the safety of the ports and waterways. The COTP may modify the geographic boundaries of the regulated area and actions to be taken under Port Condition X–RAY based on the trajectory and forecasted storm conditions.

(3) *Port Condition YANKEE.* Affected ports and waterways are closed to all inbound vessel traffic. All oceangoing tank barges and their supporting tugs and all self-propelled oceangoing vessels over 500 GT must have departed the regulated area or received permission to remain in port. The COTP may require additional precautions to ensure the safety of the ports and waterways. The COTP may modify the geographic boundaries of the regulated area and actions to be taken under Port Condition YANKEE based on the trajectory and forecasted storm conditions.

(4) *Port Condition ZULU.* Cargo operations are suspended, except final preparations that are expressly permitted by the COTP as necessary to ensure the safety of the ports and facilities. Other than vessels designated by the COTP, no vessels may enter, transit, move, or anchor within the regulated area. The COTP may modify the geographic boundaries of the regulated area and actions to be taken under Port Condition ZULU based on the trajectory and forecasted storm conditions.

(5) *Port Condition RECOVERY.* Designated areas are closed to all vessels. Based on assessments of channel conditions, navigability concerns, and hazards to navigation, the COTP may permit vessel movements with restrictions. Restrictions may include, but are not limited to, preventing, or delaying vessel movements, imposing draft, speed, size, horsepower, daylight restrictions, or directing the use of specific routes. Vessels permitted to transit the regulated area shall comply with the lawful orders or directions given by the COTP or representative.

(6) *Notification.* The Coast Guard will provide notice of where, within the regulated area, a declared Port Condition is to be in effect, via Broadcast Notice to Mariners, Marine Safety Information Bulletins, or by on-scene representatives.

(7) *Exception.* This regulation does not apply to authorized law enforcement agencies operating within the regulated area.

Dated: March 14, 2024.

David E. O'Connell,

Captain, U.S. Coast Guard, Captain of the Port Sector Maryland-National Capital Region.

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AQ90

Schedule for Rating Disabilities: The Digestive System

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the Department of Veterans Affairs (VA) Schedule for Rating Disabilities (VASRD) by revising the portion of the schedule that addresses the Digestive System. The effect of this action is to ensure that the rating schedule uses current medical terminology and provides detailed and updated criteria for evaluation of digestive conditions for disability rating purposes.

DATES: This final rule is effective May 19, 2024.

FOR FURTHER INFORMATION CONTACT: Ulia Sokol, M.D., M.B.A., Medical Officer, Regulations Staff, (218A), Compensation Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, *218VASRDPMO.VBACO@va.gov,* (202) 461–9700. (This is not a toll-free telephone number.)

SUPPLEMENTARY INFORMATION: On January 11, 2022, VA published in the **Federal Register** the proposed rule for Schedule of Rating Disabilities: The Digestive System. *See* 87 FR 1522. VA received 22 comments during the 60-day comment period, including from two Veterans Service Organizations (Paralyzed Veterans of America and The National Veterans Legal Services Program) and two Veterans advocacy groups (The National Organization of Veterans' Advocates, Inc. and The National Law School Veterans Clinic Consortium). VA appreciates the comments submitted in response to the proposed rule. Based on the rationale stated in the proposed rule and in this document, the proposed rule is adopted as a final rule with minor changes noted below.

Severability: The provisions of the proposed rule are separate and severable from one another, and if any provision is stayed or determined to be invalid, the agency would intend that the remaining provisions continue in effect. VA has carefully considered the requirements of the proposed rule, both individually and in their totality, including their potential costs to the agency and benefit to veterans. In the event a court were to stay or invalidate one or more provisions of this rule as finalized, VA would want the remaining portions of the rule as finalized to remain in full force and legal effect.

I. Comments of General Support

One commenter expressed support for utilizing ''undernutrition'' instead of ''malnutrition'' under 38 CFR 4.112. VA thanks this commenter for their input.

Another commenter expressed support for the proposed rule because it provides more comprehensive evaluative criteria for those with assisted nutrition devices such as gastrostomy tubes, total parenteral nutrition (TPN) ports, and gastric stimulators. VA thanks this commenter for their support.

One commenter expressed support for the change to DC 7326 for Crohn's disease because it comprehensively addresses the symptoms of this disease, its treatment modalities, and functional impairment caused by this disease. VA thanks this commenter for their support.

While most commenters generally welcomed modernizing the rating schedule and recognized this effort as a thoroughly-researched undertaking, some commenters shared some concerns with VA. These concerns are addressed in the sections below.

II. Comments Regarding Coexisting Abdominal Conditions Under § 4.114, Schedule of Ratings—Digestive System

Two commenters expressed concern regarding the prohibition of rating coexisting abdominal conditions under 38 CFR 4.113 and 4.114, stating they are too broad in scope. One commenter recommended VA should simply have rating specialists consider the anti-pyramiding principles set out in 38 CFR 4.14. The other commenter suggested that VA specifically reconsider adding the following diagnostic codes to the list of codes that cannot be combined with each other: DC 7303, chronic complications of upper gastrointestinal surgery, DC 7350, liver abscess, DC 7352, pancreas transplant, DC 7355, celiac disease, DC 7356, gastrointestinal dysmotility syndrome, and DC 7357, post pancreatectomy. It was the commenter's opinion that this approach is restrictive and precludes the ability to maximize benefits for veterans.

VA makes no changes based on these comments. First, the addition of the newly created diagnostic codes is appropriate due to 38 CFR 4.14 and 4.113, which advises rating personnel to avoid providing multiple evaluations for the same disability under various diagnoses. Even though VA is adding diagnostic codes for new conditions, the symptoms and functional impairment experienced by these new conditions are commonly shared with other diagnoses found in this body system and therefore cannot be combined. Next, while 38 CFR 4.114 adheres to the provisions laid out in 38 CFR 4.14, it provides a benefit that 38 CFR 4.14 does not—it allows rating personnel to elevate the evaluation to the next higher level when warranted based on the overall disability severity. This is a benefit to the veteran that is not available through the application of 38 CFR 4.14 alone and provides a favorable means of accounting for non-overlapping symptoms. For example, consider a veteran evaluated at 30% for the predominant disability of Crohn's disease (DC 7326) and 30% for diverticulitis (DC 7327) with non-overlapping symptoms. When applying the symptoms of diverticulitis to Crohn's, the resultant evaluation is higher than that of Crohn's alone warranting an elevation to the next higher level under DC 7326, which is 60%. The regulation in 38 CFR 4.14 does not allow for elevations in this way. Therefore, it is more advantageous that the provisions of 38 CFR 4.114 be applied for these diagnostic codes than 38 CFR 4.14. However, VA notes that the terminology used in this paragraph can be revised to aid its interpretation and application. The paragraph advises rating personnel to not combine diagnostic codes and to assign a single evaluation that reflects the predominant disability picture. The term ''combine'' in this paragraph refers to combining disabilities as defined in 38 CFR 4.25 for the purposes of determining the combined disability evaluation, but it can be misinterpreted as stating to not provide service connection for multiple conditions under these diagnostic codes. To simplify this language and ensure clarity, VA revises it to state that ratings under these diagnostic codes will be assigned a single evaluation that reflects the predominant disability picture and that elevation to the next higher evaluation can be provided if warranted based on the severity of the overall disability.

III. Comments Regarding DC 7202 Tongue, Loss of Whole or Part

One commenter recommended that VA remove the note under DC 7202 to review for Special Monthly Compensation (SMC) for tongue, loss of whole or part because the evaluative criteria no longer evaluates aphonia. Another commenter asked VA to, ''restore criteria under DC 7202 for the amount of tongue removed and speech impairment to address . . . situations where communication is impaired but not precluded'' as necessary for the grant of special monthly compensation for complete organic aphonia. Otherwise, the commenter recommended VA refer to another body system that adequately addresses speech impairment due to loss of tongue.

