, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Luvenia Potts,

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

For the reasons set out in the preamble, VA proposes to amend 38 CFR part 4 as set forth below:

PART 4—SCHEDULE FOR RATING DISABILITIES

Subpart B—Disability Ratings

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

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

§ 4.110 [Removed and Reserved]

■ 2. Remove and reserve § 4.110.

§ 4.111 [Removed and Reserved]

■ 3. Remove and reserve § 4.111.

■ 4. Revise § 4.112 to read as follows:

§ 4.112. Weight loss and nutrition.

The following terms apply when evaluating conditions in 38 CFR 4.114:

(a) *Weight loss.* ''Substantial weight loss'' means involuntary loss greater than 20 percent of an individual's baseline weight sustained for three months with diminished quality of self-care or work tasks. The term ''minor weight loss'' means involuntary weight loss between 10 and 20 percent of an individual's baseline weight sustained for three months with gastrointestinal-related symptoms, involving diminished quality of self-care or work tasks, or decreased food intake. The term ''inability to gain weight'' means substantial weight loss with the inability to regain it despite following appropriate therapy.

(b) *Baseline weight:* ''Baseline weight'' means the clinically documented average weight for the two-year period preceding the onset of illness or, if relevant, the weight recorded at the veteran's most recent discharge physical. If neither of these weights is available or currently relevant, then use ideal body weight as determined by either the Hamwi formula or Body Mass Index tables, whichever is most favorable to the veteran.

(c) *Undernutrition:* ''Undernutrition'' means a deficiency resulting from insufficient intake of one or multiple essential nutrients, or the inability of the body to absorb, utilize, or retain such nutrients. Undernutrition is characterized by failure of the body to maintain normal organ functions and healthy tissues. Signs and symptoms may include: Loss of subcutaneous tissue, edema, peripheral neuropathy, muscle wasting, weakness, abdominal distention, ascites, and Body Mass Index below normal range.

(d) *Nutritional support:* The following describe various nutritional support methods used to treat certain digestive conditions.

(1) Total parenteral nutrition or hyperalimentation is a special liquid mixture given into the blood through an intravenous catheter. The mixture contains proteins, carbohydrates (sugars), fats, vitamins, and minerals. Total parenteral nutrition bypasses the normal digestion in the stomach and bowel.

(2) Assisted enteral nutrition requires a special liquid mixture (containing proteins, carbohydrates (sugar), fats, vitamins and minerals) to be delivered into the stomach or bowel through a flexible feeding tube. Percutaneous endoscopic gastrostomy is a type of assisted enteral nutrition in which a flexible feeding tube is inserted through the abdominal wall and into the stomach. Nasogastric or nasoenteral feeding tube is a type of assisted parental nutrition in which a flexible feeding tube is inserted through the nose into the stomach or bowel.

■ 5. Amend § 4.114 by:

■ a. Revising the introductory text;

■ b. Revising the entries for diagnostic codes 7200 through 7205;

■ c. Adding in numerical order diagnostic codes 7206 and 7207;

■ d. Revising the entry for diagnostic code 7301;

■ e. Adding in numerical order an entry for diagnostic code 7303;

■ f. Revising the entry for diagnostic code 7304;

■ g. Removing diagnostic codes 7305 and 7306;

■ h. Revising the entries for diagnostic codes 7307 through 7310, 7312, 7314, and 7315;

■ i. Removing diagnostic code 7316;

■ j. Revising the entries for diagnostic codes 7317 through 7319;

■ k. Removing diagnostic codes 7321 and 7322;

■ l. Revising the entry for diagnostic code 7323;

■ m. Removing diagnostic code 7324;

■ n. Revising the entries for diagnostic codes 7325 through 7330, and 7332 through 7338;

■ o. Removing diagnostic codes 7339 and 7340;

■ p. Revising diagnostic codes 7344 through 7348;

■ q. Adding in numerical order an entry for diagnostic code 7350;

■ r. Revising the entry for diagnostic code 7351;

■ s. Adding in numerical order an entry for diagnostic code 7352;

■ t. Revising the entry for diagnostic code 7354;

■ u. Adding in numerical order entries for diagnostic codes 7355 through 7357.

The revisions and additions read as follows:

§ 4.114 Schedule of ratings—digestive system.

Do not combine ratings under diagnostic codes 7301 to 7329 inclusive, 7331, 7342, 7345 to 7350 inclusive, 7352, and 7355 to 7357 inclusive, with each other. Instead, assign a single evaluation under the diagnostic code that reflects the predominant disability picture, elevating it to the next higher evaluation as warranted by the severity of the overall disability.

