Avenue, SE, Washington, DC 20540–9112, and a copy of the statements of cost shall be submitted to the Copyright Office as directed in paragraph (c)(2) of this section.

(2) In the case of a rate adjustment proceeding, the statements of cost shall be sent to the CARP Specialist, P.O. Box 70977, Southwest Station, Washington, DC 20024, or hand delivered to the Office of the Copyright General Counsel, Room 403, James Madison Building, 101 Independence Avenue, SE, Washington, DC 20540.

(d) In the case of a rate adjustment proceeding, all parties to the proceeding shall have 30 days from receipt of a proper statement of cost in which to tender payment to the arbitrators, unless otherwise directed by the panel. Payment should be in the form of a money order, check, bank draft, or electronic fund transfer.

(e) In the case of a distribution proceeding, the Library of Congress shall reimburse the arbitrators directly from the royalty fees collected under title 17 of the United States Code which are the subject of the CARP proceeding. Payment of approved costs shall be made within 30 days of the receipt of a proper statement of cost in the form of an electronic fund transfer in accordance with the regulations of the Library of Congress.

Dated: April 28, 1999.

Marybeth Peters,

Register of Copyrights.

Approved by:

James H. Billington,

The Librarian of Congress.

[FR Doc. 99–11883 Filed 5–10–99; 8:45 am]

BILLING CODE 1410–33–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AF22

Schedule for Rating Disabilities; Diseases of the Ear and Other Sense Organs

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends that portion of the Department of Veterans Affairs (VA) Schedule for Rating Disabilities that addresses the ear and other sense organs. The intended effect of this action is to update this portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances that have occurred since the last review.

DATES: Effective Dates: This amendment is effective June 10, 1999.

FOR FURTHER INFORMATION CONTACT: Caroll McBrine, M.D., Consultant, Regulations Staff (211B), Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Ave., NW, Washington DC 20420, (202) 273–7230.

SUPPLEMENTARY INFORMATION: As part of its review of the Schedule for Rating Disabilities, VA published a proposal to amend that portion of the Schedule pertaining to the ear and other sense organs in the **Federal Register** of April 12, 1994 (59 FR 17295–17301). Interested persons were invited to submit written comments on or before June 13, 1994. We received comments from the Veterans of Foreign Wars, Disabled American Veterans, and three individuals.

The evaluation of hearing impairment in the previous rating schedule was based on two criteria: the results of a puretone audiometry test and the results of a controlled speech discrimination test. Based on the results of these tests, one of two tables was used to determine a Roman numeral designation for hearing impairment: Table VI, where the number is determined by combining the percent of speech discrimination with the average puretone decibel (dB) loss, and Table VIa, which is based solely on average puretone dB loss, and was used only if language difficulties or inconsistent speech audiometric scores made use of Table VI inappropriate. The Roman numeral designations determined for each ear using Table VI or VIa were then combined using Table VII, in order to determine the percentage evaluation for hearing impairment. We proposed no change in this method of evaluation and included information about it in § 4.85, ''Evaluation of hearing impairment'' and § 4.86, ''Auditory acuity, hearing aids, and evidence other than puretone audiometry and controlled speech.'' In response to several comments we received about the method of evaluation, and requesting more specific details, we have reorganized §§ 4.85 and 4.86 for the sake of clarity, as explained in detail below.

One commenter stated that nowhere is VA's authority to use the specific hearing tests it uses spelled out in the regulations. We agree that the tests required were not specified in the rating schedule and have therefore stated in § 4.85(a) that the Maryland CNC speech discrimination test and the puretone audiometry test are to be used for evaluating hearing impairment. The use of the Maryland CNC speech discrimination test and the puretone threshold average determined by an audiometry test was established by a regulation on the evaluation of hearing loss published in the **Federal Register** on November 18, 1987 (52 FR 44117). That regulation changed the method of evaluating hearing loss based on a VA study on hearing loss testing methods and assistive hearing devices that had been requested by Congress in 1984. The results of the study were published in a VA report titled ''Report on Hearing Loss Study'' that was issued on January 6, 1986. Although the regulation revised the rating schedule to incorporate rating tables based on the new method of evaluation, it did not add to the schedule specific details about the new testing methods.

One commenter stated that if only VA examinations or authorized audiological clinic examinations are to be used, this should be stated in the proposed regulation. Based on this comment, we have stated in § 4.85(a) that an examination for hearing impairment for VA purposes must be conducted by a state-licensed audiologist. This will help to assure that examinations of veterans will be accurate and consistent because state licensing agencies require that audiologists meet specific educational and training requirements and pass a national competency examination.

