classes); playing cards; printers' type; printing blocks.

17. Rubber, gutta-percha, gum, asbestos, mica and goods made from these materials and not included in other classes; plastics in extruded form for use in manufacture; packing, stopping and insulating materials; flexible pipes, not of metal.

18. Leather and imitations of leather, and goods made of these materials and not included in other classes; animal skins, hides; trunks and travelling bags; umbrellas, parasols and walking sticks; whips, harness and saddlery.

19. Building materials (non-metallic); nonmetallic rigid pipes for building; asphalt, pitch and bitumen; nonmetallic transportable buildings; monuments, not of metal.

20. Furniture, mirrors, picture frames; goods (not included in other classes) of wood, cork, reed, cane, wicker, horn, bone, ivory, whalebone, shell, amber, mother-of-pearl, meerschaum and substitutes for all these materials, or of plastics.

21. Household or kitchen utensils and containers (not of precious metal or coated therewith); combs and sponges; brushes (except paint brushes); brush-making materials; articles for cleaning purposes; steel-wool; unworked or semi-worked glass (except glass used in building); glassware, porcelain and earthenware not included in other classes.

22. Ropes, string, nets, tents, awnings, tarpaulins, sails, sacks and bags (not included in other classes); padding and stuffing materials (except of rubber or plastics); raw fibrous textile materials.

23. Yarns and threads, for textile use.

24. Textiles and textile goods, not included in other classes; beds and table covers.

25. Clothing, footwear, headgear.

26. Lace and embroidery, ribbons and braid; buttons, hooks and eyes, pins and needles; artificial flowers.

27. Carpets, rugs, mats and matting, linoleum and other materials for covering existing floors; wall hangings (non-textile).

28. Games and playthings; gymnastic and sporting articles not included in other classes; decorations for Christmas trees.

29. Meat, fish, poultry and game; meat extracts; preserved, dried and cooked fruits and vegetables; jellies, jams, fruit sauces; eggs, milk and milk products; edible oils and fats.

30. Coffee, tea, cocoa, sugar, rice, tapioca, sago, artificial coffee; flour and preparations made from cereals, bread, pastry and confectionery, ices; honey, treacle; yeast, baking powder; salt, mustard; vinegar, sauces (condiments); spices; ice.

31. Agricultural, horticultural and forestry products and grains not included in other classes; live animals; fresh fruits and vegetables; seeds, natural plants and flowers; foodstuffs for animals; malt.

32. Beers; mineral and aerated waters and other nonalcoholic drinks; fruit drinks and fruit juices; syrups and other preparations for making beverages.

33. Alcoholic beverages (except beers).

34. Tobacco; smokers' articles; matches.

Services

35. Advertising; business management; business administration; office functions.

36. Insurance; financial affairs; monetary affairs; real estate affairs.

37. Building construction; repair; installation services.

38. Telecommunications.

39. Transport; packaging and storage of goods; travel arrangement.

40. Treatment of materials.

41. Education; providing of training; entertainment; sporting and cultural activities.

42. Providing of food and drink; temporary accommodation; medical, hygienic and beauty care; veterinary and agricultural services; legal services; scientific and industrial research; computer programming; services that cannot be classified in other classes.

Dated: May 3, 1999.

Q. Todd Dickinson,

Acting Assistant Secretary of Commerce and Acting Commissioner of Patents and Trademarks.

[FR Doc. 99–11471 Filed 5–10–99; 8:45 am]

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AH43

Schedule for Rating Disabilities; Eye

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) is proposing to amend that portion of its rating schedule that addresses the eye. The intended effect of this action is to ensure that this section of the Schedule for Rating Disabilities uses current medical terminology and provides unambiguous criteria for evaluating disabilities of the eye.

DATES: Comments must be received on or before July 12, 1999.

ADDRESSES: Mail or hand-deliver written comments to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave., NW, Room 1154, Washington, DC 20420. Comments should indicate that they are in response to ''RIN 2900–AH43.'' All written comments received will be available for public inspection at the above address in the Office of Regulations Management, Room 1158, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays).

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 a comprehensive review of its rating schedule, VA published an advance notice of proposed rulemaking regarding impairments of the eye, ear and other sense organs in the **Federal Register** on May 2, 1991 (56 FR 20170). In response, we received a number of comments from private and VA physicians and from other VA employees. For the reasons discussed below, this document proposes to amend the portion of the rating schedule that addresses disabilities of the eye.

The comments received included suggestions that we delete several diagnostic codes, provide diagnostic codes for additional conditions, and change evaluation criteria for a number of conditions. We have considered these comments as explained below.

In addition to publishing an advance notice of proposed rulemaking, we also contracted with an outside consultant to recommend changes to ensure that the schedule uses current medical terminology and unambiguous criteria, and that it reflects medical advances that have occurred since the last review. The consultant convened a panel of non-VA specialists to review the portion of the rating schedule that addresses eye conditions in order to formulate recommendations. We are proposing to adopt many of the recommendations the contract consultants submitted. However, we do not propose to adopt recommendations that address areas, such as frequency of examinations, that are clearly beyond the scope of the contract or that deal with issues that affect the internal consistency of the rating schedule, such as percentage evaluations. Assignments of disability

ratings are supposed to reflect relative levels of economic impairment, and the consultants did not consider eye disabilities in relation to the other parts of the rating schedule in making their recommendations. Relevant recommendations from these individuals are discussed below.

We determined that a number of grammatical changes would be helpful in eliminating ambiguity and ensuring that the schedule presents the rating criteria for listed disabilities as precisely as possible. We are thus proposing editorial changes, primarily in syntax and punctuation, throughout this portion of the schedule. These changes, which will not be addressed individually, are intended to clarify the rating criteria and represent no substantive amendment.

For VA purposes, the evaluation of visual impairment is based on impairment of visual acuity, visual field, and muscle function. General instructions for rating these disabilities are currently contained in §§ 4.75 through 4.84a of 38 CFR, and in notes appended to various diagnostic codes. The material is randomly organized, however, and we propose to reorganize it so that all material related to a single issue is grouped together. We propose to reorganize these instructions under four topics: (1) General considerations for evaluating visual impairment; (2) Visual acuity; (3) Visual fields; and (4) Muscle function.

We propose that § 4.75, ''General considerations for evaluating visual impairment,'' be composed of six paragraphs: (a) Visual impairment, (b) Examination for visual impairment, (c) Service-connected visual impairment of only one eye, (d) Maximum evaluation for visual impairment of one eye, (e) Anatomical loss of one eye without prosthesis, and (f) Special monthly compensation.

For the sake of clarity, we propose that paragraph (a), ''Visual impairment,'' state that the evaluation of visual impairment is based on impairment of visual acuity (excluding developmental errors of refraction), visual field, and muscle function.

Proposed paragraph (b) of § 4.75, ''Examination for visual impairment,'' is derived from current §§ 4.75 and 4.77 and the notes following diagnostic code 6080 and would require that a licensed optometrist or ophthalmologist conduct the examination and that the examiner identify the disease, injury, or other pathologic process responsible for any visual impairment found. It also states that examinations for the evaluation of visual fields or muscle function will be conducted only when there is a medical indication of disease or injury that may be associated with visual field defect or impaired muscle function. It also states that the fundus must be examined with the veteran's pupils dilated (unless medically contraindicated).