	Rating
7200 Soft tissue injury of the mouth, other than tongue or lips:	
Rate as for disfigurement (diagnostic codes 7800 and 7804) and impairment of mastication.	
7201 Lips, injuries of:	
Rate as disfigurement (diagnostic codes 7800 and 7804).	
7202 Tongue, loss of whole or part:	
Absent oral nutritional intake	100
Intact oral nutritional intake with permanently impaired swallowing function that requires prescribed dietary modification	60
Intact oral nutritional intake with permanently impaired swallowing function without prescribed dietary modification	30
Note (1): Review for entitlement to special monthly compensation under § 3.350 of this chapter.	
Note (2): Dietary modifications due to this condition must be prescribed by a medical provider.	
7203 Esophagus, stricture of:	
Documented history of recurrent or refractory esophageal stricture(s) causing dysphagia with at least one of the symptoms present: (1) Aspiration, (2) undernutrition, and/or (3) substantial weight loss as defined by § 4.112(a) and treatment with either surgical correction or percutaneous esophago-gastrointestinal tube (PEG tube)	80
Documented history of recurrent or refractory esophageal stricture(s) causing dysphagia which requires at least one of the following (1) dilation 3 or more times per year, (2) dilation using steroids at least one time per year, or (3) esophageal stent placement	50
Documented history of recurrent or refractory esophageal stricture(s) causing dysphagia which requires dilatation no more than 2 times per year	30
Documented history of esophageal stricture(s) that requires daily medications to control dysphagia otherwise asymptomatic	10
Documented history without daily symptoms or requirement for daily medications	0
Note (1): Findings must be documented by barium swallow, computerized tomography, or esophagogastroduodenoscopy.	
Note (2): Non-gastrointestinal complications of procedures should be rated under the appropriate system.	
Note (3): This diagnostic code applies, but is not limited to, esophagitis, mechanical or chemical; Mallory Weiss syndrome (bleeding at junction of esophagus and stomach due to tears) due to caustic ingestion of alkali or acid; drug-induced or infectious esophagitis due to Candida, virus, or other organism; idiopathic eosinophilic, or lymphocytic esophagitis; esophagitis due to radiation therapy; esophagitis due to peptic stricture; and any esophageal condition that requires treatment with sclerotherapy.	
Note (4): Recurrent esophageal stricture is defined as the inability to maintain target esophageal diameter beyond 4 weeks after the target diameter has been achieved.	
Note (5): Refractory esophageal stricture is defined as the inability to achieve target esophageal diameter despite receiving no fewer than 5 dilation sessions performed at 2-week intervals.	
7204 Esophageal motility disorder:	
Rate as esophagus, stricture of (DC 7203).	
Note: This diagnostic code applies, but is not limited to, achalasia (cardiospasm), diffuse esophageal spasm (DES), corkscrew esophagus, nutcracker esophagus, and other motor disorders of the esophagus; esophageal rings (including Schatzki rings), mucosal webs or folds, and impairment of the esophagus caused by systemic conditions such as myasthenia gravis, scleroderma, and other neurologic conditions..	
7205 Esophagus, diverticulum of, acquired:	
Rate as esophagus, stricture of (DC 7203).	
Note: This diagnostic code, applies, but is not limited to, pharyngo- esophageal (Zenker's) diverticulum, mid-esophageal diverticulum, and epiphrenic (distal esophagus) diverticulum.	
7206 Gastroesophageal reflux disease:	
Rate as esophagus, stricture of (DC 7203).	
7207 Barrett's esophagus:	
With esophageal stricture: Rate as esophagus, stricture of (DC 7203).	
Without esophageal stricture:	
Documented by pathologic diagnosis with high-grade dysplasia	30
Documented by pathologic diagnosis with low-grade dysplasia	10
Note (1): If malignancy develops, rate as malignant neoplasms of the digestive system, exclusive of skin growths (DC 7343).	
Note (2): If the condition is resolved via surgery, radiofrequency ablation, or other treatment, rate residuals as esophagus, stricture of (DC 7203).	
7301 Peritoneum, adhesions of, due to surgery, trauma, disease, or infection:	
Persistent partial bowel obstruction that is either inoperable and refractory to treatment, or requires total parenteral nutrition (TPN) for obstructive symptoms	80
Symptomatic peritoneal adhesions, persisting or recurring after surgery, trauma, inflammatory disease process such as chronic cholecystitis or Crohn's disease, or infection, as determined by a healthcare provider; and clinical evidence of recurrent obstruction requiring hospitalization at least once a year; and medically-directed dietary modification other than total parenteral nutrition; and at least one of the following: (1) Abdominal pain, (2) nausea, (3) vomiting, (4) colic, (5) constipation, or (6) diarrhea	50
Symptomatic peritoneal adhesions, persisting or recurring after surgery, trauma, inflammatory disease process such as chronic cholecystitis or Crohn's disease, or infection, as determined by a healthcare provider; and medically-directed dietary modification other than total parenteral nutrition; and at least one of the following: (1) Abdominal pain, (2) nausea, (3) vomiting, (4) colic, (5) constipation, or (6) diarrhea	30

	Rating
Symptomatic peritoneal adhesions, persisting or recurring after surgery, trauma, inflammatory disease process such as chronic cholecystitis or Crohn's disease, or infection, as determined by a healthcare provider, and at least one of the following: (1) Abdominal pain, (2) nausea, (3) vomiting, (4) colic, (5) constipation, or (6) diarrhea	10
History of peritoneal adhesions, currently asymptomatic	0
7303 Chronic complications of upper gastrointestinal surgery:	
Requiring continuous total parenteral nutrition (TPN) or tube feeding for a period longer than 30 consecutive days in the last six months	80
Any one of the following symptoms with or without pain: (1) Daily vomiting not controlled by oral dietary modification or medication; (2) six or more watery bowel movements per day every day, or explosive bowel movements that are difficult to predict or control; (3) post-prandial (meal-induced) light-headedness (syncope) with sweating and the need for medications to specifically treat complications of upper gastrointestinal surgery such as dumping syndrome or delayed gastric emptying	50
With two or more of the following symptoms: (1) Vomiting two or more times per week or vomiting not controlled by medical treatment; (2) discomfort or pain within an hour of eating and requiring ongoing oral dietary modification; (3) three to five watery bowel movements per day every day	30
With either nausea or vomiting managed by ongoing medical treatment	10
Post-operative status, asymptomatic	0
Note (1): For resection of small intestine, use DC 7328.	
Note (2): If pancreatic surgery results in a vitamin or mineral deficiency (*e.g.,* B12, iron, calcium, or fat-soluble vitamins), evaluate under the appropriate vitamin/mineral deficiency code and assign the higher rating. For example, evaluate Vitamin A, B, C or D deficiencies under DC 6313; ocular manifestations of vitamin deficiencies, such as night blindness, under DC 6313; keratitis or keratomalacia due to Vitamin A deficiency under DC 6001; Vitamin E deficiency under neuropathy; and Vitamin K deficiency under prolonged clotting (*e.g.,* DC 7705).	
Note (3): This diagnostic code includes operations performed on the esophagus, stomach, pancreas, and small intestine, including bariatric surgery.	
7304 Peptic ulcer disease:	
Post-operative for perforation or hemorrhage, for three months	100
Continuous abdominal pain with intermittent vomiting, recurrent hematemesis (vomiting blood) or melena (tarry stools); and manifestations of anemia which require hospitalization at least once in the past 12 months	60
Episodes of abdominal pain, nausea, or vomiting, that: Last for at least three consecutive days in duration; occur four or more times in the past 12 months; and are managed by daily prescribed medication	40
Episodes of abdominal pain, nausea, or vomiting, that: Last for at least three consecutive days in duration; occur three times or less in the past 12 months; and are managed by daily prescribed medication	20
History of peptic ulcer disease documented by endoscopy or X-ray	0
Note: After three months at the 100-percent evaluation, rate on residuals as determined by mandatory VA medical examination.	
7307 Gastritis, chronic:	
Rate as peptic ulcer disease (DC 7304).	
Note: This diagnostic code includes Helicobacter pylori infection, drug-induced gastritis, Zollinger-Ellison syndrome, and portal-hypertensive gastropathy with varix-related complications.	
7308 Postgastrectomy syndrome:	
Rate residuals as chronic complications of upper gastrointestinal surgery (DC 7303).	
7309 Stomach, stenosis of:	
Rate as chronic complications of upper gastrointestinal surgery (DC 7303) or peptic ulcer disease (DC 7304), depending on the predominant disability.	
7310 Stomach, injury of, residuals:	
Pre-operative: Rate as adhesions of peritoneum due to surgery, trauma, disease, or infection (DC 7301). No adhesions are necessary when evaluating under DC 7301.	
Post-operative: Rate as chronic complications of upper gastrointestinal surgery (DC 7303).	
* * * * * *	
7312 Cirrhosis of the liver:	
Liver disease with Model for End-Stage Liver Disease score greater than or equal to 15; or with continuous daily debilitating symptoms, generalized weakness and at least one of the following: (1) Ascites (fluid in the abdomen), or (2) a history of spontaneous bacterial peritonitis, or (3) encephalopathy, or (4) variceal hemorrhage, or (5) coagulopathy, or (6) portal gastropathy, or (7) hepatopulmonary or hepatorenal syndrome	100
Liver disease with Model for End-Stage Liver Disease score greater than 11 but less than 15; or with daily fatigue and at least one episode in the last year of either (1) variceal hemorrhage, or (2) portal gastropathy or hepatic encephalopathy	60
Liver disease with Model for End-Stage Liver Disease score of 10 or 11; or with signs of portal hypertension such as splenomegaly or ascites (fluid in the abdomen) and either weakness, anorexia, abdominal pain, or malaise	30
Liver disease with Model for End-Stage Liver Disease score greater than 6 but less than 10; or with evidence of either anorexia, weakness, abdominal pain or malaise	10
Asymptomatic, but with a history of liver disease	0
Note (1): Rate hepatocellular carcinoma occurring with cirrhosis under DC 7343 (Malignant neoplasms of the digestive system, exclusive of skin growths) in lieu of DC 7312.	
Note (2): Biochemical studies, imaging studies, or biopsy must confirm liver dysfunction (including hyponatremia, thrombocytopenia, and/or coagulopathy).	
Note (3): Rate condition based on symptomatology where the evidence does not contain a Model for End-Stage Liver Disease score.	
7314 Chronic biliary tract disease:	
With three or more clinically documented attacks of right upper quadrant pain with nausea and vomiting during the past 12 months; or requiring dilatation of biliary tract strictures at least once during the past 12 months	30
With one or two clinically documented attacks of right upper quadrant pain with nausea and vomiting in the past 12 months	10