Two commenters noted that the meaning of average puretone decibel loss is not explained in the rating schedule. We agree that this information should be included in the rating schedule and have added an explanation in § 4.85(d). For VA purposes, the average puretone decibel loss means a four-frequency puretone threshold average obtained by adding the puretone thresholds at four specified frequencies'1000, 2000, 3000, and 4000 Hertz and dividing by four. This method and the reasons for its selection were explained in the 1987 regulation referred to above. Current terminology is ''puretone threshold average'' rather than ''average puretone decibel loss,'' and we have used this language in § 4.85 and have revised the labels in Tables VI and VIa. For clarity, we have also titled Table VIa, untitled in the proposed rule, ''Numeric Designation of Hearing Impairment Based Only on Puretone Threshold Average'' and retitled Table VI, titled ''Numeric Designation of Hearing Impairment'' in the proposed rule, ''Numeric Designation of Hearing Impairment Based on Puretone Threshold Average and Speech Discrimination.'' In the proposed rule we inadvertently placed

the numeric tables in § 4.86, we have moved them to § 4.85(h) as the more appropriate location. We removed the examples from § 4.85 because the directions for using the tables are clear enough without them.

We also proposed to add two new provisions for evaluating veterans with certain patterns of hearing impairment that cannot always be accurately assessed under § 4.85, because the speech discrimination test may not reflect the severity of communicative functioning these veterans experience. These veterans were identified in review studies carried out by the Veterans Health Administration's (VHA's) Audiology and Speech Pathology Service in 1991. One of the new provisions, proposed as § 4.85(d), stated that if puretone thresholds in any four of the five frequencies of 500, 1000, 2000, 3000, and 4000 Hertz are 55 dB's or more, an evaluation could be based either on Table VI or Table VIa, whichever results in a higher evaluation. (This provision has been redesignated § 4.86(a), as discussed below.)

One commenter, although offering no rationale for the comment, suggested that the level of hearing loss for this provision should be 50 dB instead of 55.

To conduct a speech discrimination test in someone with hearing impairment, the sounds must be amplified sufficiently for the individual to hear the words. The greater the dB threshold level, the higher the level of amplification that is needed. Up to a 50 dB threshold level, amplification sufficient to conduct a speech discrimination test is feasible. However, with a 55 dB threshold level—the level at which speech becomes essentially inaudible—the high level of amplification needed to attempt to conduct a speech discrimination test would be painful to most people, and speech discrimination tests may therefore not be possible or reliable. The new provision will allow evaluation of hearing impairment in such individuals on the basis of puretone threshold average only, if that results in a higher evaluation than one based on a combination of speech discrimination and puretone threshold average.

The same commenter suggested applying proposed § 4.85(d) if three of the five specified frequencies have a threshold of 55 dB or more because the frequencies of 2000 and above are the most important frequencies for speech discrimination, and precipitous hearing impairment in the high frequencies is extremely handicapping in the work environment.

The frequencies selected and the dB threshold were chosen because VHA, through their clinical studies, found that speech discrimination studies are quite variable in veterans with a 55 dB threshold in four or more frequencies and may not accurately reflect the true extent of disability. Also based on the results of their studies, they did not extend the recommendation for an alternative method of evaluation to those with that extent of hearing impairment at only three frequencies. In view of VHA's recommendations, based on tests conducted on 1565 individuals, we make no change based on this comment.

The second provision we proposed to add (as § 4.85(e)) was to direct the rating agency to choose the Roman numeral designation derived from either table VI or VIa, whichever is higher, when puretone thresholds are 30 dB or less at frequencies of 1000 Hertz and below, and are 70 dB or more at 2000 Hertz. It also directed the rating agency to elevate that Roman numeral designation one level. This provision was meant to compensate for a pattern of hearing impairment that is an extreme handicap in the presence of any environmental noise. VHA found that when this pattern of impairment is present, a speech discrimination test conducted in a quiet room with amplification of the sounds does not always reflect the extent of impairment experienced in the ordinary environment. This provision allows evaluation of hearing impairment in these individuals on puretone average only, if that results in a higher evaluation. (This provision has been redesignated § 4.86(b), as discussed below.)

One commenter said it appears in proposed § 4.85(d) and (e) that 500 Hertz is one of the frequencies to be used in the puretone average, although when § 4.85 was revised in 1987, the supplementary information stated that puretone frequencies at 1000, 2000, 3000, and 4000 Hertz were to be used to determine the puretone threshold average. The commenter also said that the use of four frequencies in some circumstances and of five or more in others requires an explanation of why such a methodology does not give rise to disparate treatment.

In the proposed rule, the four frequency puretone threshold average was the basis of the evaluation for hearing impairment in all cases, and the 500 Hertz frequency was to be used only to help select the veterans to whom the special provisions would be applied. However, in order to remove any suggestion of disparate treatment, and after consultation with VHA, we removed the 500 Hertz stipulations from the two proposed special provisions. VHA assured us that this change would not affect the need for the special provisions and would not affect the disability ratings of any group of veterans.