The method of evaluation when visual impairment of only one eye is service-connected is not specifically addressed in current regulations. We propose to add paragraph (c), ''Service-connected visual impairment of only one eye,'' to direct that when visual impairment of only one eye is service-connected, either directly or by aggravation, the visual acuity of the non-service-connected eye shall be considered to be 20/40, subject to the provisions of 38 CFR 3.383(a) (which directs that when there is blindness in one eye as a result of service-connected disability and blindness in the other eye as a result of non-service-connected disability, compensation is payable as if both were service-connected). This method is consistent with current VA practice in determining the level of disability when only one eye is service-connected. The approach is also consistent with VAOPGCPREC 32–97, in which the General Counsel held that, if a claimant has service-connected hearing loss in one ear and nonservice-connected hearing loss in the other ear, the hearing in the ear having nonservice-connected loss should be considered normal for purposes of computing the service-connected disability rating, unless the claimant is totally deaf in both ears. In VAOPGCPREC 32–97, the General Counsel noted that the statutory scheme governing VA benefits generally authorizes compensation for service-connected disabilities only, see 38 U.S.C. 101 (13), 1110, and 1131, and does not permit combination of ratings for service-connected and nonservice-connected disabilities for compensation purposes. See 38 U.S.C. 1523 (authorizing, for nonservice-connected pension purposes, combination of ratings for service-connected and nonservice-connected disabilities) and 1157 (authorizing compensation based on the combination of ratings for service-connected disabilities). *See also* 38 CFR 3.323; 38 CFR 4.14 (''the use of manifestations not resulting from service-connected disease or injury in establishing the service-connected evaluation * * * [is] to be avoided.''). Therefore, we propose to consider the visual acuity of the nonservice-connected eye to be 20/40, the level of visual acuity that warrants a zero-percent evaluation, so that any loss of visual acuity in the non-service-connected eye will not affect the determination of the level of disability for the service-connected eye. Adding the provisions of paragraph (c) will remove any doubt about the correct method of evaluation, and will assure that evaluations will be consistent, in cases where visual impairment of only one eye is service-connected.

In conjunction with the addition of paragraph (c) of § 4.75, we propose to remove current § 4.78, ''Computing aggravation,'' which states that aggravation of preexisting visual disability will be determined based upon the evaluation of vision in both eyes before and after suffering the aggravation, even if the impairment of vision in only one eye is service-connected, and that with subsequent increase in the disability of either eye due to intercurrent injury or disease not associated with service, the basis of compensation will be the condition of the eyes before suffering the subsequent increase. This section is not consistent with VA's method of evaluating visual impairment incurred in service in one eye only nor is it consistent with the statutory scheme, as discussed above. Furthermore, its application may, in some cases, result in a higher evaluation for a condition that is aggravated by service than for an identical condition incurred in service, and this is simply not equitable. This method is also inconsistent with the method of evaluating other paired organs, such as the hands, where only the service-connected hand is evaluated, regardless of the status of the non-service-connected hand, again subject to the provisions of 38 CFR 3.383(a), and where the same method is used for incurrence as for aggravation. For these reasons, we propose to remove the material in § 4.78 in favor of the clear and consistent method of evaluation described in paragraph (c).

Proposed paragraph (d) of § 4.75, ''Maximum evaluation for visual impairment of one eye,'' is derived from current § 4.80, ''Rating of one eye,'' which states that the combined ratings for disabilities of the same eye should not exceed the amount for total loss of vision of that eye unless there is enucleation or a serious cosmetic defect added to the total loss of vision. Some of this language—''disabilities of the same eye,'' ''total loss of vision,'' and ''serious cosmetic defect''—is subjective or ambiguous. Since some disabilities (e.g., malignant neoplasm) that may affect only one eye can be evaluated up to 100 percent, we propose to change the reference to ''disabilities'' of one eye to ''visual impairment'' of one eye to clarify that it is only an evaluation for

visual impairment that is limited to 30 percent. In place of ''shall not exceed the maximum,'' we propose to use the more direct language ''shall not exceed 30 percent,'' in order to remove any ambiguity. Only anatomical loss of an eye can result in a higher evaluation (under diagnostic code 6063). We further propose to change ''serious cosmetic defect'' to ''disfigurement,'' because a proposed diagnostic code (7800) and evaluation criteria for disfigurement of the head, face, or neck were published in the **Federal Register** of January 19, 1993 (*See* 58 FR 4969) as part of the revision of the portion of the rating schedule that addresses the skin, but there is no diagnostic code that addresses ''serious cosmetic defect.'' Section 4.75(d) is therefore proposed to read ''The evaluation for visual impairment of one eye shall not exceed 30 percent unless there is anatomical loss of the eye. The evaluation for visual impairment of one eye may, however, be combined with evaluations for other disabilities, e.g., disfigurement, that are not based on visual impairment.''

We propose that paragraph (e) of § 4.75, ''Anatomical loss of one eye with inability to wear a prosthesis,'' require that evaluations be increased by 10 percent when there is anatomical loss of one eye, and a prosthesis cannot be worn. This is derived from material in a footnote to diagnostic codes 6064, 6065, and 6066 concerning the evaluation for anatomical loss of one eye, and we therefore propose to delete that portion of the footnote as redundant. We further propose to add for clarity a statement that the maximum evaluation shall not exceed 100 percent.

We propose that paragraph (f) of § 4.75, ''Special monthly compensation,'' direct the rating agency to refer to 38 CFR 3.350 to determine whether the veteran may be entitled to special monthly compensation (SMC). This is similar to instructions we have placed in other revised portions of the rating schedule where there is potential entitlement to special monthly compensation, e.g., in the portion that addresses gynecological conditions and disorders of the breasts. This is intended as an additional reminder to the rating agency to assure that SMC is assigned when warranted.

We propose that §§ 4.76, 4.77, and 4.78 address impairment of visual acuity, visual fields, and muscle function, respectively, with each section containing subsections that address examinations and evaluations of the impairments, as discussed in more detail below.

We propose that § 4.76, ''Visual acuity,'' derived from material currently found in §§ 4.75 and 4.84, plus M21–1, Part VI, consist of two paragraphs: (a) Examination of visual acuity and (b) Evaluation of visual acuity.

We propose that paragraph (a) of § 4.76, which is based on current § 4.75, require that, to be adequate for VA purposes, *uncorrected* and *corrected* visual acuity for *distance* and *near* be recorded, as determined using Snellen's test type or its equivalent.

We propose two subparagraphs under proposed paragraph (b) of § 4.76, ''Evaluation of visual acuity.'' Subparagraph (1) would require that visual acuity be generally evaluated on the basis of corrected distance vision. However, when the lens required to correct distance vision in the poorer eye differs by more than three diopters from the lens required to correct distance vision in the better eye, and the difference is not due to a congenital/developmental refractive error, the visual acuity of the poorer eye for evaluation purposes shall be either its uncorrected visual acuity or its visual acuity as corrected by a lens that does not differ by more than three diopters from the lens needed for correction of the other eye, whichever results in the better combined visual acuity. The current schedule has similar provisions but uses a four-diopter, rather than a three-diopter, difference, and refers only to spherical correction. We propose to use three diopters of difference instead of four because our contract consultants suggested that, since three diopters of difference would cause a patient to be symptomatic, requiring a four-diopter difference is too stringent. The consultants further pointed out that the astigmatism that underlies this disorder may require cylindrical, as well as spherical, correction, and we therefore propose to delete the language referring to spherical correction.