	Rating
Asymptomatic, without history of a clinically documented attack of right upper quadrant pain with nausea and vomiting in the past 12 months	0
Note: This diagnostic code includes cholangitis, biliary strictures, Sphincter of Oddi dysfunction, bile duct injury, and choledochal cyst. Rate primary sclerosing cholangitis under chronic liver disease without cirrhosis (DC 7345).	
7315 Cholelithiasis, chronic:	
Rate as chronic biliary tract disease (DC 7314).	
7317 Gallbladder, injury of:	
Rate as adhesions of the peritoneum due to surgery, trauma, disease, or infection (DC 7301); or chronic gallbladder and biliary tract disease (DC 7314), or cholecystectomy (gallbladder removal), complications of (such as strictures and biliary leaks) (DC 7318), depending on the predominant disability.	
Note: No adhesions are necessary when evaluating gallbladder injuries under DC 7301.	
7318 Cholecystectomy (gallbladder removal), complications of (such as strictures and biliary leaks):	
With recurrent abdominal pain (post-prandial or nocturnal) ; and chronic diarrhea characterized by three or more watery bowel movements per day	30
With intermittent abdominal pain; and diarrhea characterized by one to two watery bowel movements per day	10
Asymptomatic	0
7319 Irritable bowel syndrome (IBS):	
Abdominal pain related to defecation at least one day per week during the previous three months; and two or more of the following: (1) Change in stool frequency, (2) change in stool form , (3) altered stool passage (straining and/or urgency), (4) mucorrhea, (5) abdominal bloating, or (6) subjective distension	30
Abdominal pain related to defecation for at least three days per month during the previous three months; and two or more of the following: (1) Change in stool frequency, (2) change in stool form, (3) altered stool passage (straining and/or urgency), (4) mucorrhea, (5) abdominal bloating, or (6) subjective distension	20
Abdominal pain related to defecation at least once during the previous three months; and two or more of the following: (1) Change in stool frequency, (2) change in stool form, (3) altered stool passage (straining and/or urgency), (4) mucorrhea, (5) abdominal bloating, or (6) subjective distention	10
Note (1): This diagnostic code may include functional digestive disorders (see 38 CFR § 3.317), such as dyspepsia, functional bloating and constipation, and diarrhea. Evaluate other symptoms of a functional digestive disorder not encompassed by this diagnostic code under the appropriate diagnostic code, to include gastrointestinal dysmotility syndrome (DC 7356), following the general principles of §§ 4.14 and 4.114.	
7323 Colitis, ulcerative:	
Rate as Crohn's disease or undifferentiated form of inflammatory bowel disease (DC 7326).	
7325 Enteritis, chronic:	
Rate as Irritable Bowel Syndrome (DC 7319) or Crohn's disease or undifferentiated form of inflammatory bowel disease (DC 7326), depending on the predominant disability.	
7326 Crohn's disease or undifferentiated form of inflammatory bowel disease:	
Severe inflammatory bowel disease that is unresponsive to treatment; and requires hospitalization at least once per year; and results in either an inability to work or is characterized by recurrent abdominal pain associated with at least two of the following: (1) Six or more episodes per day of diarrhea, (2) six or more episodes per day of rectal bleeding, (3) recurrent episodes of rectal incontinence, or (4) recurrent abdominal distention	100
Moderate inflammatory bowel disease that is managed on an outpatient basis with immunosuppressants or other biologic agents; and is characterized by recurrent abdominal pain, four to five daily episodes of diarrhea; and intermittent signs of toxicity such as fever, tachycardia, or anemia	60
Mild to moderate inflammatory bowel disease that is managed with oral and topical agents (other than immunosuppressants or other biologic agents); and is characterized by recurrent abdominal pain with three or less daily episodes of diarrhea and minimal signs of toxicity such as fever, tachycardia, or anemia	30
Minimal to mild symptomatic inflammatory bowel disease that is managed with oral or topical agents (other than immunosuppressants or other biologic agents); and is characterized by recurrent abdominal pain with three or less daily episodes of diarrhea and no signs of systemic toxicity	10
Note (1): Following colectomy/colostomy with persistent or recurrent symptoms, rate either under DC 7326 or DC 7329 (Intestine, large, resection of), whichever provides the highest rating.	
Note (2): VA requires diagnoses under DC 7326 to be confirmed by endoscopy or radiologic studies.	
Note (3): Inflammation may involve small bowel (ileitis), large bowel (colitis), or inflammation of any component of the gastrointestinal tract from the mouth to the anus.	
7327 Diverticulitis and diverticulosis:	
Diverticular disease requiring hospitalization for abdominal distress, fever, and leukocytosis (elevated white blood cells) one or more times in the past 12 months; and with at least one of the following complications: (1) Hemorrhage, (2) obstruction, (3) abscess, (4) peritonitis, or (5) perforation	30
Diverticular disease requiring hospitalization for abdominal distress, fever, and leukocytosis (elevated white blood cells) one or more times in the past 12 months; and without associated (1) hemorrhage, (2) obstruction, (3) abscess, (4) peritonitis, or (5) perforation	20
Asymptomatic; or a symptomatic diverticulitis or diverticulosis that is managed by diet and medication	0
Note: For colectomy or colostomy, use DC 7327 or DC 7329 (Intestine, large, resection of), whichever results in a higher evaluation.	
7328 Intestine, small, resection of:	
Status post intestinal resection with undernutrition and anemia; and requiring total parenteral nutrition (TPN)	80
Status post intestinal resection with undernutrition and anemia; and requiring prescribed oral dietary supplementation, continuous medication and intermittent total parental nutrition (TPN)	60
Status post intestinal resection with four or more episodes of diarrhea per day resulting in undernutrition and anemia; and requiring prescribed oral dietary supplementation and continuous medication	40
Status post intestinal resection with four or more episodes of diarrhea per day	20
Status post intestinal resection, asymptomatic	0