One commenter suggested that the language for evaluation parallel the language of 38 CFR 3.385.

The purpose of § 3.385, ''Disability due to impaired hearing,'' is to explain the basis for determining whether impaired hearing is a disability, which is different from the purpose of § 4.85, which is to explain how to evaluate hearing impairment, once it has been determined to be a disability, for purposes of disability compensation. Since these regulations serve different purposes, and different frequencies are involved, the use of parallel language is neither necessary nor feasible.

When the puretone threshold average is 105 dB or more, tables VI and VIa require a numeric designation of XI, the highest level of evaluation. This is unchanged from the previous schedule. One commenter stated that a loss of greater than 92 dB, rather than 105 dB, would result in total impairment in everyone, according to the *American Academy of Otolaryngology and Otolaryngology Guide for the Evaluation of Hearing Impairment.*

Methods of measuring hearing impairment and assessing disability based on the results vary from one organization to another, making direct comparisons infeasible. Not all organizations use the same range of frequencies, for example, to determine a puretone threshold average. While VA uses 1000, 2000, 3000, and 4000 Hertz for evaluation, based on the results of the VA study referred to above, the American Medical Association (AMA), in its ''Guides to the Evaluation of Permanent Impairment'' 4th ed., 1993, uses 500, 1000, 2000, and 3000 Hertz. The National Institute for Occupational Safety and Health proposed using puretone thresholds at 1000, 2000, 3000, and 4000 Hertz, as has the American Speech and Hearing Association Task Force, and their rationale is that these frequencies are most sensitive to discrimination ability in quiet and in noise. Not all organizations use a speech discrimination test in evaluating hearing impairment; the AMA, for example, does not. The guide referred to by the commenter is no longer in existence, but the AMA Guides states that the criteria it uses are adapted from the 1979 Academy of Otolaryngology-Head and Neck Surgery Guide. The AMA Guides considers impairment of hearing to be total if the average of the four puretone

frequencies they use is over 91.7 dB. However, total impairment of hearing under their system does not mean that a 100-percent disability evaluation is assigned. Under the AMA disability evaluation system, each disability is considered in terms of its effect on the whole person. The evaluation they would assign for a bilateral puretone threshold of 91.7 dB (in workers' compensation claims, for example) is 35 percent, not 100 percent. With a unilateral puretone threshold of 91.7 dB (with the other ear normal), the AMA system would evaluate monaural hearing impairment at 100 percent, and binaural hearing impairment at approximately 17 percent, but the actual evaluation they would assign is six percent. Thus, direct comparisons of different systems of evaluating disability due to hearing loss are not possible, and we make no change based on this comment.

One commenter pointed out that § 4.86 in the previous schedule stated that evaluations are intended to make proper allowance for improvement by hearing aids and that examination to determine the improvement is not necessary. The commenter further stated that because Table VI appears to be unchanged in the proposed regulations, it would appear that Table VI continues to be built on the assumption of improvement with hearing aids and that performing audiology tests with hearing aids or adjusting the rating values based on an assumption of improvement with hearing aids violates the policy of determining impairment of body function without the use of any prosthetic device.

We are unaware of any general policy which prohibits consideration of the effect of a prosthetic device in determining the degree of impairment. In fact, there is a standard method for measuring best corrected vision, and the rating schedule requires that examinations for visual impairment include corrected, as well as uncorrected, visual acuity. However, there is no standard procedure for measuring best corrected hearing, and the amended instruction (§ 4.85(a)) states that examinations for hearing impairment will be conducted without the use of hearing aids. Section 4.85(a) is clear enough that, in order to avoid confusion, we have removed the language in proposed § 4.86(b) stating that the evaluations are designed to measure the best residual uncorrected hearing and that examinations comparing hearing with and without hearing aids are unnecessary. VHA consultants indicated that it is well accepted in the audiological literature that the better the speech discrimination score, the better the overall result with hearing aids, but they also stated that the language in the former rating schedule about anticipated improvement by a hearing aid did not in any way affect the method of evaluation or disability ratings themselves, and that removal of that language would also have no effect on the method of evaluation or on disability ratings.

The previous § 4.87 and proposed § 4.86(a) defined ''impairment of auditory acuity,'' for VA purposes. However, that term is not used elsewhere in the rating schedule, although the terms ''hearing impairment,'' ''hearing loss,'' and ''deafness'' are used. We have therefore removed § 4.86(a) as unnecessary and have, for the sake of clarity, used ''hearing impairment'' in all other parts of the rating schedule to designate a loss of hearing except where the statutory terms ''deafness'' or ''hearing loss'' are required (by 38 U.S.C. 1114(k)).