First, the VASRD has two diagnostic codes that provide evaluations for speech impairment. One of those diagnostic codes, DC 6519 for organic aphonia, is the most appropriate catch-all for speech impairment issues due to infection, disease, or in the case of loss of whole or part of the tongue, injury. Additionally, DC 6519 provides objective criteria to adequately evaluate situations where speech is impaired but not precluded. Second, the intent of Note 1 is to provide general guidance to the rating personnel to capture any additional functional impairment that comes with the loss of the tongue, whole or partial. However, VA agrees that removing the note about SMC is warranted and that the note should more directly guide rating personnel to the more appropriate diagnostic code to evaluate speech impairment that can arise due to whole or partial loss of the tongue. Therefore, VA revises Note 1 of DC 7202 to refer rating personnel to DC 6519 or DC 6516 when there is evidence of speech impairment. VA thanks these commenters for their input.

The same commenter pointed out that in the preamble of the proposed rule for DC 7202, VA failed to demonstrate how medical treatment and rehabilitation can restore speech function to varying degrees. VA acknowledges that speech rehabilitation methodology and references to other body systems were not discussed in the preamble because those are outside the scope of this rulemaking. From a disability compensation standpoint, VA already has regulations to address evaluations that need review if speech function is restored or the condition otherwise improves. *See* 38 CFR 3.344 and 3.327. VA thanks this commenter but makes no changes based on this comment.

One commenter suggested that VA should recognize that both the abilities to swallow and to speak are highly relevant and should be considered under DC 7202. Additionally, the commenter recommended that VA provide a 30% evaluation for marked loss of speech due to loss of tongue. While VA agrees that the ability to swallow and to speak may be impaired due to the loss of tongue in whole or in part, speech is not a function of the digestive body system. Speech impairment has no effect on whether one is able to sufficiently consume or digest sustenance. Therefore, it is more appropriate for the evaluative criteria of this condition to be limited to its effect on food consumption. Thus, VA makes no changes based on this comment.

Finally, the same commenter suggested that VA specify that ''medical advisors'' under DC 7202 are not limited to physicians but may also include physician assistants, nurse practitioners and nutritionists. While VA agrees that physicians are not the only medical providers who may provide care, the term ''medical provider'' is used throughout the VASRD to encompass a variety of healthcare professionals who provide health care services, to include medical care or treatment. This is consistent with the use of the term ''medical providers'' outside of VA as well. Therefore, VA makes no changes based on this comment.

IV. Comments Regarding DC 7203 Esophagus, Stricture of

One commenter noted that VA use ''dilation'' and ''dilatation'' in the evaluation criteria and asked if the terms should be used interchangeably. VA recognized that there was a typographical error and all instances of the word should have been ''dilatation.'' VA makes a clarifying change that amends the proposed text by replacing the word ''dilation'' with ''dilatation'' at the 50% level, and in Note 5 of DC 7203.

The same commenter asked VA to clarify if surgical correction only refers to procedures to correct esophageal strictures or if it also includes surgeries that relieve gastroesophageal reflux disease (GERD) such as Nissen fundoplication. VA clarifies that surgical correction only warrants the 80% evaluation when it is used to treat esophageal stricture(s). We make no change to DC 7203 based on this comment, but make a clarifying change to similar language in DC 7206 as discussed under Section XVIII, Technical Corrections, in this document.

Another commenter noted that the definition of refractory requires at least five dilatation treatments at two-week

intervals and that the 50% criteria is warranted when dilatation occurs three or more times per year; however, refractory esophageal strictures can receive 30% evaluations, which are warranted when dilatation occurs no more than two times per year. The commenter questioned how refractory esophageal stricture could warrant a 30% evaluation if, by definition, it requires five dilatations per year. VA agrees and revises the 30% criteria to only include recurrent esophageal strictures while the 50% criteria will reference both recurrent and refractory esophageal strictures. VA appreciates the input of these commenters.

V. Comments Regarding DC 7206 Gastroesophageal Reflux Disease

One commenter questioned why there was no mention of the GERD evaluative criteria in the Economic Regulatory Impact Analysis (ERIA). The discussion regarding how GERD is evaluated was described in the preamble of the proposed rule. The ERIA is a systemic approach to assessing the positive and negative budgetary effects of proposed and existing regulation and non-regulatory alternatives. Budgetary documentation does not require information regarding how a condition is evaluated because that is not considered pertinent to cost analysis. In the ERIA, VA compares the current evaluation levels for DC 7346 with the proposed evaluation levels for new DC 7206. For budgetary discussions, this is an appropriate methodology to estimate impact of proposed changes.

The same commenter questioned why VA categorized GERD as having a ''minor budgetary impact'' in the ERIA. As stated in the ERIA, the term ''minor budgetary impact'' is defined as having costs less than $100 million over ten years. GERD as a standalone item is anticipated to have a minor budgetary impact under that definition, whereas the digestive rule overall is anticipated to have a major budgetary impact (*i.e.,* greater than $100 million over 10 years).

Four commenters recommended that VA discontinue rating GERD by analogy or reference. In its proposed rule, VA introduced a new diagnostic code, DC 7206, with instructions to rate this condition under DC 7203. VA agrees that DC 7206 warrants its own rating criteria to provide clarity in its application. However, as indicated in the proposed rule, VA proposes to evaluate GERD using rating criteria that are based on predominant picture of disability due to GERD. These criteria consider symptoms of esophageal obstruction and irritation that lead to the esophageal stricture, which are consistent with the symptoms of GERD and clearly identified under DC 7203, Esophagus, stricture of. 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). Therefore, VA amends the proposed rule by placing the text of the evaluation criteria for DC 7206 following its title. DC 7206 will not be rated by reference to DC 7203. VA thanks the commenters for their suggestions and has updated this DC to reflect this change.

Six commenters expressed concern that the evaluative criteria for DC 7206 do not include symptoms of heartburn, regurgitation, sore throat, nausea, chest pain, difficulty swallowing, laryngitis, chronic cough, new or worsening asthma, inflammation of the gums, cavities, bad breath, disrupted sleep, ulceration, erosion or Barrett's esophagus. Three of those six commenters proposed that VA continue to evaluate GERD under the current rating schedule, analogous to DC 7346 for hiatal hernia.

Even though these symptoms are important in the diagnosis and treatment of GERD, the VA rating schedule bases its evaluations on the permanent impairment due to this condition. Such permanent impairment of function is based on the scarring due to the chronic irritation of the esophagus by acid reflux and consequent development of scar tissue that causes esophageal stricture. *See* Desai JP, Moustarah F., Esophageal Stricture [Updated 2021 May 27], *https://www.ncbi.nlm.nih.gov/books/NBK542209/.* Therefore, for VA disability compensation purposes, the functional impairment due to GERD will be evaluated and based on the degree of esophageal stricture. VA makes no changes based on these comments.

Two commenters expressed concern that VA has not considered the functional impairment posed by GERD. VA disagrees. The VASRD provides evaluative criteria in line with 38 U.S.C. 1155 (the statute that governs implementation of the ratings schedule) for the evaluation based on the average impairments of earning capacity resulting from comparable injuries in civilian occupations. Accordingly, VA has incorporated considerations regarding the functional impairment caused by each disability evaluation in its rating criteria. Therefore, VA makes no changes based on these comments.

Three commenters expressed concern that while esophageal stricture is commonly caused by GERD, not all GERD cases result in esophageal stricture. While this is true, esophageal stricture is more often than not the result of under-treated, late-stage, or refractory GERD. As stated above, the purpose of the VASRD is to evaluate the permanent residuals of a disability pursuant to 38 U.S.C. 1155. VA makes no changes based on these comments.