Paragraph (b)(2) of § 4.76 would direct that, as long as the individual customarily wears contact lenses, VA evaluate visual acuity for eyes affected by a corneal disorder that results in severe irregular astigmatism that can be improved more by contact lenses than by eyeglass lenses, as corrected by contact lenses. The current § 4.75 states that the best distant vision obtainable after best correction by glasses shall be the basis of rating except in cases of keratoconus in which contact lenses are medically required. However, on the recommendation of our contract consultants, we propose to include corneal disorders other than keratoconus, if they also result in astigmatism where contact lenses are more useful for correction than eyeglasses. We propose to remove the requirement that contact lenses be ''medically required'' in order to use this method of evaluation, in favor of a requirement that it be used only if contact lenses improve visual acuity better than eyeglass lenses, and if the individual customarily wears contact lenses (because some patients cannot wear contact lenses even though they would improve their vision). This provision assures an accurate assessment of corrected vision for those with a cornea that is scarred or irregularly shaped, and in whom individually fitted contact lenses provide the best visual acuity.

Paragraph (b)(3) of § 4.76 would require that in cases where the examiner reports a difference equal to two or more scheduled steps between near and distance corrected vision, with the near vision being worse, the examination must include at least two recordings of near and distance corrected vision and an explanation of the reason for the difference. We propose to require two recordings of visual acuity and an explanation of the cause of the difference between near and distance vision to assure that the presence of such a difference, which is very unusual, is confirmed and that any pathologic condition responsible for the difference is diagnosed. Current § 4.84 states that when there is a substantial difference between the near and distant corrected vision, the case should be referred to the Director, Compensation and Pension Service. We propose to specify a difference of two or more scheduled steps because our medical consultants stated that amount would be considered a ''substantial'' difference, and this more objective standard will assure consistency in determining which cases require application of this special provision. Evaluations of visual acuity are ordinarily based on distance vision, and distance vision is normally very similar, if not identical, to near vision. Since that is not true of these cases, and because near vision is so important for many tasks, we propose to adjust the evaluation for distance vision in these cases. In order to assure consistent and fair evaluations in these cases without the need to refer them to the Director of the Compensation and Pension Service, we propose, after consultation with licensed optometrists and ophthalmologists, that evaluation be made as if distance vision were one step poorer than measured, which, while recognizing that distance vision is the principal basis of the evaluation of visual acuity, will approximately

compensate for the additional loss of near vision in these cases.

We propose that § 4.77, ''Visual Fields,'' be composed of three paragraphs: (a) Examination of visual fields, (b) Evaluation of visual fields, and (c) Combination of visual field defect and decreased visual acuity.

Paragraph (a) of § 4.77, ''Examination of visual fields,'' derived from current § 4.76, Examination of field vision, would require use of a Goldmann kinetic perimeter or equivalent kinetic method to measure visual fields. We propose to revise the language, for the sake of accuracy, by changing the requirement for using a 3mm. white test object to one for using a standard target size and luminance (Goldmann equivalent (III/4e). This equivalent is a test object with an area of 4mm^2, average diameter of 0.43 degrees visual angle, and zero decibels of attenuation of luminance (maximum brightness for the Goldmann perimeter). Although the static (automated, computerized) perimeter is now in common use, the visual fields measured by the static and kinetic methods are not always comparable, and standards remain uncertain, despite ongoing research on this subject. Until there are reliable standards for comparing the results from static and kinetic perimetry, we propose to retain the requirement for the use of Goldmann kinetic perimetry, which is more reliable than the alternatives.

Paragraph (b) of § 4.77, ''Evaluation of visual fields,'' derived from current § 4.76a, ''Computation of average concentric contraction of visual fields,'' would establish the method for determining the extent of concentric visual field defect by measuring the remaining visual field in the eight principal meridians (horizontal, vertical, and main diagonals) and averaging them. We propose to remove the example in current § 4.76a since, in our judgment, it is unnecessary. We propose to delete the statement from § 4.76 that concentric contraction to five degrees or less is the equivalent of 5/200 visual acuity because this information is included under diagnostic code 6080 (visual field defects) and there is no need, nor would it serve any useful purpose, to repeat it in § 4.76.

We propose that paragraph (c) of § 4.77, ''Combination of visual field defect and decreased visual acuity,'' direct how to determine the evaluation when both visual acuity and visual field are impaired in one or both eyes. VA's Adjudication Manual, M21–1, Part VI, currently directs that such cases be referred to the Director of the Compensation and Pension Service for evaluation. We propose that the percentage evaluation for visual acuity and for visual field loss each be determined and then combined under 38 CFR 4.25 (Combined ratings table). This change is consistent with the method of combining disabilities elsewhere in the body, which is allowed as long as the same disability is not evaluated twice, and would eliminate the need to refer these cases to the Director of the Compensation and Pension Service. It would provide a fair and consistent method of evaluation that takes into account both facets of visual impairment.

We propose that § 4.78, ''Muscle function,'' be composed of two paragraphs: (a) Examination of muscle function, and (b) Evaluation of muscle function.

Paragraph (a) of § 4.78, ''Examination of muscle function,'' derived from current § 4.77, would require that the Goldmann perimeter be used to measure muscle function and that the areas of diplopia be charted. We propose to delete as unnecessary the statement that impairment of muscle function is to be supported by record of actual appropriate pathology because § 4.75(b) includes a requirement that the disease, injury, or other pathologic process responsible for any visual impairment found must be identified and that examinations for the evaluation of visual fields or muscle function will be conducted only when there is a medical indication of disease or injury that may be associated with visual field defect or impaired muscle function. Section 4.75(b) is sufficient, in our judgment, to assure that the underlying pathology is identified.

Paragraph (b) of § 4.78, ''Evaluation of muscle function,'' would establish a revised method of evaluating muscle function when another type of visual impairment is also present. Current note (2) following diagnostic code 6090 states that an evaluation for diplopia will be applied to only one eye and may not be combined with an evaluation for decreased visual acuity or visual field loss in the same eye. It further states that when both diplopia and decreased visual acuity or visual field loss are present in both eyes, the evaluation for diplopia shall be assigned to the poorer eye, and the evaluation for either corrected visual acuity or contraction of visual field to the better eye. It does not address the situation where diplopia is present, and another type of visual impairment is present in only one eye. Under the current method, lower evaluations may result when the diplopia is taken into account in the evaluation than when it is not, unless the diplopia is very severe. VA's manual for adjudication procedures, M21–1, states that this method is to be used only if it would be advantageous to the veteran.

For the sake of equitable and fair evaluations, we propose, after consultation with licensed optometrists and ophthalmologists, that subparagraph (1) establish the following method of evaluating diplopia, whether associated with unilateral or bilateral impaired visual acuity or visual field. We propose that, for the poorer eye (or the affected eye, if only one eye is service-connected), the rating agency assign a level of visual acuity (for decreased visual acuity or visual field defect expressed as a level of visual acuity) one step poorer than it would be otherwise, if the evaluation for diplopia under diagnostic code 6090 is 20/70 or 20/100; a level two steps poorer if the evaluation for diplopia is 20/200 or 15/200; and a level three steps poorer if the evaluation for diplopia is 5/200. The adjusted level, however, could not exceed 5/200. The percentage evaluation would then be determined under diagnostic codes 6064 through 6066, using the adjusted visual acuity for the poorer eye (or the affected eye), and the corrected visual acuity for the better eye. Under this method, the severity of diplopia would correlate with the evaluation level, with the higher evaluation assigned when the diplopia is worse, and the adjusted evaluation could never be lower than one that doesn't take diplopia into account, as can happen under the current method. An evaluation for diplopia of 20/40, assigned when diplopia affects only vision at 31 to 40 degrees on upward gaze, would have no effect on the overall evaluation. This method allows a full range of evaluation for visual impairment of a single eye, but does not exceed it. Unlike the current schedule provision, it also provides a method of evaluating visual impairment when both diplopia and loss of visual acuity are present in only one eye, or when they are present in both eyes, but only one eye is service-connected.