Former section 4.86a, ''Evidence other than puretone audiometry and controlled speech,'' explained that where claims contain evidence which predates the use of puretone audiometry and controlled speech, determination of service connection will be evaluated under the regulations in effect on December 17, 1987. We proposed to retain this instruction in § 4.86(c). One commenter suggested that this is not a rating regulation and that it properly belongs in Part 3 of 38 CFR.

We agree that regulations regarding service connection are not appropriate in the rating schedule, which is used for the evaluation of disabilities, and we have removed § 4.86(c). This completes the removal of the contents of proposed § 4.86. We have, however, retained § 4.86, retitled it ''Exceptional patterns of hearing impairment,'' and added paragraphs (a) and (b) for the two provisions that were proposed as § 4.85(d) and (e). This change better highlights the unusual aspects of evaluating these uncommon patterns of hearing impairment.

The previous schedule did not provide specific instructions on evaluating bilateral hearing impairment when hearing impairment is service-connected in only one ear. One commenter suggested that we add a note indicating that a non-service-connected ear is to be treated as having normal hearing.

We concur and have added § 4.85(f) to specify that a non-service-connected ear will be assigned a Roman numeral designation of I, subject to the provisions of § 3.383, ''Special consideration for paired organs and extremities.'' This is consistent with the manner in which we evaluate other paired organs, where only one of the pair is service-connected (38 CFR 4.73 (muscle injuries) and 38 CFR 4.124a (diseases of the cranial and peripheral nerves)).

One commenter stated that the regulation should include a specific effective date and should state whether the regulatory change constitutes a liberalizing law or issue.

The effective date of the regulation will be 30 days after publication of this final rule in the **Federal Register**. The revisions of the sections addressing ear and other sense organs are part of the overall revision of the rating schedule based on medical advances, etc., rather than representing liberalizing interpretations of regulations. We have explained above the reasons for the provisions of § 4.86. The preamble erred in discussing these provisions as liberalizations. Rather, they are an attempt to assure more equitable evaluations in a small number of veterans with unusual patterns of hearing impairment.

Special monthly compensation (SMC) is a benefit authorized by 38 U.S.C. 1114 that is payable in addition to the compensation payable for specific disabilities, or combinations of disabilities, based upon the extent of impairment under the Schedule for Rating Disabilities. We proposed removing the footnote regarding SMC in Table VII in favor of a single note at the end of § 4.85 directing the rating agency to refer to § 3.350 (''Special monthly compensation ratings'') to determine whether a claimant is entitled to SMC. One commenter suggested that we retain this footnote.

In response to the comment, and for the sake of consistency with references to SMC that we have made in other revised sections of the rating schedule, we have added this information as § 4.85(g) and also restored a footnote to Table VII, Percentage Evaluations for Hearing Impairment, indicating that the rating agency is to review for entitlement to special monthly compensation under § 3.350. (We proposed to put the information now in § 4.85(g) in a footnote following § 4.86, but moved it to § 4.85 instead to remove ambiguity about whether it referred only to the provisions of § 4.86 or to all hearing evaluations.) A single footnote to Table VII is adequate because we have deleted all but one diagnostic code (DC), 6100, for hearing impairment, since it is unnecessary for any practical purpose to have multiple diagnostic codes to indicate various evaluation

levels of the same disability. SMC may be warranted not only when hearing impairment is evaluated at 100 percent, but also for various levels of deafness (or hearing impairment) when they occur in combination with blindness, and the single footnote will assure that SMC is always considered when there is hearing impairment. We believe that the combination of the footnote and § 4.85(g) is the most effective method for ensuring complete review for special monthly compensation.

38 U.S.C. 1114(k) authorizes payment of SMC if there is absence of air and bone conduction in both ears. The implementing regulation, 38 CFR 3.350(a)(5), states that deafness of both ears, having absence of air and bone conduction, will be held to exist when bilateral hearing loss is equal to or greater than the minimum bilateral hearing loss required for a maximum rating (100 percent) under the schedule. One commenter suggested that we add a footnote to the 80- and 90-percent levels indicating entitlement to special monthly compensation, because these evaluations constitute deafness, for all practical purposes.

We do not concur. Complete loss of air and bone conduction would result in no response on audiometry, even at 105 dB, according to VHA consultants, and would therefore warrant a 100-percent evaluation. If there is a response on audiometry, which would necessarily be the case to establish an 80- or 90-percent evaluation for hearing impairment, there is not complete absence of air and bone conduction, and the hearing impairment in those cases would not meet the requirements of 38 U.S.C. 1114(k). Such a footnote would therefore be contrary to statutory requirements.