Two commenters expressed concern that by changing the VASRD for digestive disabilities, including GERD, VA is attempting to save money and create a higher burden to obtain compensable evaluations. VA disagrees. As stated in the preamble of the proposed rule, the purpose of this rule was to reflect medical and scientific advances in the understanding and treatment of digestive disorders. 87 FR 1522 (Jan. 11, 2022). For example, GERD is more appropriately evaluated as esophageal stricture than hiatal hernia based on objective findings. Id. at 1525 (citing 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)). This adjustment from evaluating GERD based on subjective symptoms to objective measurements is consistent with the stated purpose of this rule. Therefore, VA makes no changes based on these comments.

One commenter was concerned because the 2004 study cited in the proposed rule stated its objective was to ''develop up-to-date evidence-based recommendations relevant to the needs of Canadian health care providers for the management of the esophageal manifestations of GERD,'' and the study's author noted that ''GERD significantly impairs quality of life, both in patients with erosive esophagitis and in those who have no endoscopic evidence of injury[.]''

As stated above, functional impairment is the basis for formulating VASRD evaluative criteria. However, ''quality of life'' is not a quantifiable measurement for VA disability purposes as VA measures functional impairment pursuant to 38 U.S.C. 1155. It is the intent of this rule to incorporate modernized terminology and accepted clinical treatment into the VASRD. VA recognizes the importance of the symptoms that were mentioned by the commenter (*e.g.,* erosions, ulcerations and Barrett's esophagus) in the diagnosis and treatment of GERD; however, the VASRD concentrates on the ongoing impairment due to this condition. Ongoing impairment of function due to GERD is based on the scarring due to the chronic irritation of the esophagus by acid reflux and consequent development of scar tissue

that causes esophageal stricture. Therefore, for VA disability compensation purposes, the functional impairment due to GERD will be evaluated and based on the degree of esophageal stricture. Thus, VA makes no changes based on this comment.

One commenter suggested that acid reflux more than three times a week should warrant a 20% evaluation. VA disagrees. Acid reflux is already considered in the 10% evaluation, but VA sought a more objective measure—specifically, the prescription of medication on a daily basis—rather than assessing frequency of acid reflux events. And VA compensates such medication usage at the 10% level consistent with other conditions that require daily medication for control (*e.g.,* cardiac conditions rated under 38 CFR 4.104). VA thanks the commenter for their suggestion but makes no changes to the rule.

VI. Comments Regarding DC 7319 Irritable Bowel Syndrome (IBS)

One commenter asked whether an individual could submit a claim for DC 7207 Barrett's esophagus and DC 7319 irritable bowel syndrome (IBS) or DC 7326 Crohn's disease. Neither 38 CFR 4.113 nor 38 CFR 4.114 prohibit separate evaluations of any 7200 series conditions and 7300 series conditions. Thus, Barrett's esophagus and either IBS or Crohn's disease may be separately evaluated without pyramiding if there are no similar comorbid symptoms. The same commenter asked a question regarding submitting a personal benefit application for these conditions. VA always encourages veterans to file claims for benefits to which they believe they are entitled and to seek assistance with filing claims from accredited representatives whenever necessary. However, VA does not respond to comments regarding individual claims in rulemakings. VA thanks the commenter and makes no changes based on this comment.

One commenter expressed concern that the terms ''change in stool frequency'' and ''change in stool form'' used under DC 7319 are ambiguous and highly subjective and could cause confusion and disagreements as to the timeframe such change occurred. The commenter further stated that while it generally supports VA implementing more objective rating criteria based on the Rome IV criteria, the proposed changes ''should not mirror this undefined language in the Rome IV criteria.'' Instead, the commenter suggested explicitly stating in the evaluative criteria that these changes occurred after the onset of IBS.

VA reserves some of the more detailed instructions, such as the definition of ''change'' as it relates to stools for IBS, for its subregulatory guidance. Generally, the VASRD does not provide definitions of common clinical guidelines. Rather, VA relies on the medical community to adhere to current medical practice and standards, or otherwise provides the definition of medical terms in subregulatory guidance. In this instance, VA will accept the recorded findings of a qualified medical provider using the Bristol Stool Scale, also known as Meyers Scale, to indicate whether stool frequency and form has changed. VA will identify these findings in the training for use of the appropriate disability benefits questionnaires (DBQs). Therefore, VA makes no changes based on this comment.

One commenter stated that limiting the evaluation of IBS under DC 7319 to a maximum schedular evaluation of 30% does not contemplate the functional impairment posed by those experiencing severe and frequent symptoms. The commenter suggested that DC 7319 instead provide a 50% evaluation, comparable to migraine headaches under DC 8100, to account for severe economic inadaptability. For evaluative purposes, severe economic inadaptability denotes a degree of substantial work impairment but does not preclude substantially gainful employment.

Since the 1960s, VA has moved away from including work-specific criterion and instead focused solely on the functional impact caused by the condition in its evaluative criteria. The establishment of a maximum 30% schedular evaluation reflects VA's judgement as to the average occupational impairment resulting from IBS. In exceptional cases where IBS has an unusually severe impact on earning capacity, VA may consider extraschedular ratings under 38 CFR 3.321 and 4.16.

Additionally, in its proposed rule, VA did not propose to change the number of disability levels for the assessment of functional impairment due to IBS. VA kept the same 30%, 10%, and 0% evaluation levels, but updated them with more objective criteria derived from the Rome IV criteria for IBS. *See* 87 FR 1522, 1530 (Jan. 11, 2022) (citing Brian Lacy, ''Bowel Disorders,'' Gastroenterology, 150: 1393–1407 (2016)). VA thanks the commenter for the suggestion but makes no change based on this comment.

Finally, the same commenter suggested that VA include a reference to DC 7332 for impairment of sphincter control of the rectum and anus for veterans who experience incontinence due to IBS. VA does not routinely create notes for all possible comorbid manifestations of a disease process and declines to do so in this circumstance. The regulation in 38 CFR 4.2 advises rating specialists to interpret medical evidence so that the appropriate disability is evaluated. VA thanks the commenter for this suggestion, but makes no changes based on this comment.

VII. Comments Regarding DC 7326 Crohn's Disease or Undifferentiated Form of Inflammatory Bowel Disease

One commenter expressed support for the change to DC 7326 for Crohn's disease because it comprehensively addresses the symptoms of this disease, all treatment modalities and functional impairment caused by this disease. VA thanks this commenter for their support.

One commenter shared their personal experience with Crohn's disease treatment and management. Additionally, the commenter expressed concern about medical coverage for veterans and the burden of co-payments for medical treatment. VA appreciates this comment, but medical care benefit issues are outside of the scope of this rulemaking. Therefore, VA makes no changes based on this comment.

The same commenter noted that mental disorders are frequently diagnosed subsequent to Crohn's disease and should be addressed accordingly. Currently, VA has the authority to grant entitlement to service connection on a secondary basis for disabilities that are proximately due to, or aggravated by, service-connected disease or injury pursuant to 38 CFR 3.310. This would allow VA to service connect a mental disorder due to Crohn's disease without any additional revisions to the portion of the rating schedule which addressed digestive disabilities. Therefore, VA makes no changes based on this comment.

The same commenter suggested using a 100-point system developed by Crohn's and Colitis Foundation of America. However, this point system was developed for diagnosis, treatment and management of these diseases in a clinical setting and is not appropriate to be used for disability evaluation. Therefore, VA makes no changes based on this comment.

Finally, the same commenter expressed support for the rule change for DC 7326 Crohn's disease because it more accurately defines the functional impairment in its rating criteria. VA thanks the commenter for their support.

VIII. Comments Regarding DC 7329, Intestine, Large, Resection of

One commenter suggested that the 100% evaluation criteria for DC 7329 Intestine, large, resection of, should simply consist of the elements from the 60% criteria with one additional element (high-output syndrome) instead of three additional elements. The commenter's concern was that veterans could experience inconsistent ratings if they fall between these two requirements, such as a total colectomy with high-output syndrome but no ileostomy. Additionally, the commenter suggested adding an intermediary 80% evaluation under this DC to cover the cases that fall between these two requirements.