The current schedule contains a statement that diplopia which is occasional or correctable is not considered a disability. Since this fact is pertinent to the issue of service connection for diplopia, but has no bearing on evaluation, including it in the rating schedule is unnecessary and inappropriate.

Paragraph (b)(2) of § 4.78, derived from § 4.77 and the third note following diagnostic code 6090, would define impairment of muscle function and establish the procedure for evaluating

diplopia when the affected field extends beyond more than one quadrant or range of degrees.

Paragraph (b)(3) of § 4.78, derived from note (4) following diagnostic code 6090, would require that the evaluation for diplopia under diagnostic code 6090 be increased to the next higher evaluation provided in the rating schedule whenever diplopia exists in separate areas of the same eye.

Current § 4.79, ''Loss of use of one eye, having only light perception,'' duplicates 38 CFR 3.350(a)(4), (b)(2) and (b)(3), which reflect statutory criteria for entitlement to special monthly compensation. Because it is redundant, we propose to delete § 4.79 in favor of a footnote following diagnostic codes 6066 and 6080 referring the rating agency to § 3.350.

We propose to delete current §§ 4.80 and 4.84 and the notes following the diagnostic codes in these sections because the material will be moved to proposed §§ 4.75 through 4.78.

Current Table IV, ''Table for Rating Bilateral Blindness or Blindness Combined with Hearing Loss with Dictator's Code and 38 CFR Citations,'' is a chart displaying SMC codes to be used by the rating agency when dictating rating decisions for transcription. The dictator's rating codes have been changed since they were first published in Table IV, and they appear in their current form in Appendix A of Part I of M21–1, VA's Adjudication Procedures Manual. This chart's only purpose is to simplify the process of dictating ratings to a transcription unit. Since it has no bearing on the evaluation of disabilities, and contains no policy guidelines which rating agencies must follow, we propose to delete Table IV from the rating schedule.

Current Table V, ''Ratings for Central Visual Acuity Impairment,'' repeats the evaluations and diagnostic codes for impaired visual acuity in chart form. Since diagnostic codes 6061 through 6066 establish evaluation criteria in a format which is consistent with the rest of the rating schedule, we propose to delete Table V as redundant and unnecessary for any regulatory purpose. Since current § 4.83a explains how to use Table V, we also propose to remove § 4.83a. Current § 4.83 explains how to record ratings for impairment of central visual acuity, and it is therefore directed more at examiners than at rating agencies. Since the method described is standard, we propose to delete that section as unnecessary.

Uveitis, keratitis, scleritis, iritis, cyclitis, choroiditis, retinitis, recent intra-ocular hemorrhage, detachment of retina, and unhealed eye injury (diagnostic codes 6000 through 6009) are currently evaluated at levels of 10 to 100 percent based on impairment of visual acuity or field loss, pain, rest-requirements, or episodic incapacity, combining an additional rating of 10 percent during continuance of active pathology. We propose a revised set of evaluation criteria in the form of a general rating formula following diagnostic code 6009. We propose that evaluation be based either on visual impairment or on incapacitating episodes, whichever results in a higher evaluation. We propose to define an incapacitating episode, for VA purposes, as one requiring bedrest and treatment by a physician or other healthcare provider. We propose to establish evaluation levels of 10, 20, 40, and 60 percent based on incapacitating episodes, in order to accommodate this broad group of conditions with the potential for a wide range of length of periods of incapacitation. We propose an evaluation of 60 percent with incapacitating episodes of at least six weeks total duration per year; of 40 percent with incapacitating episodes of at least four weeks, but less than six weeks, total duration per year; of 20 percent with incapacitating episodes of at least two weeks, but less than four weeks, total duration per year; and of 10 percent with incapacitating episodes total of at least one week, but less than two weeks, total duration per year. These criteria are clearer and more objective than current criteria, and will allow the extent of incapacitating episodes to be consistently taken into account.

We propose to change the terminology in several diagnostic codes to reflect current medical usage, in accord with suggestions by our consultants. We propose to change the title of diagnostic code 6000, ''uveitis,'' to ''choroidopathy,'' because the term ''choroidopathy'' includes pathological conditions of the choroid other than inflammation, and also encompasses the subcategories of uveitis, iritis, cyclitis, and choroiditis. We therefore propose to delete diagnostic codes 6003 (iritis), 6004 (cyclitis), and 6005 (choroiditis), since they are included in diagnostic code 6000. Similarly, we propose to change the title of diagnostic code 6001, ''keratitis,'' to ''keratopathy,'' a broader category that includes corneal conditions other than inflammation, and the title of diagnostic code 6006, ''retinitis,'' to ''retinopathy or maculopathy,'' broader terms that encompass not only retinitis but other retinal and macular diseases and degenerations, for the same reason. We propose to revise the title of diagnostic code 6007 (hemorrhage, intra-ocular, recent) to ''intra-ocular hemorrhage'' because both recent (or acute) and chronic intra-ocular hemorrhage may be disabling. We propose to edit the title of diagnostic code 6010 (tuberculosis of eye) and to correct an erroneous reference to codes under which inactive tuberculosis of the eye is evaluated. The current schedule refers to §§ 4.88b and 4.89, but § 4.88b was redesignated § 4.88c in a separate rulemaking, and the correct section references are now 4.88c and 4.89. We propose to simplify the title of diagnostic code 6011 from ''retina, localized scars, atrophy, or irregularities of, centrally located, with irregular, duplicated, enlarged or diminished image'' to ''retinal scars, atrophy, or irregularities.'' We propose to retain a ten-percent evaluation under diagnostic code 6011 for localized scars, atrophy, or irregularities that are centrally located and that result in an irregular, duplicated, enlarged, or diminished image. Evaluation of these conditions would otherwise be based on visual impairment, as defined in proposed § 4.75(a).

We propose to revise the title of diagnostic code 6012, ''glaucoma, congestive or inflammatory,'' to ''angle-closure glaucoma,'' the current medical term for the condition. For the same reason, we propose to change the title of diagnostic code 6013, ''glaucoma, simple, primary, noncongestive,'' to ''open-angle glaucoma.''

Diagnostic code 6012, angle-closure glaucoma, is currently evaluated either as iritis (diagnostic code 6003) or by rating at 100 percent if there are ''frequent attacks of considerable duration; during continuance of actual total disability.'' ''Frequent'' and ''considerable'' are subjective terms that are susceptible to different interpretations. In addition, these criteria are difficult to apply because acute attacks are usually of short duration, and it is unlikely that an examination for disability could be scheduled and conducted during such an attack. Therefore, we propose to evaluate this condition similarly to diagnostic codes 6000 through 6009, based either on visual impairment or on incapacitating episodes, whichever results in a higher evaluation. Because in some cases this condition is characterized primarily by frequent and sometimes prolonged intermittent episodes of incapacitation, we propose to provide a wide range of evaluations—from 20 to 60 percent—based on incapacitating episodes. We also propose to establish a ten-percent

minimum evaluation if continuous medication is required. A minimum evaluation is not warranted if there is no visual impairment and no treatment is needed other than frequent observation. We propose these more objective criteria in order to provide clearer guidance on evaluation and to assure more consistent evaluations. With these criteria, the direction to rate as iritis is not needed, and we propose to delete it.