	Rating
Note: This diagnostic code includes short bowel syndrome, mesenteric ischemic thrombosis, and post-bariatric surgery complications. Where short bowel syndrome results in high-output syndrome, to include high-output stoma, consider assigning a higher evaluation under DC 7329 (Intestine, large, resection of).	
7329 Intestine, large, resection of:	
Total colectomy with formation of ileostomy, high-output syndrome, and more than two episodes of dehydration requiring intravenous hydration in the past 12 months	100
Total colectomy without high-output syndrome	60
Partial colectomy with permanent colostomy	40
Partial colectomy with reanastomosis (reconnection of the intestinal tube) with loss of ileocecal valve and recurrent episodes of diarrhea more than 3 times per day	20
Partial colectomy with reanastomosis (reconnection of the intestinal tube)	10
7330 Intestinal fistulous disease, external:	
Requiring total parenteral nutrition (TPN); or enteral nutrition along with at least one of the following: (1) Daily discharge equivalent to four or more ostomy bags, (2) requiring ten or more pad changes per day, or (3) both a Body Mass Index (BMI) less than 16 and persistent drainage (any amount) for more than 1 month during the past 12 months	100
Requiring enteral nutritional support along with at least one of the following: (1) Daily discharge equivalent to three or less ostomy bags (sized 130 cc), (2) requiring fewer than ten pad changes per day, or (3) a Body Mass Index (BMI) of 16 to 18 inclusive and persistent drainage (any amount) for more than 2 months in the past 12 months	60
Intermittent fecal discharge with persistent drainage for more than 3 months in the past 12 months	30
Note: This code applies to external fistulas that have developed as a consequence of abdominal trauma, surgery, radiation, malignancy, infection, or ischemia..	
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7332 Rectum and anus, impairment of sphincter control:	
Complete loss of sphincter control characterized by incontinence or retention that is not responsive to a physician-prescribed bowel program and requires either surgery or digital stimulation, medication (beyond laxative use), and special diet; or incontinence to solids and/or liquids two or more times per day, which requires changing a pad two or more times per day	100
Complete or partial loss of sphincter control characterized by incontinence or retention that is partially responsive to a physician-prescribed bowel program and requires either surgery or digital stimulation, medication (beyond laxative use), and special diet; or incontinence to solids and/or liquids two or more times per week, which requires wearing a pad two or more times per week	60
Complete or partial loss of sphincter control characterized by incontinence or retention that is fully responsive to a physician-prescribed bowel program and requires digital stimulation, medication (beyond laxative use), and special diet; or incontinence to solids and/or liquids two or more times per month, which requires wearing a pad two or more times per month	30
Complete or partial loss of sphincter control characterized by incontinence or retention that is fully responsive to a physician-prescribed bowel program and requires medication or special diet; or incontinence to solids and/or liquids at least once every six months, which requires wearing a pad at least once every six months.	10
History of loss of sphincter control, currently asymptomatic	0
Note: Complete or partial loss of sphincter control refers to the inability to retain or expel stool at an appropriate time and place.	
7333 Rectum and anus, stricture of:	
Inability to open the anus with inability to expel solid feces	100
Reduction of the lumen 50 percent or more, with pain and straining during defecation	60
Reduction of the lumen by less than 50 percent, with straining during defecation	30
Luminal narrowing with or without straining, managed by dietary intervention	10
Note (1): Conditions rated under this code include dyssynergic defecation (levator ani) and anismus (functional constipation)	
Note (2): Evaluate an ostomy as Intestine, large, resection of (DC 7329).	
7334 Rectum, prolapse of:	
Persistent irreducible prolapse, repairable or unrepairable	100
Manually reducible prolapse that is not repairable and occurs at times other than bowel movements, exertion, or while performing the Valsalva maneuver	50
Manually reducible prolapse that is not repairable and occurs only after bowel movements, exertion, or while performing the Valsalva maneuver	30
Spontaneously reducible prolapse that is not repairable	10
Note (1): For repairable prolapse of the rectum, continue the 100-percent evaluation for two months following repair. Thereafter, determine the appropriate evaluation based on residuals by mandatory VA examination. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination.	
Note (2): Where impairment of sphincter control constitutes the predominant disability, rate under diagnostic code 7332 (Rectum and anus, impairment of sphincter control).	
7335 Ano, fistula in, including anorectal fistula and anorectal abscess:	
More than two constant or near-constant fistulas with abscesses, drainage, and pain, which are refractory to medical and surgical treatment	60
One or two simultaneous fistulas, with abscess, drainage, and pain	40
Two or more simultaneous fistulas with drainage and pain, but without abscesses	20
One fistula with drainage and pain, but without abscess	10
7336 Hemorrhoids, external or internal:	
Internal or external hemorrhoids with persistent bleeding and anemia; or continuously prolapsed internal hemorrhoids with three or more episodes per year of thrombosis	20
Prolapsed internal hemorrhoids with two or less episodes per year of thrombosis; or external hemorrhoids with three or more episodes per year of thrombosis	10
7337 Pruritus ani (anal itching):	