The proposed 100% evaluation criteria include three major elements, (1) total colectomy with (2) formation of ileostomy and (3) high-output syndrome with more than two episodes of dehydration in the past 12 months. The episodes of dehydration that require intravenous hydration are reflective of the gravity of the consequences of the large intestine resection, demonstrating total impairment. The functional impairment due to total colectomy with high-output syndrome and total colectomy without high-output syndrome has clear demarcation along the absence or presence of said high-output syndrome. Therefore, VA proposed clearly identifiable levels of disability for the 60% and 100% evaluation based on that principle. Furthermore, 38 CFR 4.7 already provides guidance to rating specialists to assign the next higher evaluation should the disability picture more closely approximate that level of disability. VA thanks the commenter for their suggestions but declines to make changes based on this comment.

However, during its internal review, VA noted a minor inconsistency in using certain terminology for surgical outcomes for a 40% evaluation for a partial colectomy with permanent colostomy and for a 60% evaluation for total colectomy without high-output syndrome. VA corrects this inconsistent use of medical terminology by revising the 40% evaluative criteria to read as ''Partial colectomy with permanent colostomy or ileostomy without high-output syndrome'' and 60% evaluative criteria to read as ''Total colectomy with or without permanent colostomy or ileostomy without high-output syndrome.'' This clerical change brings additional clarity to the rating criteria for the 20%, 40%, 60% and 100% ratings, and assures their consistent application by rating specialists. This revision does not result in any substantive changes to the criteria under DC 7329.

IX. Comments Regarding DC 7332, Rectum and Anus, Impairment of Sphincter Control

One commenter requested clarification between the terminology ''wearing'' and ''changing'' of pads under DC 7332, rectum and anus, impairment of sphincter control. VA's proposed rating criteria provided descriptive criteria that track the 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, the frequency of incontinence, and the extent to which it alters a person's life. *See* A.M. Kaiser, ''The McGraw-Hill Manual of Colorectal Surgery,'' 743 (2009). For the purposes of VA disability compensation, the term ''changing'' of pads refers to the need to change a pad due to an incontinence to gas, incontinence to liquid or incontinence to solid and the resulting soiling of the pad. The term ''wearing'' of pads refers to a necessary or advisable measure to address the effects of incontinence, regardless of the frequency with which soiling occurs.

One commenter expressed concern regarding the proposed changes to DC 7332 because the evaluative criteria list specific findings that may be applied more rigidly than the existing criteria. The same commenter proposed VA instead create a non-exclusive example to demonstrate levels of loss of control without applying specific findings. As compared to the existing rating criteria, the proposed rule contains successive criteria, which offer clear and objective findings at each level of impairment in line with the CCIS. Additionally, the proposed criteria replace subjective terminology such as ''extensive,'' ''frequent,'' ''occasional,'' and ''slight'' with measurable descriptive findings that clarify existing rating criteria. Furthermore, each level of disability allows for evaluation based on responsiveness to treatment or frequency of incontinence with use of pads, which allows flexibility in applying disability evaluation. VA thanks the commenter for their suggestion but makes no changes to the rule based on this comment.

The same commenter was concerned that the proposed criteria under DC 7332 may impose a higher burden than current procedures to award entitlement to special monthly compensation (SMC) under 38 CFR 3.350(e)(2) and 38 U.S.C. 1114(o) for paraplegia. VA disagrees. Aside from making the criteria more objective, VA's proposed revision to this diagnostic code includes consideration as to whether loss of anal sphincter control is responsive to treatment. This is not incompatible with SMC for paraplegia. Rather, 38 CFR 3.350(e)(2) states that ''[t]he requirement of loss of anal and bladder sphincter control is met even though incontinence has been overcome under a strict regimen of rehabilitation of bowel and bladder training and other auxiliary measures.'' The fact that the evaluative criteria have become more objective and include consideration of treatment response does not make it more difficult to be awarded SMC due to paraplegia than under current requirements. Therefore, VA makes no changes to this rule based on this comment.

X. Comments Regarding DC 7336, Hemorrhoids, External or Internal

One commenter expressed concern that the 0% (noncompensable) evaluation for hemorrhoids under DC 7336 was removed without explanation and requested VA reinstate this evaluation. Current VASRD criteria warrant a 0% evaluation for mild or moderate internal or external hemorrhoids. These rating criteria are unquantifiable and nonspecific; therefore, VA removed them. However, 38 CFR 4.31 requires VA raters to assign a noncompensable evaluation for any diagnostic code in the VASRD where one is not present when the requirements for a compensable evaluation are not met. Therefore, VA can still assign 0% evaluations for hemorrhoids despite the evaluation level being removed.

Additionally, the commenter was concerned that without a noncompensable evaluation under DC 7336 for hemorrhoids, veterans would not be eligible for the 10% evaluation awarded for two or more noncompensable evaluations under 38 CFR 3.324. As stated above, despite the removal of the noncompensable evaluation under DC 7336, veterans may be eligible for a 10% rating based on two or more noncompensable evaluations under 38 CFR 3.324 even if those noncompensable evaluations are awards through 38 CFR 4.31. Therefore, VA makes no changes based on this comment.

XI. Comments Regarding DC 7345, Chronic Liver Disease Without Cirrhosis

One commenter suggested adding a 10% evaluation under DC 7345 for chronic liver disease without cirrhosis to account for those in remission who

may experience spontaneous reactivation of hepatitis B and/or experience mental health symptoms related to the anxiety that spontaneous reactivation could occur. Proposed DC 7345 provides a 0% evaluation for those with a history of liver disease who are asymptomatic. Compensable evaluations, 10% or more, are based on laboratory findings and/or symptoms associated with a disease. Should the disease recur, the veteran may submit a claim for increase based on recurrence and level of severity. Regarding mental symptoms associated with chronic liver disease, VA may grant entitlement to service connection on a secondary basis for disabilities that are proximately due to, or aggravated by, service-connected disease or injury pursuant to 38 CFR 3.310. VA thanks this commenter, but makes no changes based on this comment.

XII. Comments Regarding DC 7347, Pancreatitis, Chronic

One commenter was concerned that the enteral feeding element of the rating criteria is not included in every evaluation level under DC 7347, Pancreatitis, chronic. Additionally, the commenter asked for further clarification on how to rate this condition if it requires enteral feeding, regardless of whether or not the feeding causes complication. The commenter also stated that other proposed criteria, specifically DCs 7301, 7303, and 7328, provide an 80% disability rating for enteral feeding whereas this code and 7330 only provide 60%. The commenter suggested that VA consider applying the 80% rating for enteral feeding to align it with the rest of the proposed ratings.

First, VA closely examined the full range of functional impairment due to the chronic pancreatitis during its review of this VASRD body system. VA found that the proposed rating criteria is aligned appropriately with the functional impairment due to the chronic pancreatitis, as described in the preamble of the proposed rule. To that end, consideration of enteral feeding is not necessary at every evaluation level.

Second, DCs 7301, 7303, and 7328 provide an 80% disability rating for TPN, not enteral feeding. TPN provides nutrition outside of the digestive tract (intravenously), whereas enteral feeding provides nutrition through the digestive tract by way of a feeding tube. Additionally, TPN is primarily indicated when enteral feeding is not possible. *See* Maudar K.K. (1995), TOTAL PARENTERAL NUTRITION, *Medical journal, Armed Forces India, 51*(2), 122–126, *https://doi.org/10.1016/S0377-1237(17)30942-5.* Thus, TPN is assigned a higher evaluation than enteral feeding based on the need for intravenous nutrition due to the greater impairment of functioning of the digestive tract. Therefore, VA makes no changes based on this comment.