Diagnostic code 6013, open-angle glaucoma, is currently evaluated on impairment of visual acuity or field loss, with a minimum evaluation of ten percent. We propose that it be evaluated on visual impairment, which will allow consideration of impairment of visual acuity, visual field, or muscle function, with a ten-percent minimum evaluation if continuous medication is required. A minimum evaluation is not warranted if there is no visual impairment and no treatment is needed other than frequent observation.

We propose to update the term ''new growth'' to ''neoplasm'' in the titles of diagnostic codes 6014 and 6015, which address malignant and benign eye tumors, respectively.

Malignant neoplasms (diagnostic code 6014) are now evaluated at 100 percent pending completion of surgery or other indicated treatment, and, when healed, are rated on residuals. However, not all malignant neoplasms of the eye are totally disabling or require treatment that is totally disabling for a period of time. For example, eye malignancies such as iris melanoma and choroid melanoma often require no treatment other than observation, even though they are malignant on pathology examination. We therefore propose to evaluate malignancies of the eyeball similar to the way we proposed to evaluate skin malignancies (published in the **Federal Register** of January 19, 1993 (*See* 58 FR 4969)). If a malignant neoplasm of the eyeball requires therapy that is comparable to that used for internal malignancies, i.e., systemic chemotherapy, X-ray therapy more extensive than to the eye, or surgery more extensive than enucleation, a 100 percent evaluation would be assigned from the date of onset of treatment, and would continue, with a mandatory VA examination six months following the completion of such antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination would be subject to the effective date provisions of § 3.105(e). If there has been no local recurrence or metastasis, evaluation would then be made on residuals. These revisions are similar to those now in effect for malignant neoplasms in several revised sections of the rating schedule (e.g., gynecological conditions and disorders of the breast, respiratory system, endocrine system). If treatment is confined to the eye, the provisions for a 100 percent evaluation would not apply. If no treatment other than observation is required, we propose that evaluation be made by separately evaluating visual impairment and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combining the evaluations under § 4.25. In our judgment, neoplasms that require only periodic observation, without surgical or other medical intervention, are not totally disabling and therefore do not warrant the total evaluation ordinarily provided for malignant neoplasms. If treatment comparable to that for internal malignancies is needed, eye malignancies would be evaluated in the same manner as internal malignancies requiring treatment.

Benign neoplasms (diagnostic code 6015) are currently evaluated on impaired vision, with a minimum evaluation of 10 percent, and healed benign neoplasms are rated on residuals. A standard ophthalmology text, (Frank W. Newell, M.D., *Ophthalmology Principles and Concepts,* p. 207, 7th ed. 1992), indicates no specific impairment due to benign neoplasms, and no need for continuing medication. A minimum evaluation for all cases is therefore not warranted, and we propose to remove it. We propose that evaluation be based on visual impairment, with that evaluation to be combined with an evaluation for any nonvisual impairment, e.g., disfigurement. These criteria better encompass the impairments that may result from benign neoplasms. We propose to revise the title of diagnostic code 6015 from ''new growths, benign (eyeball and adnexa, other than superficial)'' to ''benign neoplasms (of eyeball and adnexa)'' because without the requirement for a minimum evaluation, the distinction between superficial and other types of benign neoplasm is not relevant.

We propose to edit the title of diagnostic code 6017, ''conjunctivitis, trachomatous, chronic'' to ''trachomatous conjunctivitis'' and the title of diagnostic code 6018, ''conjunctivitis, other, chronic'' to ''chronic conjunctivitis (nontrachomatous).'' Evaluations of healed trachomatous and nontrachomatous conjunctivitis are currently based on residuals, with a zero-percent evaluation if there are no residuals. We propose to remove the zero-percent evaluation level. 38 CFR 4.31 provides for a zero-percent evaluation in all cases when the criteria for a compensable evaluation is not met, which obviates the need to include zero-percent evaluation criteria in this case. Active trachomatous conjunctivitis is currently evaluated on impairment of visual acuity, with a minimum evaluation of 30 percent while there is active pathology; other forms of active conjunctivitis are evaluated at 10 percent when there are ''objective symptoms.'' We propose to change ''objective symptoms'' to ''objective findings, such as red, thick conjunctivae, mucous secretion, etc.'' under diagnostic code 6018, since symptoms are, by definition, subjective, and to change ''healed'' to ''inactive'' because conjunctivitis may be active intermittently. We propose that inactive trachomatous conjunctivitis and inactive chronic conjunctivitis be evaluated on residuals, such as visual impairment, disfigurement (diagnostic code 7800), etc. Our contract consultants suggested that these categories of conjunctivitis be combined because of the rarity of trachoma. Because trachoma is much more severe than most other types of chronic conjunctivitis and often leads to blindness, it warrants a 30-percent minimum evaluation, when active, an evaluation level that cannot be justified for other types of conjunctivitis. Since we must assure appropriate evaluations for these disparate conditions, we do not propose to adopt the consultants' suggestion.

Ptosis (diagnostic code 6019) is currently evaluated equivalent to visual acuity of 5/200 whenever the pupil is wholly obscured, equivalent to 20/100 if the pupil is one-half or more obscured, and on disfigurement if less than one-half of the pupil is obscured. The extent to which a pupil is obscured can be difficult to determine reliably, and an evaluation for ptosis based directly on visual impairment was recommended by our contract consultants. We propose to adopt their suggestion and, in the absence of visual impairment, base evaluation on disfigurement (diagnostic code 7800).

Our contract consultants recommended that we add a note providing an alternative evaluation as disfigurement (diagnostic code 7800) for ectropion (diagnostic code 6020), entropion (diagnostic code 6121), lagophthalmos (diagnostic code 6022), eyebrows, loss of complete, unilateral or bilateral (diagnostic code 6023), eyelashes, loss of, complete, unilateral or bilateral (diagnostic code 6024), and epiphora (diagnostic code 6025). The diagnosis of one of these conditions is

sufficient to assign the current percentage evaluations because the diagnosis itself implies the presence of some degree of disfigurement, which is the primary basis of these evaluations. Since an evaluation for disfigurement is encompassed in the percentages provided, the suggested note would be redundant, and we do not propose to adopt the consultants' suggestion.

We propose to change the title of diagnostic code 6025 from ''epiphora'' to ''disorders of the lacrimal apparatus (epiphora, dacryocystitis, etc.)'' because all disorders of the lacrimal apparatus are evaluated in the same way, and they commonly occur together. In conjunction with this change, we propose to delete dacryocystitis (diagnostic code 6031), as our consultants suggested, because it will be included under diagnostic code 6025.

We propose to change the title of diagnostic code 6026 from ''neuritis, optic'', to ''optic neuropathy'', a broader term that includes conditions other than inflammation of the optic nerve. It is likely that optic nerve conditions other than neuritis are currently being evaluated under this code, because there is no other diagnostic code that specifically addresses diseases of the optic nerve, but this change will assure consistency by including all optic nerve disorders under diagnostic code 6026.