	Rating
With bleeding or excoriation	10
Without bleeding or excoriation	0
7338 Hernia, including femoral, inguinal, umbilical, ventral, incisional, and other (but not including hiatal).	
Irreparable hernia (new or recurrent) present for 12 months or more; with both of the following present for 12 months or more: 1. Size equal to 15 cm or greater in one dimension; and 2. Pain when performing at least three of the following activities: (1) Bending over, (2) activities of daily living (ADLs), (3) walking, and (4) climbing stairs	100
Irreparable hernia (new or recurrent) present for 12 months or more; with both of the following present for 12 months or more: 1. Size equal to 15 cm or greater in one dimension; and 2. Pain when performing two of the following activities: (1) Bending over, (2) activities of daily living (ADLs), (3) walking, and (4) climbing stairs	60
Irreparable hernia (new or recurrent) present for 12 months or more; with both of the following present for 12 months or more: 1. Size equal to 3 cm or greater but less than 15 cm in one dimension; and 2. Pain when performing at least two of the following activities: (1) Bending over, (2) activities of daily living (ADLs), (3) walking, and (4) climbing stairs	30
Irreparable hernia (new or recurrent) present for 12 months or more; with both of the following present for 12 months or more: 1. Size equal to 3 cm or greater but less than 15 cm in one dimension; and 2. Pain when performing one of the following activities: (1) Bending over, (2) activities of daily living (ADLs), (3) walking, and (4) climbing stairs	20
Irreparable hernia (new or recurrent) present for 12 months or more; with hernia size smaller than 3 cm	10
Asymptomatic hernia; present and repairable, or repaired	0
Note (1): With two compensable inguinal hernias, evaluate the more severely disabling hernia first, and then add 10 percent to that rating to account for the second compensable hernia. Do not add 10 percent to that rating if the more severely disabling hernia is rated at 100-percent.	
Note (2): Any one of the following activities of daily living are sufficient for evaluation: Bathing, dressing, hygiene, and/or transfers.	
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7344 Benign neoplasms, exclusive of skin growths:	
Evaluate under a diagnostic code appropriate to the predominant disability or the specific residuals after treatment.	
Note: This diagnostic code includes lipoma, leiomyoma, colon polyps, or villous adenoma.	
7345 Chronic liver disease without cirrhosis:	
Progressive chronic liver disease requiring use of both parenteral antiviral therapy (direct antiviral agents), and parenteral immunomodulatory therapy (interferon and other); and for six months following discontinuance of treatment	100
Progressive chronic liver disease requiring continuous medication and causing substantial weight loss and at least two of the following: (1) Daily fatigue, (2) malaise, (3) anorexia, (4) hepatomegaly, (5) pruritus, and (6) arthralgia	60
Progressive chronic liver disease requiring continuous medication and causing minor weight loss and at least two of the following: (1) Daily fatigue, (2) malaise, (3) anorexia, (4) hepatomegaly, (5) pruritus, and (6) arthralgia	40
Chronic liver disease with at least one of the following: (1) Intermittent fatigue, (2) malaise, (3) anorexia, (4) hepatomegaly, or (5) pruritus	20
Previous history of liver disease, currently asymptomatic	0
Note (1): 100-percent evaluation shall continue for six months following discontinuance of parenteral antiviral therapy and administration of parenteral immunomodulatory drugs. Six months after discontinuance of parenteral antiviral therapy and parenteral immunomodulatory drugs, determine the appropriate disability rating by mandatory VA exam. Apply the provisions of § 3.105(e) to any change in evaluation based upon that or any subsequent examination.	
Note (2): For individuals for whom physicians recommend both parenteral antiviral therapy and parenteral immunomodulatory drugs, but for whom treatment is medically contraindicated, rate according to DC 7312 (Cirrhosis of the liver).	
Note (3): This diagnostic code includes Hepatitis B (confirmed by serologic testing), primary biliary cirrhosis (PBC), primary sclerosing cholangitis (PSC), autoimmune liver disease, Wilson's disease, Alpha-1-antitrypsin deficiency, hemochromatosis, drug-induced hepatitis, and non-alcoholic steatohepatitis (NASH). Track Hepatitis C (or non-A, non-B hepatitis) under DC 7354 but evaluate it using the criteria above.	
Note (4): Evaluate sequelae, such as cirrhosis or malignancy of the liver, under an appropriate diagnostic code, but do not use the same signs and symptoms as the basis for evaluation under DC 7354 and under a diagnostic code for sequelae. (See § 4.14).	
7346 Hiatal hernia and paraesophageal hernia:	
Rate as esophagus, stricture of (DC 7203).	
7347 Pancreatitis, chronic:	
Daily episodes of abdominal or mid-back pain that require three or more hospitalizations per year; and pain management by a physician; and maldigestion and malabsorption requiring dietary restriction and pancreatic enzyme supplementation	100
Three or more episodes of abdominal or mid-back pain per year and at least one episode per year requiring hospitalization for management either of complications related to abdominal pain or complications of tube enteral feeding	60
At least one episode per year of abdominal or mid-back pain that requires ongoing outpatient medical treatment for pain, digestive problems, or management of related complications including but not limited to cyst, pseudocyst, intestinal obstruction, or ascites	30
Note (1): Appropriate diagnostic studies must confirm that abdominal pain in this condition results from pancreatitis.	
Note (2): Separately rate endocrine dysfunction resulting in diabetes due to pancreatic insufficiency under DC 7913 (Diabetes mellitus).	
7348 Vagotomy with pyloroplasty or gastroenterostomy:	
Following confirmation of postoperative complications of stricture or continuing gastric retention	40
With symptoms and confirmed diagnosis of alkaline gastritis, or with confirmed persisting diarrhea	30
With incomplete vagotomy	20