XIII. Comments Regarding DC 7355, Celiac Disease

One commenter suggested using ''undernutrition'' instead of ''malabsorption syndrome'' under DC 7355 for celiac disease because malabsorption is not defined in the VASRD, and it ultimately results in undernutrition. VA disagrees. Malabsorption syndrome is separate from undernutrition condition; these two conditions cannot be used interchangeably. Furthermore, malabsorption syndrome has its own clear clinical definition and does not have to be defined in the VASRD. Therefore, VA makes no changes based on this comment.

XIV. Comments Regarding Dysphagia

One commenter asked whether the term dysphagia is defined in this rule as difficulty swallowing or a condition encompassing a variety of symptoms such as pain while swallowing, a sensation of food getting stuck in the throat or chest, drooling, hoarseness, regurgitation, etc. As stated above, the VASRD does not provide detailed definitions of common clinical guidelines. Qualified clinicians may determine the presence or absence of any symptoms of GERD upon examination, including the common symptom of dysphasia, which may manifest as a variety of symptoms including difficulty of swallowing. VA thanks the commenter but makes no changes to the rule based on this comment.

XV. Comments Regarding General Terminology

One commenter expressed concern regarding with the inconsistency of using general terminology, such as ''prescribed dietary modification,'' ''dietary intervention,'' and ''dietary restriction'' under a number of diagnostic codes. VA uses all three references—prescribed dietary modification, dietary intervention, and dietary restriction—to describe different types of therapeutic diets. A therapeutic diet is a meal plan that controls the intake of certain foods or nutrients and is part of the treatment of a medical condition and is normally prescribed by a physician and planned by a dietician. A therapeutic diet is usually a modification of a regular diet, and it is modified or tailored to fit the nutrition needs of a particular person. VA uses these references as appropriate under specific diagnostic codes according to specific clinical situations. Additionally, in issuing its proposed rule, VA provided specific examples of prescribed dietary modification (*e.g.,* therapeutic diets can be modified for nutrients or texture due to impaired swallowing or frequent aspiration), dietary intervention (*e.g.,* a prescribed gluten-free diet), and dietary restriction (*e.g.,* a reduction of particular or total nutrient intake without causing malnutrition). Therefore, VA makes no changes based on this comment.

The same commenter stated that the 30% criteria for DC 7356, Gastrointestinal dysmotility syndrome, is repetitive and misleading because it requires both symptoms of intestinal pseudo-obstruction (CIPO) and symptoms of intestinal motility disorder, but CIPO is an intestinal motility disorder. VA agrees and revises the criteria at the 30% level to use ''or'' instead of ''; and.'' CIPO is a specific diagnosis of an intestinal motility disorder, so use of the conjunctive ''and'' makes reference to CIPO redundant. VA thanks the commenter for their comment.

Additionally, the commenter questioned whether recurrent emergency treatment for the 50% evaluation for DC 7356 only applies to episodes of intestinal obstruction or if it also applies to regurgitation. VA clarifies once more that the recurrent emergency treatment for the 50% evaluation also applies to regurgitation due to poor gastric emptying, abdominal pain, recurrent nausea or recurrent vomiting. The commenter asked that VA adjust the wording for further clarification. However, VA notes that when evaluation criteria use the disjunctive ''or'' without a semi-colon, then ''or'' indicates that the qualifier applies to criterion on both sides of the ''or.'' That is the case regarding recurrent emergency treatment in this evaluation. Conversely, when VA uses ''or'' with a semi-colon, then the qualifier only applies to the criterion on the same side of the semi-colon. Therefore, a 50% evaluation would be warranted if the evidence demonstrated intermittent tube feeding for nutritional support, along with recurrent emergency treatment for either intestinal obstruction due to poor gastric emptying, abdominal pain, recurrent nausea, or recurrent vomiting *or* regurgitation due to poor gastric emptying, abdominal pain, recurrent nausea, or recurrent vomiting. VA makes no changes based on these comments.

XVI. Comments of General Disagreement

One commenter indicated that the current VASRD does not incorporate the most up-to-date and accurate scientific data because its rating criteria do not allow clinicians to more accurately diagnose and therefore to fairly distribute disability services. The VASRD is not intended to be utilized in a clinical setting to identify, diagnose or treat injuries, diseases or disorders. The VASRD provides evaluative criteria based on the average impairments of earning capacity resulting from comparable injuries in civilian occupations, in line with VA's authority under 38 U.S.C. 1155 to adopt a rating schedule. Clinicians are urged to utilize standard diagnostic and treatment practices in their respective clinical setting. Therefore, VA makes no changes based on this comment.

Two commenters expressed concern that VA is taking benefits away from veterans and disagreed with the rule change in general. The commenters did not offer any specific recommendations. The primary objective for this rule is to revise the rating criteria to reflect updated medical advances, add new medical conditions and update terminology. There are no provisions in this rule that seek to remove any entitlement to benefits, and this rule would not disturb ratings currently in effect. Therefore, VA makes no changes based on these comments.

XVII. Comments Beyond the Scope of This Rulemaking

One commenter shared their experience seeking diagnoses for their digestive symptoms due to Gulf War Illness. The regulation in 38 CFR 3.317(a)(2)(i)(B)(*3*) creates a presumption of service connection for certain Persian Gulf veterans who exhibit functional gastrointestinal disorders. The presumption of service connection for those disorders falls outside the scope of this rulemaking. Commentary or advice for questions regarding individual claims also fall outside of the scope of this rulemaking. Therefore, VA makes no changes based on this comment.

XVIII. Technical Corrections

During its internal review, VA identified a number of minor issues that are clerical and typographical in nature and took a corrective action in its final rule with minor changes as noted below.

VA makes a minor typographical correction to revised § 4.112(d)(2). In the proposed rule, the last sentence of the revised regulation used the word ''parental'' when describing the function of nasogastric or nasoenteral feeding tubes. VA amends this sentence by replacing ''assisted parental nutrition'' with ''assisted parenteral nutrition.'' This change to the language does not result in any substantive changes to § 4.112(d)(2).

VA makes minor clerical changes to the paragraph under 38 CFR 4.114, Schedule of ratings—digestive system. To streamline this regulatory language and to ensure its clarity, VA revises 38 CFR 4.114 to (1) state that ratings under these diagnostic codes will be assigned a single evaluation that reflects the predominant disability picture and (2) that, if warranted, elevation of the disability rating to the next higher evaluation level can be provided and will be based on the severity of the overall disability under 38 CFR 4.114. This change to the language does not result in any substantive changes to the paragraph under 38 CFR 4.114, Schedule of ratings—digestive system.

VA makes a minor clerical correction to DC 7206, Gastroesophageal reflux disease, to the 80% disability level language. To promote clarity, VA amends the evaluative criteria for an 80% disability rating by adding the words ''of esophageal stricture(s)'' after ''treatment with either surgical correction.'' This clerical change is intended to specify that the surgical correction applies only to correction of esophageal stricture(s) and not any other conditions. This change does not result in any substantive changes to the criteria under DC 7206.

VA makes clerical changes under DC 7303, Chronic complications of upper gastrointestinal surgery. The 30% and 50% disability ratings discussed ''vomiting not controlled by oral dietary modification'' or ''vomiting not controlled by medical treatment.'' To promote clarity, VA removes the phrase ''not controlled by'' and replaces it with the word ''despite.'' This change to the language does not result in any substantive changes to the criteria under DC 7303.

VA makes two clerical changes under DC 7304, Peptic ulcer disease. First, the rating criteria under the 0% disability rating mentions an x-ray test as one of the diagnostic imaging studies to record a history of peptic ulcer disease. VA replaces the reference to just one diagnostic imaging study, such as an x-ray test, with a general reference to diagnostic imaging studies, such as an X-ray, CT scan, MRI, and others. This clerical change brings additional clarity to the rating criteria for a 0% evaluation. This change to the language does not result in any substantive changes to the criteria under DC 7304.

