

**38 CFR Part 4****[Docket No. VA-2025-VBA-0139]****RIN 2900-AS39****Eliminating the Requirement for Laparoscopy to Establish Service Connection for Endometriosis****AGENCY:** Department of Veterans Affairs.**ACTION:** Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to remove the note under diagnostic code (DC) 7629 requiring an endometriosis diagnosis that is confirmed by laparoscopy. This update would ensure the VA Schedule for Rating Disabilities (VASRD) continues to align with current medical practice and would expedite the process for establishing service connection.

DATES: Comments must be received on or before [INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

ADDRESSES: You may submit comments through www.regulations.gov under RIN 2900-AS39. That website includes a plain-language summary of this rulemaking. Instructions for accessing agency documents, submitting comments, and viewing the rulemaking docket are available on www.regulations.gov under “FAQ.”

FOR FURTHER INFORMATION CONTACT: Virginia Greenwood and Maria Welch, Regulations Analysts, Compensation Service, Veterans Benefits Administration, (202) 461-9700.

SUPPLEMENTARY INFORMATION:I. Background

As part of the ongoing revision of the VASRD, VA proposes to remove the note under title 38 Code of Federal Regulations (CFR) 4.116, DC 7629, Endometriosis. This

change would help VA align DC 7629 with current medical science and clinical practice and expedite the process for establishing service connection. VA last updated the Gynecological Conditions and Disorders of the Breast body system in 2018. See 83 FR 15068 (April 9, 2018). However, VA did not address DC 7629 at that time. VA added DC 7629 to the VASRD to evaluate endometriosis in 1995 with a note that stated, “Diagnosis of endometriosis must be substantiated by laparoscopy.” 60 FR 19851, 19856 (April 21, 1995). VA established this note because medical professionals consider laparoscopy, which is an invasive surgical procedure that allows a surgeon to visually inspect the pelvis, as “the gold standard” for the confirmatory diagnosis of endometriosis. See Bafort, C. et al., “Laparoscopic surgery for endometriosis,” Cochrane Database of Systematic Reviews (2020), <https://doi.org/10.1002/14651858.CD011031>. To date, laparoscopically confirmed endometriosis is still the medical “gold standard.” Because of the note to DC 7629, VA cannot grant service connection for endometriosis in the absence of confirmation by laparoscopy.

In recent years, there has been an increased interest in establishing non-invasive means to clinically diagnose endometriosis, such as patient interviews, physical examinations, and imaging techniques. See Agarwal, S. et al., “Clinical diagnosis of endometriosis: a call to action,” American Journal of Obstetrics and Gynecology (2019), <https://doi.org/10.1016/j.ajog.2018.12.039>. Nevertheless, researchers suggest that “none of [these tools] have been proven to be [a] definitive clinical tool for diagnosis of endometriosis.” Parasar, P. et al., “Endometriosis: Epidemiology, Diagnosis, and Clinical Management,” Current Obstetrics and Gynecology Reports (2017), <https://doi.org/10.1007/s13669-017-0187-1>. Since medical providers are unlikely to use laparoscopy as a first line diagnostic tool based on the variability of symptoms among patients, a diagnosis of endometriosis can be delayed by 8 to 12 years. Kiesel, L. &

Sourouni, M., "Diagnosis of endometriosis in the 21st century," *Climacteric* (2019), <https://doi.org/10.1080/13697137.2019.1578743>.

II. Need for Change

Due to the issues mentioned, VA contends that service connection for endometriosis should no longer be dependent upon obtaining a diagnosis via laparoscopy. Even though laparoscopy is the current standard to definitively diagnose endometriosis, medical providers can make a preliminary diagnosis using non-invasive methods. After obtaining the patient's clinical history, clinicians can physically examine the patient and perform pelvic and transvaginal ultrasounds, magnetic resonance imaging, and computed tomography scans to characterize pelvic masses. Parasar, P. et al., "Endometriosis: Epidemiology, Diagnosis, and Clinical Management," *Current Obstetrics and Gynecology Reports* (2017), <https://doi.org/10.1007/s13669-017-0187-1>. Therefore, VA considers a preliminary diagnosis of endometriosis using these other methods as sufficiently reliable to warrant service connection for the condition and evaluation at the 10% and 30% levels in the current rating criteria.