The previous schedule listed mastoiditis under its own diagnostic code (6206), with evaluation based on suppuration and impairment of hearing. We proposed to combine it with suppurative otitis media under DC 6200. The previous schedule provided neither diagnostic code nor evaluation criteria for cholesteatoma; raters have generally evaluated it analogous to otitis media. We also proposed to include cholesteatoma under DC 6200, because the three conditions are closely related, and their manifestations may be essentially the same. One commenter suggested that we assign separate diagnostic codes for cholesteatoma and mastoiditis because the proposed rule is ambiguous as to whether one of these conditions must accompany otitis media to assign a 10-percent evaluation and because mastoiditis and cholesteatoma can exist without forming pus (suppuration).

Chronic otitis media, mastoiditis, and cholesteatoma may exist with or without suppuration. However, two or more of these conditions, all of which are interrelated, commonly coexist, and their manifestations may be very similar. For example, chronic mastoiditis may develop simultaneously with otitis media or may occur as a later complication. Therefore, a single diagnostic code and set of evaluation criteria for all three conditions is appropriate, and we have revised the title of DC 6200 to clarify that it can apply to any of these conditions. We have also added aural polyps to the criteria for a 10-percent evaluation because they are a possible consequence of chronic otitis media. We have also expanded the note directing that hearing impairment be evaluated separately to include a list of other possible complications—labyrinthitis, tinnitus, facial nerve paralysis, and bone loss of skull—that would also warrant separate evaluations. These criteria better encompass the usual range of impairments that may develop in this group of conditions. Placing these related conditions under a single diagnostic code will help assure that the same impairment is not evaluated twice when more than one of these conditions is present in an individual.

The previous schedule addressed otitis interna under DC 6203 and evaluated it based on the extent of hearing loss. We proposed to eliminate this diagnostic code because otitis interna is an archaic name for a general ear infection condition which is more accurately classified as a peripheral vestibular disorder, DC 6204. One commenter suggested that we provide instructions under peripheral vestibular disorders explaining how to evaluate otitis interna. We do not concur. Otitis interna is an obsolete term, and conditions which it formerly encompassed are best evaluated under the criteria for peripheral vestibular disorders.

The previous rating schedule provided three evaluation levels for Meniere's syndrome, DC 6205, based on the severity and frequency of attacks. Among other things, we proposed to provide objective measures for the frequency of the attacks. One commenter stated that the prodromal signs, the duration of the episode, and the recovery period for an attack may last as long as ten days, and therefore suggested that the frequency of attacks proposed for the 100-percent evaluation (more than once weekly) and 60-percent evaluation (once a week or less) was too stringent. The commenter also said that ''attacks occurring once a week or less'' should be better defined.

Attacks of vertigo in Meniere's syndrome appear suddenly and last from a few to 24 hours (*Boies Fundamentals of Otolaryngology, Sixth Edition*, W.B. Saunders Company, 1989, p.139, and *The Merck Manual of Diagnosis and Therapy*, Merck Research Laboratories, 1992, p. 2336). Since the attacks of vertigo (often accompanied by nausea, vomiting, hearing impairment, and tinnitus) generally subside within 24 hours, requiring attacks more than once weekly for a 100-percent level, and one to four times a month for a 60-percent level, are reasonable requirements, in our judgment, that are equivalent to, but more objective than, the requirements of ''frequent and typical,'' and ''less frequent'' in the previous schedule. In response to the comment, however, we better defined the criteria by changing the requirements for a 60-percent evaluation from ''deafness with attacks of vertigo and cerebellar gait occurring once a week or less'' to ''hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus,'' and by changing the requirements for a 30-percent evaluation from ''deafness with occasional vertigo'' to ''hearing impairment with vertigo less than once a month, with or without tinnitus.'' Tinnitus is commonly, but not universally, present in Meniere's syndrome. We included the phrase ''with or without tinnitus'' in these criteria to emphasize that the overall evaluation of Meniere's syndrome is the same whether or not tinnitus is present. This will avoid the assignment of a separate evaluation for tinnitus when evaluating the syndrome under DC 6205, and at the same time, indicate that the absence of tinnitus in certain cases has no effect on the evaluation to be assigned under DC 6205.

We proposed to retain ''deafness'' as one of the criteria at the 100-percent evaluation level of Meniere's syndrome (DC 6205). One commenter suggested that there be a footnote appended to the 100-percent level, signaling that entitlement to Special Monthly Compensation is payable.

We do not concur. A particular level of impaired hearing is not a requirement for the 100-percent level for Meniere's syndrome. The term ''deafness'' was meant to indicate any level of hearing impairment, and we have changed ''deafness'' to ''hearing impairment'' in the criteria for Meniere's syndrome to make that clear. The requirements for a 100-percent evaluation of Meniere's syndrome are met if there is any level

of hearing impairment, and vertigo and cerebellar gait occur more than once weekly. 38 CFR 3.350(a)(5), on the other hand, requires an absence of air and bone conduction and hearing loss equal to or greater than the minimum bilateral hearing loss required for a 100-percent rating, for entitlement to SMC on the basis of hearing impairment. For this reason, a footnote referring to entitlement to SMC is not appropriate here, and § 4.85(g) and the footnote to Table VII will assure consideration of SMC in any case of hearing impairment.