Second, VA amends the note under DC 7304 to include the following standard instruction: ''Apply the provisions of § 3.105(e) to any change in evaluation based upon that or any subsequent examination.'' This clerical change is consistent with the reduction of evaluations under 38 CFR 3.105(e) and with notes regarding mandatory VA medical examinations throughout the VASRD. While VA inadvertently left this instruction out of the proposed rule, this addition does not result in any substantive changes to the criteria under DC 7304.

VA makes a clerical change under DC 7312, Cirrhosis of the liver. In the proposed rule, one of the criteria for a 100% evaluation is listed as encephalopathy, whereas one of the criteria for a 60% evaluation is listed as hepatic encephalopathy. To avoid confusion and ensure consistency in the application of the rating schedule, VA replaces the phrase ''encephalopathy'' in the 100% criteria with ''hepatic encephalopathy.'' This change to the language does not result in any substantive changes to the criteria under DC 7312.

VA makes a clerical change to the note under DC 7317, Gallbladder, injury of. In the proposed rule, VA instructs adjudicators that adhesions are not necessary when rating under DC 7301 (Adhesions of the peritoneum due to surgery, trauma, disease, or infection). As written, this note appears contradictory and could lead to confusion in applying the correct evaluation. To clarify the intent of this note, VA makes a minor clerical change by stating that when gallbladder injuries are rated by analogy under DC 7301, a finding of adhesion is not necessary. This change is structural in nature and does not result in any substantive changes to the rating criteria.

VA identified that DC 7319 had one note labeled Note 1. There is only one note in relation to DC 7319 and, therefore, no numerical designation is required. To provide consistency and clarity, VA corrects this typographical error and revises DC 7319 to remove the numerical designation.

VA makes a clerical change under DC 7319, Irritable bowel syndrome (IBS) and DC 7326, Crohn's Disease. In the proposed rule, VA listed ''distension'' under the evaluative criteria for the 20% and 30% evaluations levels under DC 7319 and listed ''distention'' under the 10% evaluation level of DC 7319 and the 100% evaluation level of DC 7326. To ensure consistency, VA corrects this typographical error and changes the

spelling at the 10% level under DC 7319 and the 100% evaluation under DC 7326 to ''distension.''

VA makes two minor clerical corrections to DC 7330, Intestinal fistulous disease, external at the 100% evaluation. VA amends the evaluative language by replacing ''enteral nutrition'' with ''enteral nutritional support.'' Additionally, VA specifies the size of the ostomy bags by adding ''(sized 130cc).'' This language is consistent with the 60% evaluative criteria under DC 7330. These changes do not result in any substantive changes to the criteria under DC 7330.

VA makes two minor clerical corrections to DC 7351, Liver transplant, at the 30 and 60-percent disability levels. To promote clarity, VA amends the evaluative criteria for 30% disability rating by adding the words ''Following transplant surgery,'' to the existing language ''minimum rating.'' The minimum rating for liver transplant surgery was applicable to the veterans with liver transplant. The minimum rating's intent was to compensate veterans for post-transplant functional impairment due to antirejection therapy and other liver transplant medical management treatment modalities. Therefore, this change to the language does not result in any substantive changes to the criteria under DC 7351.

VA amends the evaluative criteria for a 60% disability rating by replacing the word ''retransplantation'' with the words ''transplant surgery,'' which is consistent with medical terminology that is currently used to describe both first organ transplant surgery and any subsequent organ transplant surgery. Additionally, VA adds the word ''eligible'' to the language ''awaiting'' to read ''Eligible and awaiting transplant surgery, minimum rating.'' This clerical change brings additional clarity to VA's intent in revising the rating criteria for a 60% disability rating, which is to capture a specific population of veterans who are awaiting liver transplant surgery and who are eligible candidates for such surgery. This change to the language does not result in any substantive changes to the criteria under DC 7351.

VA noted a minor inconsistency in the use of the preposition ''with'' in the 30%, 50%, and 80% disability levels under DC 7355, Celiac disease. At the 30% level, it reads, ''Malabsorption syndrome with chronic diarrhea'', whereas at the 50% level it reads, ''Malabsorption syndrome that causes chronic diarrhea.'' To promote clarity and consistency, VA amends the proposed text at the 50% level by replacing ''that causes'' with the preposition ''with.'' The 50% level now begins with the phrase, ''Malabsorption syndrome with chronic diarrhea.'' To ensure standardization at all levels, VA makes a similar amendment to the proposed text at the 80% level by replacing ''that causes'' with the preposition ''with.'' The 80% level now begins with the phrase, ''Malabsorption syndrome with weakness.'' This change to the language does not result in any substantive changes to the criteria under DC 7355, Celiac disease.

VA makes five clerical corrections under 38 CFR 4.114 for DCs 7301 Peritoneum, adhesions of, due to surgery, trauma, disease, or infection, 7303 Chronic complications of upper gastrointestinal surgery, 7328 Intestine, small, resection of, 7330 Intestinal fistulous disease, external, and 7356 Gastrointestinal dysmotility syndrome. For consistency and clarity, VA amends the evaluative language for each occurrence where a total parenteral nutrition is mentioned. Throughout its regulation, VA will refer to total parenteral nutrition as ''total parenteral nutrition (TPN).'' These changes do not result in any substantive changes to the criteria under DCs 7301, 7303, 7328, 7330, and 7356.

Executive Orders 12866, 13563 and 14094

Executive Order 12866 (Regulatory Planning and Review) directs agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 14094 (Executive Order on Modernizing Regulatory Review) supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866 of September 30, 1993 (Regulatory Planning and Review), and Executive Order 13563 of January 18, 2011 (Improving Regulation and Regulatory Review). The Office of Information and Regulatory Affairs has determined that this rulemaking is a significant regulatory action under Executive Order 12866, section 3(f)(1), as amended by Executive Order 14094. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *www.regulations.gov.*

Regulatory Flexibility Act

The Secretary hereby certifies that this final 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 factual basis for this 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 one year. This final rule would have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

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

Congressional Review Act

Under the Congressional Review Act, this regulatory action may result in an annual effect on the economy of $100 million or more, 5 U.S.C. 804(2), and so is subject to the 60-day delay in effective date under 5 U.S.C. 801(a)(3). In accordance with 5 U.S.C. 801(a)(1), VA will submit to the Comptroller General and to Congress a copy of this regulation and the Regulatory Impact Analysis (RIA) associated with the regulation.

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved and signed this document on March 4, 2024, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication

electronically as an official document of the Department of Veterans Affairs.

Jeffrey M. Martin,

Assistant Director, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

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

PART 4—SCHEDULE FOR RATING DISABILITIES

■ 1. The authority citation for part 4 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 § 4.114:

(a) *Weight loss. Substantial weight loss* means involuntary loss greater than 20% 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% 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.* Paragraphs (d)(1) and (2) of this section describe various nutritional support methods used to treat certain digestive conditions.

(1) Total parenteral nutrition (TPN) 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. TPN 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 parenteral nutrition in which a flexible feeding tube is inserted through the nose into the stomach or bowel.