This change would allow VA to align DC 7629 with other rated conditions where medical providers experience challenges with providing an immediate confirmed diagnosis. For example, there is currently no standard definitive test available to diagnose multiple sclerosis (DC 8018), Parkinson's disease (DC 8004 for Paralysis agitans), or chronic fatigue syndrome (DC 6354), which means a medical professional must generally rely on the patient's symptoms and medical history, and then eliminate other diseases that present similar symptoms. Because of these known challenges, VA did not include criteria within the VASRD requiring a specific test for confirming a diagnosis for these conditions. Moreover, even for purposes of confirming diagnoses in disability compensation claims, Veterans Health Administration and contract examiners cannot order surgical or other invasive procedures, such as laparoscopy. See VA's

Adjudication Procedures Manual, Part X, Subpart i, Chapter 6, Section F, Topic 2, Paragraph i. As previously stated, medical providers are not likely to use laparoscopy as a first line diagnostic tool; therefore, VA does not want to impose barriers to obtaining disability compensation that do not align with established medical practices.

VA further considers this change appropriate for endometriosis since it has established procedures under 38 CFR 3.105 for addressing instances of misdiagnosis and changes in diagnosis if a preliminary diagnosis of endometriosis later changes to a different condition upon laparoscopy results or further medical evaluation.

III. Regulatory Amendments

VA bases the evaluations for endometriosis under DC 7629 on successive rating criteria derived from continuous treatment and whether symptoms are controlled by treatment. Currently, VA awards a 10% evaluation for pelvic pain or heavy or irregular bleeding requiring continuous treatment for control and a 30% evaluation for pelvic pain or heavy or irregular bleeding not controlled by treatment. VA assigns a 50% evaluation if there are (1) lesions involving the bowel or bladder confirmed by laparoscopy, (2) pelvic pain or heavy or irregular bleeding not controlled by treatment, and (3) bowel or bladder symptoms. To effectuate the change described in this rulemaking, VA proposes to remove the note for DC 7629, which states that the diagnosis of endometriosis must be substantiated by laparoscopy. This removal will have a two-fold effect: it will (1) allow VA to establish service connection for endometriosis by diagnosis without a laparoscopy (assuming the other elements of service connection are present) and (2) allow VA to assign evaluations up to 30% disabling without a laparoscopy. Please note that the criteria for the 50% evaluation will remain the same and will continue to require laparoscopy to confirm that there are lesions involving the bowel or bladder.

This amendment will ensure VA uses similar evidentiary standards across body systems when evaluating conditions having similar diagnostic challenges. By removing

the note requiring laparoscopic confirmation for service connection, VA can provide benefits to veterans suffering from endometriosis faster without requiring an invasive procedure for entitlement.

Executive Orders 12866, 13563, and 14192

VA examined the impact of this rulemaking as required by Executive Orders 12866 (September 30, 1993) and 13563 (January 18, 2011), which direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. The Office of Information and Regulatory Affairs has determined that this rulemaking is not a significant regulatory action under Executive Order 12866, as supplemented by Executive Order 13563. This proposed rule is not expected to be an Executive Order 14192 regulatory action because this rule is not significant under Executive Order 12866. The regulatory impact analysis associated with this rulemaking can be found as a supporting document at www.regulations.gov.

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601-612). This certification is based on the fact that small entities or businesses are not impacted by VASRD revisions. 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

This proposed rule would not 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.

Paperwork Reduction Act

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

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

SIGNING AUTHORITY

Douglas A. Collins, Secretary of Veterans Affairs, approved this document on September 25, 2025, 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.

Taylor N. Mattson,

Alternate Federal Register Liaison Officer, Department of Veterans Affairs.

[FR Doc. 2025-19229 Filed: 9/30/2025 8:45 am; Publication Date: 10/1/2025]