Current diagnostic codes 6027, ''cataract, traumatic,'' and 6028, ''cataract, senile, and others,'' are evaluated under the same criteria—impairment of vision preoperatively, and impairment of vision and aphakia postoperatively—because they result in identical impairment. We therefore propose to delete diagnostic code 6028 and to establish a single diagnostic code, 6027, ''cataract of any type,'' for all types of cataracts. We propose that evaluation preoperatively be based on visual impairment and postoperatively on visual impairment if a replacement lens is present, and on aphakia if there is no replacement lens. Our contract consultants suggested we add a diagnostic code for pseudophakia to the rating schedule. The term ''pseudophakia'' has two meanings—one, a condition where the lens has been replaced status post-cataract removal and the other, a condition in which a degenerated lens is spontaneously replaced by some other type of tissue. Dorland's Illustrated Medical Dictionary (27th ed. 1988) does not include the former definition. Therefore, to avoid confusion, instead of adding a code for pseudophakia, we propose to use clear and unambiguous language in diagnostic code 6027 concerning the post-operative evaluation of cataracts and to include pseudophakia as a parenthetical expression after ''if a replacement lens is present.''

Current diagnostic codes 6029, ''aphakia,'' and 6033, ''lens, crystalline, dislocation of,'' are evaluated under the same criteria because they result in identical impairments. We propose to combine the conditions under diagnostic code 6029, retitle it ''aphakia or dislocation of crystalline lens,'' and delete diagnostic code 6033, since there is no need to retain two separate diagnostic codes for these conditions for statistical or other purposes. There is currently a minimum evaluation of 30 percent under diagnostic code 6029, whether unilateral or bilateral, and there are a number of additional rules for evaluation that are applied depending on whether one or both eyes are aphakic. In order to simplify the current method of evaluation, which has sometimes caused confusion, we propose to instruct the rating agency to evaluate on the basis of visual impairment, elevated by one step. We propose to retain the minimum 30-percent evaluation for unilateral or bilateral aphakia. These minimum evaluations are warranted because the severe hyperopia that results from aphakia cannot be adequately corrected. In addition, there is substantial magnification of the image in an aphakic eye, peripheral vision is reduced, and with aphakia of a single eye, image fusion may be difficult because of the great difference in refraction between the eyes. Glare and photophobia are common additional problems, and eyeglasses cause a ring scotoma so that objects appear to jump in and out of view. The proposed criteria are consistent with other methods of evaluating conditions manifested primarily by visual impairment, take into account visual problems other than loss of visual acuity that are not precisely measurable, and are clearer, which should assure consistent evaluations.

We propose to revise the title of diagnostic code 6030 from ''accommodation, paralysis of'' to ''paralysis of accommodation (due to neuropathy of the Oculomotor Nerve)'' because pathology of that cranial nerve is the usual etiology.

We propose to change the title of diagnostic code 6032 from ''eyelids, loss of portion of'' to ''loss of eyelids, partial or complete,'' because complete loss of eyelids may also require evaluation and can be evaluated under the same criteria. Diagnostic code 6032 is currently rated as disfigurement (diagnostic code 7800). Our contract consultants suggested we combine an evaluation for the underlying disease (none of which they named) with an evaluation for visual impairment. Instead, we propose to direct that an evaluation for visual impairment be combined with an evaluation for disfigurement (diagnostic code 7800). An underlying disease producing other impairments would be evaluated under the appropriate body system, but it is not necessary to provide this instruction here because it is not unique to this condition.

Pterygium, diagnostic code 6034, is currently evaluated on loss of vision, if any, and we propose that it be evaluated on visual impairment, disfigurement (diagnostic code 7800), conjunctivitis (diagnostic code 6018), etc. This proposed change better encompasses the possible range of impairments from pterygium.

A note currently following diagnostic code 6035, keratoconus, requires a 30-percent minimum evaluation when ''contact lenses are medically required.'' We propose to delete the minimum evaluation and base evaluation on corrected visual acuity (using contact lenses rather than eyeglass lenses for that determination if they provide the best corrected visual acuity and are customarily worn by the individual) because decreased visual acuity is the only disabling effect of keratoconus. If contact lenses best correct the visual impairment, and can be worn by the individual, there would be no significant additional disability to warrant a minimum evaluation, and the corrected visual acuity using contact lenses would be a reasonable basis of evaluation. If eyeglass lenses can correct the visual acuity, the usual method of determining corrected visual acuity would be the basis of evaluation.

We propose to add diagnostic code 6036 for ''status post corneal transplant,'' a common condition, with evaluation based on visual impairment. Either loss of visual acuity or visual field loss or both may occur in corneal transplant, and this direction allows any visual impairment to be evaluated. Since pain, photophobia, and glare sensitivity may be disabling following corneal transplant, we propose a minimum of evaluation of ten percent if those symptoms are present.

The current schedule uses 19 different diagnostic codes to designate impairment of central visual acuity, and some designate more than one level of visual acuity, e.g., diagnostic code 6078 designates six different levels. No useful purpose is served by this large number of codes, and we propose to decrease the number to six for more ease of use.

We propose to retain separate codes for anatomical loss of both eyes (diagnostic code 6061); for light perception only, both eyes (diagnostic code 6062); for anatomical loss of one eye (diagnostic code 6063); for light perception only, one eye, (diagnostic code 6064); for vision in one eye 5/200 (1.5/60) (diagnostic code 6065); and for impairment of visual acuity 10/200 (3/60) or better (diagnostic code 6066). In addition, we propose to remove the term ''blindness'' from the titles of diagnostic codes 6062 and 6064 in favor of the terms ''light perception only, both eyes'' and ''light perception only, one eye,'' respectively because the term ''blindness,'' as used in 38 U.S.C. 1114, ''Rates of wartime disability compensation,'' has more than one meaning, and using it in the rating schedule to refer to only one level of visual impairment promotes confusion.

In the current rating schedule, footnote number five, attached to diagnostic codes 6061–63 and 6067–71, refers to entitlement to SMC, and footnote number six, attached to diagnostic codes 6064–66, refers both to entitlement to SMC and to evaluation when there is inability to wear a prosthesis following anatomical loss of an eye. (Footnotes number five and six are currently the only footnotes in this section.) We have discussed above our proposal to remove the part of the footnote that addresses the inability to wear a prosthesis. We propose to place the material concerning SMC in footnote number one, following diagnostic code 6066 and also following diagnostic code 6080. We propose to remove footnotes five and six and to attach footnote number one to diagnostic codes 6061 through 6064, under diagnostic code 6065 at the 100 percent evaluation for ''vision in one eye 5/200, in the other eye 5/200,'' and under diagnostic code 6080 at ''visual field, concentric contraction of, to 5 degrees'' (because concentric contraction of the visual field to five degrees is the equivalent of 5/200, and must also be considered for SMC (see 38 CFR 3.350)). This combination of footnotes and paragraph (f) of § 4.75 referring to SMC is, in our opinion, the best way to ensure complete review for SMC.