	Rating
Note: Rate recurrent ulcer following complete vagotomy under DC 7304 (Peptic ulcer disease), with a minimum rating of 20 percent; and rate post-operative residuals not addressed by this diagnostic code under DC 7303 (Chronic complications of upper gastrointestinal surgery).	
7350 Liver abscess:	
Assign a rating of 100 percent for 6 months from the date of initial diagnosis. Six months following initial diagnosis, determine the appropriate disability rating by mandatory VA examination. Thereafter, rate the condition based on chronic residuals under the appropriate body system. Apply the provisions of § 3.105(e) to any reduction in evaluation.	
Note: This diagnostic code includes abscesses caused by bacterial, viral, amebic (*e.g.,* E. hystolytica), fungal (*e.g.,* C. albicans), and other agents.	
7351 Liver transplant:	
For an indefinite period from the date of hospital admission for transplant surgery	100
Awaiting retransplantation, minimum rating	60
Minimum rating	30
Note: Assign a rating of 100 percent as of the date of hospital admission for transplant surgery. One year following discharge, determine the appropriate disability rating by mandatory VA examination. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination. Rate residuals of any recurrent underlying liver disease under the appropriate diagnostic code and, when appropriate, combine with other post-transplant residuals under the appropriate body system(s), subject to the provisions of §§ 4.14 and 4.114.	
7352 Pancreas transplant:	
For an indefinite period from the date of hospital admission for transplant surgery	100
Minimum rating	30
Note: Assign a rating of 100 percent as of the date of hospital admission for transplant surgery. One year following discharge, determine the appropriate disability rating by mandatory VA examination. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent examination.	
7354 Hepatitis C (or non-A, non-B hepatitis):	
Rate under DC 7345 (Chronic liver disease without cirrhosis).	
7355 Celiac disease:	
Malabsorption syndrome that causes weakness which interferes with activities of daily living; and weight loss resulting in wasting and nutritional deficiencies; and with systemic manifestations including but not limited to, weakness and fatigue, dermatitis, lymph node enlargement, hypocalcemia, low vitamin levels; and anemia related to malabsorption; and episodes of abdominal pain and diarrhea due to lactase deficiency or pancreatic insufficiency	80
Malabsorption syndrome that causes chronic diarrhea managed by medically-prescribed dietary intervention such as prescribed gluten-free diet, with nutritional deficiencies due to lactase and pancreatic insufficiency; and with systemic manifestations including, but not limited to, weakness and fatigue, dermatitis, lymph node enlargement, hypocalcemia, low vitamin levels, or atrophy of the inner intestinal lining shown on biopsy	50
Malabsorption syndrome with chronic diarrhea managed by medically-prescribed dietary intervention such as prescribed gluten-free diet; and without nutritional deficiencies	30
Note (1): An appropriate serum antibody test or endoscopy with biopsy must confirm the diagnosis.	
Note (2): For evaluation of celiac disease with the predominant disability of malabsorption, use the greater evaluation between DC 7328 or celiac disease under DC 7355.	
7356 Gastrointestinal dysmotility syndrome:	
Requiring complete dependence on total parenteral nutrition (TPN) or continuous tube feeding for nutritional support	80
Requiring intermittent tube feeding for nutritional support; with recurrent emergency treatment for episodes of intestinal obstruction or regurgitation due to poor gastric emptying, abdominal pain, recurrent nausea, or recurrent vomiting	50
With symptoms of intestinal pseudo-obstruction (CIPO); and symptoms of intestinal motility disorder, including but not limited to, abdominal pain, bloating, feeling of epigastric fullness, dyspepsia, nausea and vomiting, regurgitation, constipation, and diarrhea, managed by ambulatory care; and requiring prescribed dietary management or manipulation	30
Intermittent abdominal pain with epigastric fullness associated with bloating; and without evidence of a structural gastrointestinal disease	10
Note: Use this diagnostic code for illnesses associated with 38 CFR 3.317(a)(2)(i)(B)(3), other than those which can be evaluated under DC 7319.	
7357 Post pancreatectomy syndrome:	
Following total or partial pancreatectomy, evaluate under Pancreatitis, chronic (DC 7347), Chronic complications of upper gastrointestinal surgery (DC 7303), or based on residuals such as malabsorption (Intestine, small, resection of, DC 7328), diarrhea (Irritable bowel syndrome, DC 7319, or Crohn's disease or undifferentiated form of inflammatory bowel disease, DC 7326), or diabetes (DC 7913), whichever provides the highest evaluation. Minimum	30

■ 6. Amend appendix A to part 4 by:

■ a. Adding entries for §§ 4.110, 4.111 and 4.112;

■ b. In the entry for § 4.114:

■ i. Adding in numerical order entries for diagnostic codes 7200 through 7207 and 7301 through 7303;

■ ii. Revising the entries for diagnostic codes 7304 through 7305;

■ iii. Adding in numerical order entries for diagnostic codes 7306 and 7307;

■ iv. Revising the entry for diagnostic code 7308;

■ v. Adding in numerical order entries for diagnostic codes 7309 and 7310;

■ vi. Revising the entry for diagnostic code 7312;

■ vii. Adding in numerical order entries for diagnostic codes 7314 through 7318;

■ viii. Revising the entries for diagnostic codes 7319 and 7321;

■ ix. Adding in numerical order entries for diagnostic codes 7322 through 7327;

■ x. Revising the entries for diagnostic codes 7328 through 7330 and 7332;

■ xi. Adding in numerical order an entry for diagnostic code 7333;

■ xii. Revising the entry for diagnostic codes 7334;

■ xiii. Adding in numerical order entries for diagnostic codes 7335 through 7338;

■ xiv. Revising the entry for diagnostic code 7339;

■ xv. Adding in numerical order an entry for diagnostic code 7340;

■ xvi. Revising the entries for diagnostic codes 7344 through 7348;

■ xvii. Adding in numerical order an entry for diagnostic code 7350;

■ xviii. Revising the entry for diagnostic code 7351;

■ xix. Adding in numerical order an entry for diagnostic code 7352;

■ xx. Revising the entry for diagnostic code 7354; and

■ xxi. Adding in numerical order entries for diagnostic codes 7355 through 7357;

The revisions and additions read as follows:

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

Sec.	Diagnostic code No.	
*	*	* * * * * * *
4.110		Removed and reserved [*Effective date of final rule*].
4.111		Removed and reserved [*Effective date of final rule*].
4.112		Revised [*Effective date of final rule*].
*	*	* * * * * * *
4.114		Introduction paragraph revised March 10, 1976; introduction paragraph revised [*Effective date of final rule*].
	7200	Title, criterion [*Effective date of final rule*].
	7201	Criterion [*Effective date of final rule*].
	7202	Evaluation, criterion, note [*Effective date of final rule*].
	7203	Evaluation, criterion, note [*Effective date of final rule*].
	7204	Title, note [*Effective date of final rule*].
	7205	Note [*Effective date of final rule*].
	7206	Added [*Effective date of final rule*].
	7207	Added [*Effective date of final rule*].
	7301	Title, Evaluation, criterion, note [*Effective date of final rule*].
	7302	Removed April 8, 1959.
	7303	Added [*Effective date of final rule*].
	7304	Evaluation November 1, 1962; title, evaluation, criterion, and note [*Effective date of final rule*].
	7305	Evaluation November 1, 1962; Removed [*Effective date of final rule*].
	7306	Criterion April 8, 1959; Removed [*Effective date of final rule*].
	7307	Evaluation May 22, 1964; Criterion May 22, 1964; Note May 22, 1964; title, evaluation, criterion, and note [*Effective date of final rule*].
	7308	Title April 8, 1959; evaluation April 8, 1959; evaluation and criterion [*Effective date of final rule*].
	7309	Evaluation [*Effective date of final rule*].
	7310	Evaluation [*Effective date of final rule*].
*	*	* * * * * * *
	7312	Evaluation March 10, 1976; evaluation July 2, 2001; title, evaluation, criterion, and note [*Effective date of final rule*].
	7314	Title, evaluation, note [*Effective date of final rule*].
	7315	Evaluation [*Effective date of final rule*].
	7316	Removed [*Effective date of final rule*].
	7317	Note [*Effective date of final rule*].
	7318	Title, evaluation, and criterion [*Effective date of final rule*].
	7319	Title November 1, 1962; evaluation November 1, 1962; title, evaluation, criterion, and note [*Effective date of final rule*].
	7321	Evaluation July 6, 1950; criterion March 10, 1976; Removed [*Effective date of final rule*].
	7322	Removed [*Effective date of final rule*].
	7323	Criterion and note [*Effective date of final rule*].
	7324	Removed [*Effective date of final rule*].
	7325	Note November 1, 1962; note [*Effective date of final rule*].
	7326	Note November 1, 1962; title, evaluation, criterion and note [*Effective date of final rule*].
	7327	Evaluation November 1, 1962; criterion November 1, 1962; note November 1, 1962; title, evaluation, criterion, and note [*Effective date of final rule*].
	7328	Evaluation November 1, 1962; title, evaluation, criterion, and note [*Effective date of final rule*].
	7329	Evaluation November 1, 1962; evaluation, criterion, and note [*Effective date of final rule*].
	7330	Evaluation November 1, 1962; criterion and note [*Effective date of final rule*].
*	*	* * * * * * *
	7332	Evaluation November 1, 1962; evaluation, criterion, and note [*Effective date of final rule*].
	7333	Evaluation, criterion, and note [*Effective date of final rule*].
	7334	Evaluation July 6, 1950; evaluation November 1, 1962; evaluation, criterion, and note [*Effective date of final rule*].
	7335	Evaluation and criterion [*Effective date of final rule*].
	7336	Criterion November 1, 1962; criterion [*Effective date of final rule*].
	7337	Title, evaluation, and criterion [*Effective date of final rule*].
	7338	Title, evaluation, criterion, and note [*Effective date of final rule*].
	7339	Criterion March 10, 1976; removed [*Effective date of final rule*].
	7340	Removed [*Effective date of final rule*].
*	*	* * * * * * *
	7344	Criterion July 2, 2001; note [*Effective date of final rule*].
	7345	Evaluation August 23, 1948; evaluation February 17, 1955; evaluation July 2, 2001; title [*Effective date of final rule*]; evaluation, criterion, and note [*Effective date of final rule*].

Sec.	Diagnostic code No.	
	7346	Evaluation February 1, 1962; title [*Effective date of final rule*]; evaluation, criterion, and note [*Effective date of final rule*].
	7347	Added September 9, 1975; title [*Effective date of final rule*]; evaluation, criterion, and note [*Effective date of final rule*].
	7348	Added March 10, 1976; criterion and note [*Effective date of final rule*].
	7350	Added [*Effective date of final rule*].
	7351	Added July 2, 2001; evaluation, criterion, and note [*Effective date of final rule*].
	7352	Added [*Effective date of final rule*].
	7354	Added July 2, 2001; evaluation, criterion, and note [*Effective date of final rule*].
	7355	Added [*Effective date of final rule*].
	7356	Added [*Effective date of final rule*].
	7357	Added [*Effective date of final rule*].
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■ 7. Amend appendix B to part 4 in the table under ''The Digestive System'' by:

■ a. Revising the entries for diagnostic codes 7200, 7202, and 7204;

■ b. Adding in numerical order entries for diagnostic codes 7206 and 7207;

■ c. Revising the entry for diagnostic code 7301;

■ d. Adding in numerical order an entry for diagnostic code 7303;

■ e. Revising the entries for diagnostic codes 7304 through 7307, 7312, 7314, 7316 through 7319, 7321, 7322, 7324, 7326 through 7328, 7330, 7332, 7335 through 7340, and 7344 through 7348;

■ f. Adding in numerical order entries for diagnostic codes 7350 and 7352;

■ g. Revising the entry for diagnostic code 7354; and

■ h. Adding in numerical order entries for diagnostic codes 7355 through 7357.

The revisions and additions read as follows:

Appendix B to Part 4—Numerical Index of Disabilities

Diagnostic code No.	
*	* * * * * * *
THE DIGESTIVE SYSTEM	
7200	Soft tissue injury of the mouth, other than tongue or lips.
*	* * * * * * *
7202	Tongue, loss of whole or part.
*	* * * * * * *
7204	Esophageal motility disorder.
*	* * * * * * *
7206	Gastroesophageal reflux disease.
7207	Barrett's esophagus.
*	* * * * * * *
7301	Peritoneum, adhesions of, due to surgery, trauma, or infection.
7303	Chronic complications of upper gastrointestinal surgery.
7304	Peptic ulcer disease.
7305	Removed.
7306	Removed.
7307	Gastritis, chronic.
*	* * * * * * *
7312	Cirrhosis of the liver.
7314	Chronic biliary tract disease.
*	* * * * * * *
7316	Removed.
7317	Gallbladder, injury of.
7318	Cholecystectomy (gallbladder removal), complications of (such as strictures and biliary leaks).
7319	Irritable bowel syndrome (IBS).
*	* * * * * * *
7321	Removed.
7322	Removed.
*	* * * * * * *
7324	Removed.
*	* * * * * * *
7326	Crohn's disease or undifferentiated form of inflammatory bowel disease.