■ 5. Amends § 4.114 by:

■ a. Revising the introductory text and the entries for diagnostic codes 7200 through 7205;

■ 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 entry for diagnostic code 7304;

■ f. Removing the entries for diagnostic codes 7305 and 7306;

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

■ h. Removing the entry for diagnostic code 7316;

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

■ j. Removing the entries for diagnostic codes 7321 and 7322;

■ k. Revising the entry for diagnostic code 7323;

■ l. Removing the entry for diagnostic code 7324;

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

■ n. Removing the entries for diagnostic codes 7339 and 7340;

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

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

■ q. Revising the entry for diagnostic code 7351;

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

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

■ t. 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 through 7329 inclusive, 7331, 7342, 7345 through 7350 inclusive, 7352, and 7355 through 7357 inclusive, with each other. Instead, when more than one rating is warranted under those diagnostic codes, assign a single evaluation under the diagnostic code that reflects the predominant disability picture, and elevate it to the next higher evaluation if 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): Rate the residuals of speech impairment as complete organic aphonia (DC 6519) or incomplete aphonia as laryngitis, chronic (DC 6516).	
Note (2): Dietary modifications due to this condition must be prescribed by a medical provider.	
7203 Esophagus, stricture of:	

	Rating
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) dilatation 3 or more times per year, (2) dilatation using steroids at least one time per year, or (3) esophageal stent placement	50
Documented history of recurrent 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 dilatation 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:	
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 of esophageal stricture(s) 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) dilatation 3 or more times per year, (2) dilatation using steroids at least one time per year, or (3) esophageal stent placement	50
Documented history of recurrent 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 dilatation sessions performed at 2-week intervals.	
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 (TPN); 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 (TPN); 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 despite 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 despite 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 diagnostic imaging studies	0
Note: After three months at the 100% evaluation, rate on residuals as determined by mandatory VA medical examination. Apply the provisions of § 3.105(e) of this chapter to any change in evaluation based upon that or any subsequent 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).	
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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) hepatic 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: When rating gallbladder injuries analogous to DC 7301, a finding of adhesions is not necessary.	
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 distension	10
Note: This diagnostic code may include functional digestive disorders (see § 3.317 of this chapter), 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 this section.	
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 distension	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 parenteral 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 with or without permanent colostomy or ileostomy without high-output syndrome	60
Partial colectomy with permanent colostomy or ileostomy without high-output syndrome	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 nutritional support along with at least one of the following: (1) daily discharge equivalent to four or more ostomy bags (sized 130 cc), (2) requiring ten or more pad changes per day, or (3) 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.	
* * * * * * *	
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% or more, with pain and straining during defecation	60
Reduction of the lumen by less than 50%, 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% 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

	Rating
7337 Pruritus ani (anal itching):	
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% to that rating to account for the second compensable hernia. Do not add 10% to that rating if the more severely disabling hernia is rated at 100%.	
Note (2): Any one of the following activities of daily living are sufficient for evaluation: bathing, dressing, hygiene, and/or transfers.	
* * * * * * *	
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% 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) of this chapter 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 in this entry.	
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:	

	Rating
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
Note: Rate recurrent ulcer following complete vagotomy under DC 7304 (Peptic ulcer disease), with a minimum rating of 20%; 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% 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) of this chapter 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
Eligible and awaiting transplant surgery, minimum rating	60
Following transplant surgery, minimum rating	30
Note: Assign a rating of 100% 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 this section.	
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% 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 with 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 with 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 chronic intestinal pseudo-obstruction (CIPO) or 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 § 3.317(a)(2)(i)(B)(*3*) of this chapter, 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

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■ 6. Amend appendix A to part 4 by:

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

■ b. Revising and republishing the entry for § 4.114.

The additions and revision 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 May 19, 2024.
4.111		Removed and reserved May 19, 2024.
4.112		Revised May 19, 2024.
*	*	* * * * * * *
4.114		Introduction paragraph revised March 10, 1976; introduction paragraph revised May 19, 2024.
	7200	Title, criterion May 19, 2024.
	7201	Criterion May 19, 2024.
	7202	Evaluation, criterion, note May 19, 2024.
	7203	Evaluation, criterion, note May 19, 2024.
	7204	Title, note May 19, 2024.
	7205	Note May 19, 2024.
	7206	Added May 19, 2024.
	7207	Added May 19, 2024.
	7301	Title, Evaluation, criterion, note May 19, 2024.
	7302	Removed April 8, 1959.
	7303	Added May 19, 2024.
	7304	Evaluation November 1, 1962; title, evaluation, criterion, and note May 19, 2024.
	7305	Evaluation November 1, 1962; Removed May 19, 2024.
	7306	Criterion April 8, 1959; Removed May 19, 2024.
	7307	Evaluation May 22, 1964; Criterion May 22, 1964; Note May 22, 1964; title, evaluation, criterion, and note May 19, 2024.
	7308	Title April 8, 1959; evaluation April 8, 1959; evaluation and criterion May 19, 2024.
	7309	Evaluation May 19, 2024.
	7310	Evaluation May 19, 2024.
	7311	Criterion July 2, 2001.
	7312	Evaluation March 10, 1976; evaluation July 2, 2001; title, evaluation, criterion, and note May 19, 2024.
	7313	Evaluation March 10, 1976; removed July 2, 2001.
	7314	Title, evaluation, note May 19, 2024.
	7315	Evaluation May 19, 2024.
	7316	Removed May 19, 2024.
	7317	Note May 19, 2024.
	7318	Title, evaluation, and criterion May 19, 2024.
	7319	Title November 1, 1962; evaluation November 1, 1962; title, evaluation, criterion, and note May 19, 2024.
	7321	Evaluation July 6, 1950; criterion March 10, 1976; Removed May 19, 2024.
	7322	Removed May 19, 2024.
	7323	Criterion and note May 19, 2024.
	7324	Removed May 19, 2024.
	7325	Note November 1, 1962; note May 19, 2024.
	7326	Note November 1, 1962; title, evaluation, criterion and note May 19, 2024.
	7327	Evaluation November 1, 1962; criterion November 1, 1962; note November 1, 1962; title, evaluation, criterion, and note May 19, 2024.
	7328	Evaluation November 1, 1962; title, evaluation, criterion, and note May 19, 2024.
	7329	Evaluation November 1, 1962; evaluation, criterion, and note May 19, 2024.
	7330	Evaluation November 1, 1962; criterion and note May 19, 2024.
	7331	Criterion March 11, 1969.
	7332	Evaluation November 1, 1962; evaluation, criterion, and note May 19, 2024.
	7333	Evaluation, criterion, and note May 19, 2024.
	7334	Evaluation July 6, 1950; evaluation November 1, 1962; evaluation, criterion, and note May 19, 2024.
	7335	Evaluation and criterion May 19, 2024.
	7336	Criterion November 1, 1962; criterion May 19, 2024.
	7337	Title, evaluation, and criterion May 19, 2024.
	7338	Title, evaluation, criterion, and note May 19, 2024.
	7339	Criterion March 10, 1976; removed May 19, 2024.
	7340	Removed May 19, 2024.
	7341	Removed March 10, 1976.
	7343	Criterion March 10, 1976; criterion July 2, 2001.
	7344	Criterion July 2, 2001; note May 19, 2024.
	7345	Evaluation August 23, 1948; evaluation February 17, 1955; evaluation July 2, 2001; title May 19, 2024; evaluation, criterion, and note May 19, 2024.
	7346	Evaluation February 1, 1962; title May 19, 2024; evaluation, criterion, and note May 19, 2024.
	7347	Added September 9, 1975; title May 19, 2024; evaluation, criterion, and note May 19, 2024.
	7348	Added March 10, 1976; criterion and note May 19, 2024.
	7350	Added May 19, 2024.
	7351	Added July 2, 2001; evaluation, criterion, and note May 19, 2024.
	7352	Added May 19, 2024.
	7354	Added July 2, 2001; evaluation, criterion, and note May 19, 2024.