We propose to update the subpart title ''Ratings for Impairment of Field of Vision'' to ''Ratings for Impairment of Visual Fields'' and the title of diagnostic code 6080 from ''Field vision, impairment of'' to ''Visual field defects,'' in accordance with current usage. In order to make the evaluations for visual field defects under diagnostic code 6080 more comprehensive, as suggested by our consultants, we propose to add evaluations for loss of superior and inferior altitudinal fields. Inferior field loss will be evaluated at 10 percent for the unilateral and 30 percent for the bilateral condition (or impaired visual acuity of 20/70 (6/21) for each affected eye), and superior field loss will be evaluated at 10 percent for both the unilateral and bilateral conditions (or impaired visual acuity of 20/50 (6/15) for each affected eye). For the sake of accuracy, we propose, under diagnostic code 6080, to make 10 percent (or impaired visual acuity of 20/50 (6/15) for each affected eye), instead of 20 percent, the evaluation for unilateral or bilateral condition for both concentric contraction to 46 to 60 degrees and for loss of the nasal half of the visual field. This will correct the bilateral percentage evaluation, currently indicated to be 20 percent for these conditions, because both bilateral and unilateral visual acuity of 20/50 warrant a 10-percent, not a 20-percent, evaluation. Notes one and two, currently following diagnostic code 6080, discuss the requirements for correct diagnosis, demonstrable pathology, and contraction within the stated degrees for concentric contraction ratings. We propose to delete these notes because similar information is contained in § 4.1, proposed § 4.77(a), and under diagnostic code 6080, and they are therefore redundant.

We propose to revise the evaluation criteria for diagnostic code 6081, ''scotoma, unilateral,'' which currently provide a minimum 10-percent evaluation for a large or centrally located scotoma, by changing ''large'' to ''affecting at least one-quarter of the visual field (quadrantanopsia).'' This language is clearer, and the term ''quadrantanopsia,'' is widely accepted. We propose that evaluation otherwise be based on visual impairment, which is not a substantive change from the current direction to ''rate on loss of central visual acuity or impairment of field vision.''

Symblepharon (diagnostic code 6091) is currently rated under the criteria for diagnostic code 6090 (diplopia). However, it may also result in other types of impairments, and we therefore propose to direct that it be evaluated on visual impairment, lagophthalmos (diagnostic code 6022), disfigurement (diagnostic code 7800), etc.

Diplopia is currently evaluated under diagnostic code 6090 and also under diagnostic code 6092, which is described as ''diplopia, due to limited muscle function'' and evaluated according to the criteria under diagnostic code 6090. We propose to eliminate diagnostic code 6092 because diplopia due to limited muscle function is not functionally distinct from diplopia (double vision) and does not warrant a separate code. As stated above, we propose to delete the note following diagnostic code 6090 regarding a citing of the correct diagnosis as redundant.

For purposes of clarity, we propose to make numerous additional nonsubstantive changes in this document.

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 regulation 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: December 14, 1998.

Togo D. West, Jr.,

Secretary of Veterans Affairs.

For the reasons set out in the preamble, 38 CFR part 4, subpart B, is proposed to be 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. Sections 4.75 and 4.76 are revised to read as follows:

§ 4.75 General considerations for evaluating visual impairment.

(a) *Visual impairment.* The evaluation of visual impairment is based on impairment of visual acuity (excluding developmental errors of refraction), visual field, and muscle function.

(b) *Examination for visual impairment.* To be adequate for VA purposes, an examination to evaluate visual impairment must be conducted by a licensed optometrist or

ophthalmologist. The examiner must identify the disease, injury, or other pathologic process responsible for any visual impairment found. Examinations for the evaluation of visual fields or muscle function will be conducted only when there is a medical indication of disease or injury that may be associated with visual field defect or impaired muscle function. The fundus must be examined with the veteran's pupils dilated (unless medically contraindicated).

(c) *Service-connected visual impairment of only one eye.* If visual impairment of only one eye is service-connected, either directly or by aggravation, the visual acuity of the non-service-connected eye shall be considered to be 20/40 for evaluation purposes, subject to the provisions of § 3.383(a) of this chapter.

(d) *Maximum evaluation for visual impairment of one eye.* The evaluation for visual impairment of one eye shall not exceed 30 percent unless there is anatomical loss of the eye. The evaluation for visual impairment of one eye may, however, be combined with evaluations for other disabilities, e.g., disfigurement, that are not based on visual impairment.

(e) *Anatomical loss of one eye with inability to wear a prosthesis.* When there is anatomical loss of one eye, the evaluation for visual acuity under diagnostic code 6063 shall be increased by 10 percent if the veteran is unable to wear a prosthesis, but the maximum evaluation shall not exceed 100 percent.

(f) *Special monthly compensation.* When evaluating any claim involving visual impairment, the rating agency shall refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate levels of visual impairment that potentially establish entitlement to special monthly compensation; however, other levels of visual impairment combined with disabilities of other body systems may also establish entitlement.

(Authority: 38 U.S.C. 1155 and 1114)

§ 4.76 Visual acuity.

(a) *Examination of visual acuity.* To be adequate for VA purposes, an examination to evaluate visual acuity must record *uncorrected* and *corrected* visual acuity for *distance* and *near,* as determined using Snellen's test type or its equivalent.

(b) *Evaluation of visual acuity.* (1) For VA purposes, visual acuity shall generally be evaluated on the basis of corrected distance vision. However, when the lens required to correct distance vision in the poorer eye differs by more than three diopters from the lens required to correct distance vision in the better eye, and the difference is not due to congenital or developmental refractive error, the visual acuity of the poorer eye for evaluation purposes shall be either its uncorrected visual acuity or its visual acuity as corrected by a lens that does not differ by more than three diopters from the lens needed for correction of the other eye, whichever results in better combined visual acuity.

(2) Provided that he or she customarily wears contact lenses, VA shall evaluate the visual acuity of any individual affected by a corneal disorder that results in severe irregular astigmatism that can be improved more by contact lenses than by eyeglass lenses, as corrected by contact lenses.

(3) In any case where the examiner reports that there is a difference equal to two or more scheduled steps between near and distance corrected vision, with the near vision being worse, the examination report must include at least two recordings of near and distance corrected vision and explain the reason for the difference. Evaluation in those cases will be based on distance vision adjusted to one step poorer than measured.

§ 4.76a [Removed]

3. Section 4.76a is removed.

4. Sections 4.77, 4.78 and 4.79 are revised to read as follows:

§ 4.77 Visual fields.

(a) *Examination of visual fields.* To be adequate for VA purposes, examinations of visual fields must be conducted using a Goldmann kinetic perimeter or equivalent kinetic method, using a standard target size and luminance (Goldmann's equivalent (III/4-e)). At least two recordings of visual fields must be made, and the examination must be supplemented by the use of a tangent screen when the examiner indicates it is necessary. At least 16 meridians 22½ degrees apart must be charted for each eye (see Figure 1). See Table III for the normal extent of the visual fields (in degrees) at the 8 principal meridians (45 degrees apart). The confirmed visual fields shall be made a part of the examination report.

(b) *Evaluation of visual fields.* The average concentric contraction of the visual field of each eye is determined by measuring the remaining visual field (in degrees) at each of eight principal meridians 45 degrees apart, adding them, and dividing the sum by eight.

(c) *Combination of visual field defect and decreased visual acuity.* To determine the evaluation for visual impairment when both decreased visual acuity and visual field defect are present in one or both eyes, the rating agency shall combine the evaluations for visual acuity and visual field defect (expressed as a level of visual acuity) (see § 4.25).

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

§ 4.78 Muscle function.