Another commenter suggested that we add a note under Meniere's syndrome instructing the rating agency that hearing impairment will be rated separately and combined. We did not adopt this suggestion because the evaluation criteria and percentages are based on all of the manifestations of Meniere's syndrome, with attacks often consisting of hearing impairment, vertigo, tinnitus, and staggering gait. Any of the symptoms may be intermittent. It would be contrary to 38 CFR 4.14 (Avoidance of pyramiding), which prohibits the evaluation of the same manifestation under different diagnoses, to evaluate hearing impairment separately, and also use it to support an evaluation under DC 6205. However, we have added a note stating that Meniere's syndrome may be evaluated either under DC 6205 or by separately evaluating vertigo (as a peripheral vestibular disorder), hearing impairment, and tinnitus, whichever method results in a higher overall evaluation. The note also prohibits combining an evaluation for hearing impairment, tinnitus, or vertigo with an evaluation under DC 6205.

The previous schedule provided a minimum 10-percent evaluation for malignant neoplasms of the ear, DC 6208. We proposed to delete the minimum evaluation. One commenter suggested that we reinstate the minimum 10-percent evaluation because it was meant to compensate for skull loss.

In our judgment, loss of function is the most accurate and equitable basis for evaluating the residuals of this condition. If a malignant neoplasm results in skull loss, the skull loss would be separately evaluated under the skeletal system (DC 5296).

The previous rating schedule provided a 10-percent evaluation for tinnitus, DC 6260, with the criteria being: ''persistent as a symptom of head injury, concussion or acoustic trauma.'' We proposed to remove the requirement that tinnitus be a symptom of head injury, concussion or acoustic trauma and that it be persistent and instead provide a 10-percent evaluation for recurrent tinnitus. One commenter suggested that we add a note following tinnitus instructing that the evaluation for tinnitus be combined with ratings for hearing impairment, suppurative otitis media, and peripheral vestibular disorder.

We agree and have added a note under DC 6260 stating that a separate evaluation for tinnitus under DC 6260 may be combined with an evaluation under DC's 6100, 6200, 6204, or other diagnostic code except when tinnitus supports an evaluation under one of those diagnostic codes.

We added the word ''nonsuppurative'' to the proposed title of DC 6201, ''chronic nonsuppurative otitis media with effusion (serous otitis media),'' to better distinguish it from DC 6200, ''chronic suppurative otitis media, mastoiditis, or cholesteatoma.'' We also made additional nonsubstantive changes throughout this final rule for the sake of clarity and succinctness.

The Secretary hereby certifies that this regulatory amendment 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 reason for this certification is that this amendment would not directly affect any small entities. Only VA beneficiaries could be directly affected. Therefore, pursuant to 5 U.S.C. 605 (b), this amendment is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

This regulatory action has been reviewed by the Office of Management and Budget under Executive Order 12866.

The Catalog of Federal Domestic Assistance numbers are 64.104 and 64.109.

List of Subjects in 38 CFR Part 4

Disability benefits, Individuals with disabilities, Pensions, Veterans.

Approved: January 8, 1999.

Togo D. West, Jr.,

Secretary of Veterans Affairs.

For the reasons set out in the preamble, 38 CFR part 4 is amended 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.

Subpart B—Disability Ratings

2. Section 4.85 is revised to read as follows:

§ 4.85 Evaluation of hearing impairment.

(a) An examination for hearing impairment for VA purposes must be conducted by a state-licensed audiologist and must include a controlled speech discrimination test (Maryland CNC) and a puretone audiometry test. Examinations will be conducted without the use of hearing aids.

(b) Table VI, ''Numeric Designation of Hearing Impairment Based on Puretone Threshold Average and Speech Discrimination,'' is used to determine a Roman numeral designation (I through XI) for hearing impairment based on a combination of the percent of speech discrimination (horizontal rows) and the puretone threshold average (vertical columns). The Roman numeral designation is located at the point where the percentage of speech discrimination and puretone threshold average intersect.

(c) Table VIa, ''Numeric Designation of Hearing Impairment Based Only on Puretone Threshold Average,'' is used to determine a Roman numeral designation (I through XI) for hearing impairment based only on the puretone threshold average. Table VIa will be used when the examiner certifies that use of the speech discrimination test is not appropriate because of language difficulties, inconsistent speech discrimination scores, etc., or when indicated under the provisions of § 4.86.

(d) ''Puretone threshold average,'' as used in Tables VI and VIa, is the sum of the puretone thresholds at 1000, 2000, 3000 and 4000 Hertz, divided by four. This average is used in all cases (including those in § 4.86) to determine the Roman numeral designation for hearing impairment from Table VI or VIa.