Diagnostic code No.	
7327	Diverticulitis and diverticulosis.
7328	Intestine, small, resection of.
* * * * * * *	
7330	Intestinal fistulous diseases, external.
* * * * * * *	
7332	Rectum and anus, impairment of sphincter control.
* * * * * * *	
7335	Ano, fistula in, including anorectal fistula, anorectal abscess.
7336	Hemorrhoids, external or internal.
7337	Pruritus ani (anal itching).
7338	Hernia, including femoral, inguinal, umbilical, ventral, incisional, and other (but not including hiatal).
7339	Removed.
7340	Removed.
* * * * * * *	
7344	Benign neoplasms, exclusive of skin growths.
7345	Chronic liver disease without cirrhosis.
7346	Hiatal hernia and paraesophageal hernia.
7347	Pancreatitis, chronic.
7348	Vagotomy with pyloroplasty or gastroenterostomy.
7350	Liver abscess.
* * * * * * *	
7352	Pancreas transplant.
7354	Hepatitis C (or non-A, non-B hepatitis).
7355	Celiac disease.
7356	Gastrointestinal dysmotility syndrome.
7357	Post pancreatectomy syndrome.
* * * * * * *	

■ 8. Amend appendix C to part 4 by:
■ a. Adding in alphabetical order under the entry for ''Abscess'', entries for ''Anorectal'' and ''Liver'';
■ b. Revising the entry for ''Cholangitis, chronic'';
■ c. Adding in alphabetical order an entry for ''Cholecystectomy (gallbladder removal), complications of (such as strictures and biliary leaks)'';
■ d. Adding in alphabetical order under the entry for ''Disease'', entries for ''Celiac'', ''Crohn's'', ''Gallbladder and biliary tract, chronic'', and ''Inflammatory bowel'';
■ e. Removing the entry for ''Diverticulitis'' and adding in its place an entry for ''Diverticulitis and diverticulosis'';
■ f. Adding in alphabetical order under the entry for ''Esophagus'', entries for ''Barrett's'' and ''Motility disorder'';
■ g. Removing the entry for ''Gastritis, hypertrophic'' and adding in its place an entry for ''Gastritis, chronic'';
■ h. Adding, in alphabetical order, an entry for ''Gastroesophageal reflux disease'';
■ i. Removing, under the entry for ''Hernia'', entries for ''Femoral,'' and ''Hiatal'' and adding in their place entries for ''Femoral, inguinal, umbilical, ventral, incisional, and other'' and ''Hiatal and parasophageal'', respectively;
■ j. Removing, under the entry for ''Hernia'', entries for ''Inguinal'' and ''Ventral'';
■ k. Removing, under the entry for ''Injury'', the entries for ''Gall bladder'' and ''Mouth'' and adding in their place entries for ''Gallbladder'' and ''Mouth, soft tissue'', respectively;
■ l. Removing the entry for ''Intestine, fistula of'' and adding in its place an entry for ''Intestine:'';
■ m. Adding in alphabetical order under the entry for ''Intestine'', entries for ''Fistulous disease, external'', ''Large, resection of'', and ''Small, resection of'';
■ n. Removing the entry for ''Irritable colon syndrome'' and adding in its place an entry for ''Irritable bowel syndrome (IBS)'';
■ o. Removing the entry for ''Pancreatitis'' and adding in its place an entry for ''Pancreas:'';
■ p. Adding in alphabetical order under the entry for ''Pancreas'', entries for ''Chronic pancreatitis'', ''Post pancreatectomy syndrome'', ''Surgery, complications of'', and ''Transplant'';
■ q. Revising the entry for ''Pruritus ani'';
■ r. Removing the entry for ''Stomach, stenosis of'' and adding in its place an entry for ''Stomach:'';
■ s. Adding in alphabetical order under entry for ''Stomach'', entries for ''Postgastrectomy syndrome'', ''Stenosis of'', and ''Surgery, complications of'';
■ t. Adding in alphabetical order under the entry for ''Syndromes'', entries for ''Gastrointestinal dysmotility'', ''Postgastrectomy'', and ''Post pancreatectomy'';
■ u. Removing the entry for ''Ulcer'' and adding in its place an entry for ''Ulcer, peptic'';
■ v. Removing under the entry for ''Ulcer, peptic'' the entries for ''Duodenal'', ''Gastric'', and ''Marginal''.

The revisions and additions read as follows:

Appendix C to Part 4—Alphabetical Index of Disabilities

	Diagnostic Code No.
* * * * * * *	
Abscess:	
Anorectal	7335
* * * * * * *	
Liver	7350
* * * * * * *	
* * * * * * *	
Cholangitis, chronic	7314
Cholecystectomy (gallbladder removal) complications of (such as strictures and biliary leaks)	7318
* * * * * * *	
Disease:	
* * * * * * *	
Celiac	7355
* * * * * * *	
Crohn's	7326
Gallbladder and biliary tract, chronic	7314
* * * * * * *	
Inflammatory bowel	7326
* * * * * * *	
Diverticulitis and diverticulosis	7327
* * * * * * *	
Esophagus:	
Barrett's	7207
* * * * * * *	
Motility disorder	7204
* * * * * * *	
Gastritis, chronic	7307
Gastroesophageal reflux disease	7206
* * * * * * *	
Hernia:	
Femoral, inguinal, umbilical, ventral, incisional, and other	7338
Hiatal and parasophageal	7346
* * * * * * *	
Injury:	
* * * * * * *	
Gallbladder	7317
* * * * * * *	
Mouth, soft tissue	7200
* * * * * * *	
Intestine:	
Fistulous disease, external	7330
Large, resection of	7329
Small, resection of	7328
Irritable bowel syndrome (IBS)	7319
* * * * * * *	
Pancreas:	
Chronic pancreatitis	7347
Post pancreatectomy syndrome	7357
Surgery, complications of	7303
Transplant	7352
* * * * * * *	
Pruritus ani (anal itching)	7337
* * * * * * *	
Stomach:	

	Diagnostic Code No.
Postgastrectomy syndrome	7308
Stenosis of	7309
Surgery, complications of	7303
* * * * * * *	
Syndromes:	
* * * * * * *	
Gastrointestinal dysmotility	7356
* * * * * * *	
Postgastrectomy	7308
Post pancreatectomy	7357
* * * * * * *	
* * * * * * *	
Ulcer, peptic	7304
* * * * * * *	

[FR Doc. 2021–28314 Filed 1–10–22; 8:45 am]

BILLING CODE 8320–01–P