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

Sec.	Diagnostic code No.	
	7355	Added May 19, 2024.
	7356	Added May 19, 2024.
	7357	Added May 19, 2024.
* * * * * * *		

■ 7. Amend appendix B to part 4 by revising and republishing the entries in the table under ''The Digestive System'' to 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.
7201	Lips, injuries.
7202	Tongue, loss of whole or part.
7203	Esophagus, stricture.
7204	Esophageal motility disorder.
7205	Esophagus, diverticulum.
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.
7308	Postgastrectomy syndromes.
7309	Stomach, stenosis.
7310	Stomach, injury of, residuals.
7311	Liver, injury of, residuals.
7312	Cirrhosis of the liver.
7314	Chronic biliary tract disease.
7315	Cholelithiasis, chronic.
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].
7323	Colitis, ulcerative.
7324	[Removed].
7325	Enteritis, chronic.
7326	Crohn's disease or undifferentiated form of inflammatory bowel disease.
7327	Diverticulitis and diverticulosis.
7328	Intestine, small, resection of.
7329	Intestine, large, resection.
7330	Intestinal fistulous diseases, external.
7331	Peritonitis.
7332	Rectum and anus, impairment of sphincter control.
7333	Rectum & anus, stricture.
7334	Rectum, prolapse.
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].
7342	Visceroptosis.
7343	Neoplasms, malignant.
7344	Benign neoplasms, exclusive of skin growths.
7345	Chronic liver disease without cirrhosis.
7346	Hiatal hernia and paraesophageal hernia.
7347	Pancreatitis, chronic.

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

Diagnostic code No.	
7348	Vagotomy with pyloroplasty or gastroenterostomy.
7350	Liver abscess.
7351	Liver transplant.
7352	Pancreas transplant.
7354	Hepatitis C (or non-A, non-B hepatitis).
7355	Celiac disease.
7356	Gastrointestinal dysmotility syndrome.
7357	Post pancreatectomy syndrome.

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■ 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. Revising the entry for ''Hernia'';
■ j. 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;
■ k. Removing the entry for ''Intestine, fistula of'' and adding in its place an entry for ''Intestine:'' and subentries for ''Fistulous disease, external'', ''Large, resection of'', and ''Small, resection of'';
■ l. Removing the entry for ''Irritable colon syndrome'' and adding in its place an entry for ''Irritable bowel syndrome (IBS)'';
■ m. Removing the entry for ''Pancreatitis'' and adding in its place an entry for ''Pancreas:'' and subentries for ''Chronic pancreatitis'', ''Post pancreatectomy syndrome'', ''Surgery, complications of'', and ''Transplant'';
■ n. Removing the entry for ''Pruritus ani'' and adding in its place an entry for ''Pruritus ani (anal itching)'';
■ o. Removing the entry for ''Stomach, stenosis of'' and adding in its place an entry for ''Stomach:'' and subentries for ''Postgastrectomy syndrome'', ''Stenosis of'', and ''Surgery, complications of'';
■ p. Adding in alphabetical order under the entry for ''Syndromes'', entries for ''Gastrointestinal dysmotility'', ''Postgastrectomy'', and ''Post pancreatectomy''; and
■ q. Removing the entry for ''Ulcer'' and subentries ''Duodenal'', ''Gastric'', and ''Marginal'' adding in their place an entry for ''Ulcer, peptic''.

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

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

	Diagnostic code No.
* * * * * * *	
* * * * * * *	
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
Muscle	5326
* * * * * * *	
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:	
Postgastrectomy syndrome	7308
Stenosis of	7309
Surgery, complications of	7303
* * * * * * *	
Syndromes:	
* * * * * * *	
Gastrointestinal dysmotility	7356
* * * * * * *	
Postgastrectomy	7308
Post pancreatectomy	7357
* * * * * * *	
* * * * * * *	
Ulcer, peptic	7304

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

						Diagnostic code No.
*	*	*	*	*	*	*

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AGENCY FOR INTERNATIONAL DEVELOPMENT

48 CFR Chapter 7

RIN 0412–AA87

USAID Acquisition Regulation (AIDAR): Security and Information Technology Requirements

AGENCY: U.S. Agency for International Development.

ACTION: Final rule.

SUMMARY: This final rule amends the U.S. Agency for International Development (USAID) Acquisition Regulation (AIDAR) to incorporate a revised definition of ''information technology'' (IT) and new contract clauses relating to information security, cybersecurity, and IT resources. The purpose of these revisions is to provide increased oversight of contractor acquisition and use of IT resources.

DATES: This final rule is effective May 20, 2024.

FOR FURTHER INFORMATION CONTACT: Jasen Andersen, Procurement Analyst, USAID M/OAA/P, at 202–286–3116 or *policymailbox@usaid.gov* for clarification of content or information pertaining to status or publication schedules. All communications regarding this rule must cite RIN No. 0412–AA87.

SUPPLEMENTARY INFORMATION:

A. Background

USAID published a proposed rule on March 21, 2019 (84 FR 10469) to amend the AIDAR to implement various requirements related to information security and IT resources that support the operations and assets of the agency, including those managed by contractors. These new requirements will strengthen protections of agency information systems and facilities. The public comment period closed on May 20, 2019.

B. Discussion and Analysis

USAID updated the final rule to incorporate feedback from public comments, streamline requirements by removing duplicative or unnecessary elements from the rule, and maintain consistency with the Federal Acquisition Regulation (FAR). USAID received four public comments in response to the proposed rule. USAID assessed the public comments in the development of the final rule. The full text of the comments is available at the Federal Rulemaking Portal, *www.regulations.gov.* A summary of the comments, USAID's responses, and changes made to the rule as a result are as follows:

(1) Summary of Significant Changes

The following significant changes from the proposed rule are made in the final rule, organized below using the section titles from the proposed rule:

(i) AIDAR Part 739, Acquisition of Information Technology. No changes were made to the definition of ''information technology'' as a result of the public comments received. Minor administrative changes were made to revise AIDAR Part 739 to add a section regarding the scope of the part, as well as the prescriptions for the applicable contract clauses included in this final rule.

(ii) AIDAR 752.204–72 Homeland Security Presidential Directive–12 (HSPD–12) and Personal Identity Verification (PIV). Several changes were made to this clause as a result of the public comments received. In response to a commenter's concerns that the proposed rule limited access to only U.S. citizens and resident aliens, USAID revised the clause to clarify that various types of credentials are available to different types of users—including non-U.S. citizens—who require physical access to USAID facilities and/or logical access to USAID information systems. Similarly, revisions also update the forms of identity source documents that must be presented to the Enrollment Office personnel, based on the credential type, as well as applicability of any security background investigation. To avoid confusion generated by the reference to the PIV credential, which may only be issued to U.S. citizens and resident aliens, USAID reverted the title of the clause back to its prior name, ''Access to USAID Facilities and USAID's Information Systems.'' The revisions also provide clarity regarding the contents of the monthly staffing report required by the clause. Finally, a new Subpart 704.13 was created to house the prescription for this clause, with this prescription moved from AIDAR 704.404 to AIDAR 704.1303.

(iii) AIDAR 752.204–XX USAID-Financed Third-Party Websites. The public comments led to several revisions in this clause. One commenter highlighted that the clause did not differentiate appropriately between a contractor's website used to implement a project versus a Federal agency's website maintained by a contractor on behalf of the agency. In its subsequent analysis, USAID further determined that ''third-party website,'' as defined in OMB Memorandum No. M–10–23 (''Guidance for Agency Use of Third-Party Websites and Applications''), was not the correct terminology for this clause. While the contract funds the website, the contractor does not operate the website on the agency's behalf. Instead, the final rule now defines a new term and establishes applicability of the clause to ''project websites.'' As further explained in this new definition, there are multiple differentiators that distinguish a ''project website'' from a ''Federal agency website'' under OMB Memorandum No. M–23–10 (''The Registration and Use of .gov Domains in the Federal Government'')—where it is hosted, who is responsible for all operations and management, whether the website is operated on behalf of USAID, and whether the website provides official communications, information, or services from USAID. USAID renamed the clause to ''USAID-Financed Project Websites'' to reflect this change in terminology. In addition, based on public comments, USAID removed certain requirements from the clause, such as the notification to and approval from the Contracting Officer's Representative and the USAID Legislative and Public Affairs (LPA) division, or the authorization of USAID to conduct periodic vulnerability scans. Instead, the contractor is solely responsible for all project website content, operations, management, information security, and disposition. Other requirements were removed from the clause because they are covered by other standard contract requirements—for example, USAID branding/marking requirements were removed from this