(e) Table VII, ''Percentage Evaluations for Hearing Impairment,'' is used to determine the percentage evaluation by combining the Roman numeral designations for hearing impairment of each ear. The horizontal rows represent the ear having the better hearing and the vertical columns the ear having the poorer hearing. The percentage evaluation is located at the point where the row and column intersect.

(f) If impaired hearing is service-connected in only one ear, in order to determine the percentage evaluation from Table VII, the non-service-connected ear will be assigned a Roman Numeral designation for hearing

impairment of I, subject to the provisions of § 3.383 of this chapter.

(g) When evaluating any claim for impaired hearing, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation due either to deafness, or to deafness in combination with other specified disabilities.

(h) *Numeric tables VI, VIA*, and VII.*

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TABLE VI

NUMERIC DESIGNATION OF HEARING IMPAIRMENT BASED ON PURETONE THRESHOLD AVERAGE AND SPEECH DISCRIMINATION

Puretone Threshold Average

% of discrimination	0-41	42-49	50-57	58-65	66-73	74-81	82-89	90-97	98+
92-100	I	I	I	II	II	II	III	III	IV
84-90	II	II	II	III	III	III	IV	IV	IV
76-82	III	III	IV	IV	IV	V	V	V	V
68-74	IV	IV	V	V	VI	VI	VII	VII	VII
60-66	V	V	VI	VI	VII	VII	VIII	VIII	VIII
52-58	VI	VI	VII	VII	VIII	VIII	VIII	VIII	IX
44-50	VII	VII	VIII	VIII	VIII	IX	IX	IX	X
36-42	VIII	VIII	VIII	IX	IX	IX	X	X	X
0-34	IX	X	XI	XI	XI	XI	XI	XI	XI

TABLE VIA*

NUMERIC DESIGNATION OF HEARING IMPAIRMENT BASED ONLY ON PURETONE THRESHOLD AVERAGE

Puretone Threshold Average

0-41	42-48	49-55	56-62	63-69	70-76	77-83	84-90	91-97	98-104	105+
I	II	III	IV	V	VI	VII	VIII	IX	X	XI

* This table is for use only as specified in §§ 4.85 and 4.86.

TABLE VII

PERCENTAGE EVALUATION FOR HEARING IMPAIRMENT (DIAGNOSTIC CODE 6100)

Poorer Ear

Better Ear	XI	X	IX	VIII	VII	VI	V	IV	III	II	I
XI	100*										
X	90	80									
IX	80	70	60								
VIII	70	60	50	50							
VII	60	60	50	40	40						
VI	50	50	40	40	30	30					
V	40	40	40	30	30	20	20				
IV	30	30	30	20	20	20	10	10			
III	20	20	20	20	20	10	10	10	0		
II	10	10	10	10	10	10	10	0	0	0	
I	10	10	0	0	0	0	0	0	0	0	0

* Review for entitlement to special monthly compensation under §3.350 of this chapter.

BILLING CODE 8320–01–C

3. Section 4.86 is revised to read as follows:

§ 4.86 Exceptional patterns of hearing impairment.

(a) When the puretone threshold at each of the four specified frequencies (1000, 2000, 3000, and 4000 Hertz) is 55 decibels or more, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. Each ear will be evaluated separately.

(b) When the puretone threshold is 30 decibels or less at 1000 Hertz, and 70 decibels or more at 2000 Hertz, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. That numeral will then be elevated to the next higher Roman numeral. Each ear will be evaluated separately.

(Authority: 38 U.S.C. 1155)

§ 4.86a [Removed]

4. Section 4.86a is removed.

5. Section 4.87 is revised to read as follows:

§ 4.87 Schedule of ratings—ear.

	Rating
DISEASES OF THE EAR	
6200 Chronic suppurative otitis media, mastoiditis, or cholesteatoma (or any combination):	
During suppuration, or with aural polyps	10
Note: Evaluate hearing impairment, and complications such as labyrinthitis, tinnitus, facial nerve paralysis, or bone loss of skull, separately.	
6201 Chronic nonsuppurative otitis media with effusion (serous otitis media):	
Rate hearing impairment	
6202 Otosclerosis:	
Rate hearing impairment	
6204 Peripheral vestibular disorders:	
Dizziness and occasional staggering	30
Occasional dizziness	10
Note: Objective findings supporting the diagnosis of vestibular disequilibrium are required before a compensable evaluation can be assigned under this code. Hearing impairment or suppuration shall be separately rated and combined.	
6205 Meniere's syndrome (endolymphatic hydrops):	
Hearing impairment with attacks of vertigo and cerebellar gait occurring more than once weekly, with or without tinnitus	100
Hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus	60
Hearing impairment with vertigo less than once a month, with or without tinnitus	30
Note: Evaluate Meniere's syndrome either under these criteria or by separately evaluating vertigo (as a peripheral vestibular disorder), hearing impairment, and tinnitus, whichever method results in a higher overall evaluation. But do not combine an evaluation for hearing impairment, tinnitus, or vertigo with an evaluation under diagnostic code 6205.	
6207 Loss of auricle:	
Complete loss of both	50
Complete loss of one	30
Deformity of one, with loss of one-third or more of the substance	10
6208 Malignant neoplasm of the ear (other than skin only)	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation treatment, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based on that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
6209 Benign neoplasms of the ear (other than skin only):	
Rate on impairment of function.	
6210 Chronic otitis externa:	
Swelling, dry and scaly or serous discharge, and itching requiring frequent and prolonged treatment	10
6211 Tympanic membrane, perforation of	0
6260 Tinnitus, recurrent	10
Note: A separate evaluation for tinnitus may be combined with an evaluation under diagnostic codes 6100, 6200, 6204, or other diagnostic code, except when tinnitus supports an evaluation under one of those diagnostic codes.	

(Authority: 38 U.S.C. 1155)

6. Section 4.87a is revised to read as follows:

§ 4.87a Schedule of ratings—other sense organs.

	Rating
6275 Sense of smell, complete loss	10
6276 Sense of taste, complete loss	10
Note: Evaluation will be assigned under diagnostic codes 6275 or 6276 only if there is an anatomical or pathological basis for the condition.	

(Authority: 38 U.S.C. 1155)

§ 4.87b [Removed]

7. Section 4.87b is removed.

[FR Doc. 99–11768 Filed 5–10–99; 8:45 am]

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[NV 030–0015; FRL–6339–4]

Clean Air Act Approval and Promulgation of New Source Review Provisions Implementation Plan for Nevada State Clark County Air Pollution Control District

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The EPA is promulgating approval of the new source review (NSR) program submitted by the Clark County Air Pollution Control District (CCAPCD) for the purpose of meeting the nonattainment and prevention of significant deterioration (PSD) NSR requirements of the Clean Air Act, as amended in 1990 (CAA or the Act). The requested revision was submitted by the State to satisfy certain Federal requirements for an approvable nonattainment new source review SIP. This submittal also satisfies the requirements for a Prevention of Significant Deterioration (PSD) program. The intended effect of this rulemaking is to regulate air pollution in accordance with the Act. Thus, EPA is finalizing the approval of these revisions into the Nevada state implementation plan (SIP) under provisions of the CAA regarding EPA action on SIP submittals, SIPs for national primary and secondary ambient air quality standards and plan requirements for nonattainment areas.

EFFECTIVE DATE: This action is effective on June 10, 1999.

ADDRESSES: Copies of the rules and EPA's evaluation report for the rules are available for public inspection at EPA's Region IX office during normal business hours. Copies of the submitted rules are available for inspection at the following locations:

Permits Office (Air-3), Air Division, EPA Region IX, 75 Hawthorne Street, San Francisco, CA 94105

Environmental Protection Agency, Air Docket (6102), 401 ''M'' Street, SW, Washington, DC 20406.

Clark County Health District, 625 Shadow Lane, Las Vegas, NV 89127

Nevada Division of Environmental Protection, 333 W. Nye Lane, Carson City, NV 89710

FOR FURTHER INFORMATION CONTACT: Steve Branoff, Environmental Engineer, Permits Office (Air-3), Air Division, EPA Region IX, 75 Hawthorne Street, San Francisco, CA 94105, Telephone: (415) 744–1290.

SUPPLEMENTARY INFORMATION:

Background and Purpose

The air quality planning requirements for nonattainment NSR are set out in Part D of Title I of the Act, with implementing regulations at 40 CFR 51.160 through 51.165. The air quality planning requirements for PSD are set out in Part C of Title I of the Act, with implementing regulations at 40 CFR 51.166. On November 30, 1993, CCAPCD submitted its NSR rules to EPA as a proposed revision to the SIP. On July 28, 1995, EPA proposed to approve with contingencies, and to disapprove in the alternative, the submitted SIP revisions. See 61 FR 17675. Full approval as a final action was contingent upon CCAPCD making required changes to the submitted rules. EPA requested public comments on the proposed approval and received none.

CCAPCD has since submitted to EPA revised NSR rules. The revisions contain the required changes and EPA is therefore promulgating final approval of the revised rules. The specific changes that CCAPCD made to its rules are detailed below.

The Clark County Board of Health (the governing board for the CCAPCD) adopted changes to the new source review rules in ''installments'' at public hearings on December 21, 1995; December 19, 1996; January 23, 1997; April 24, 1997; June 26, 1997, January 22, 1998 and April 23, 1998. There was substantial input from the public and the regulated community at these