(a) *Examination of muscle function.* To be adequate for VA purposes, measurement of muscle function must be performed using a Goldmann Perimeter Chart which identifies the four major quadrants, (upward, downward, left and right lateral) and the central field (20 degrees or less) (see Figure 2). The examiner will chart the areas in which diplopia exists and include the plotted chart in the examination report.

(b) *Evaluation of muscle function.* (1) An evaluation for diplopia shall be assigned to only one eye. When both diplopia and decreased visual acuity or visual field defect are present in an individual, the rating agency shall assign a level of corrected visual acuity for the poorer eye (or the affected eye, if only one eye is service-connected), that is: one step poorer than it would otherwise warrant if the evaluation for diplopia under diagnostic code 6090 is 20/70 or 20/100; two steps poorer if the evaluation under diagnostic code 6090 is 20/200 or 15/200; and three steps poorer if the evaluation under diagnostic code 6090 is 5/200. These adjusted levels of corrected visual acuity, however, shall not exceed a level of 5/200. The percentage evaluation for visual impairment shall then be determined under diagnostic codes 6064 through 6066, using the adjusted visual acuity for the poorer eye (or the affected eye), and the corrected visual acuity for the better eye.

(2) When diplopia is present in more than one quadrant or range of degrees, the rating agency shall evaluate diplopia on the quadrant and degree range that provides the highest evaluation.

(3) When diplopia exists in two separate areas of the same eye, the equivalent visual acuity under diagnostic code 6090 shall be increased to the next poorer level of visual acuity, but not to exceed 5/200.

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

§ 4.79 Schedule of ratings—eye.

DISEASES OF THE EYE

	Rating
6000 Choroidopathy, including uveitis, iritis, cyclitis, and choroiditis	
6001 Keratopathy	
6002 Scleritis	
6006 Retinopathy or maculopathy	
6007 Intraocular hemorrhage	
6008 Detachment of retina	
6009 Unhealed eye injury	

GENERAL RATING FORMULA FOR DIAGNOSTIC CODES 6000 THROUGH 6009

	Rating
Evaluate on the basis of either visual impairment or incapacitating episodes, whichever results in a higher evaluation.	
With incapacitating episodes of at least six weeks total duration per year	60
With incapacitating episodes of at least four weeks, but less than six weeks, total duration per year	40
With incapacitating episodes of at least two weeks, but less than four weeks, total duration per year	20
With incapacitating episodes of at least one week, but less than two weeks, total duration per year	10
Note: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require bed rest and treatment by a physician or other healthcare provider.	
6010 Tuberculosis of eye:	
Active:	100
Inactive: Rate under §§ 4.88c or 4.89 of this part, whichever is appropriate.	
6011 Retinal scars, atrophy, or irregularities:	
Localized scars, atrophy, or irregularities of the retina, unilateral or bilateral, that are centrally located and that result in an irregular, duplicated, enlarged, or diminished image	10
Otherwise, evaluate on visual impairment.	
6012 Angle-closure glaucoma:	
Evaluate on the basis of either visual impairment or incapacitating episodes, whichever results in a higher evaluation.	
Minimum evaluation if continuous medication is required	10
With incapacitating episodes of at least six weeks total duration per year	60
With incapacitating episodes of at least four weeks, but less than six weeks, total duration per year	40
With incapacitating episodes of at least two weeks, but less than four weeks, total duration per year	20
Note: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require bed rest and treatment by a physician or other healthcare provider.	
6013 Open-angle:	
Evaluate on visual impairment.	
Minimum evaluation if continuous medication is required	10
6014 Malignant neoplasms (eyeball only):	
Note (1): If a malignant neoplasm of the eyeball requires therapy that is comparable to that used for systemic malignancies, i.e., systemic chemotherapy, X-ray therapy more extensive than to the area of the eye, or surgery more extensive than enucleation, a rating of 100 percent shall be assigned that shall continue beyond the cessation of any surgical, X-ray, 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 upon 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.	
Note (2): To evaluate residuals, or malignant neoplasms that do not require therapy comparable to that for systemic malignancies, evaluate visual impairment and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), separately and combine the evaluations.	
6015 Benign neoplasms (of eyeball and adnexa):	
Evaluate visual impairment and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), separately and combine the evaluations.	
6016 Nystagmus, central	10
6017 Trachomatous conjunctivitis:	
Active: Evaluate on visual impairment, minimum	30
Inactive: Evaluate on residuals, such as visual impairment and disfigurement (diagnostic code 7800).	
6018 Chronic conjunctivitis (nontrachomatous):	
Active (with objective findings, such as red, thick conjunctivae, Mucous secretion, etc.)	10
Inactive: Evaluate on residuals, such as visual impairment and disfigurement (diagnostic code 7800).	
6019 Ptosis, unilateral or bilateral:	
Evaluate on visual impairment, or; in the absence of visual impairment, evaluate on disfigurement (diagnostic code 7800).	
6020 Ectropion:	
Bilateral	20
Unilateral	10
6021 Entropion:	
Bilateral	20
Unilateral	10
6022 Lagophthalmos:	
Bilateral	20
Unilateral	10
6023 Loss of eyebrows, complete, unilateral or bilateral	10
6024 Loss of eyelashes, complete, unilateral or bilateral	10
6025 Disorders of the lacrimal apparatus (epiphora, dacryocystitis, etc.):	

GENERAL RATING FORMULA FOR DIAGNOSTIC CODES 6000 THROUGH 6009—Continued

	Rating
Bilateral	20
Unilateral	10
6026 Optic neuropathy:	
Evaluate on visual impairment.	
6027 Cataract of any type:	
Preoperative:	
Evaluate on visual impairment.	
Postoperative:	
If a replacement lens is present (pseudophakia), evaluate on visual impairment. If there is no replacement lens, evaluate on aphakia.	
6029 Aphakia or dislocation of crystalline lens:	
Evaluate on visual impairment, and elevate the resulting level of visual impairment one step.	
Minimum (unilateral or bilateral)	30
6030 Paralysis of accommodation (due to neuropathy of the Oculomotor Nerve)	20
6032 Loss of eyelids, partial or complete:	
Evaluate both visual impairment and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), separately and combine the evaluations.	
6034 Pterygium:	
Evaluate on visual impairment, disfigurement (diagnostic code 7800), conjunctivitis (diagnostic code 6018), etc.	
6035 Keratoconus:	
Evaluate loss of visual acuity.	
6036 Status post corneal transplant	
Evaluate visual impairment.	
Minimum, if there is pain, photophobia, and glare sensitivity	10
6037 Pinguecula:	
Evaluate on disfigurement (diagnostic code 7800).	
Impairment of Central Visual Acuity:	
6061 Anatomical loss both eyes [1]	100
6062 Light perception only, in both eyes [1]	100
6063 Anatomical loss of one eye: [1]	
In the other eye 5/200 (1.5/60)	100
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	60
In the other eye 20/50 (6/15)	50
In the other eye 20/40 (6/12)	40
6064 Light perception only, in one eye: [1]	
In the other eye 5/200 (1.5/60)	100
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
6065 Vision in one eye 5/200 (1.5/60):	
In the other eye 5/200 (1.5/60)	[1] 100
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
6066 Visual acuity in one eye 10/200 (3/60) or better	
Vision in one eye 10/200 (3/60):	
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
Vision in one eye 15/200 (4.5/60):	
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	40
In the other eye 20/50 (6/15)	30
In the other eye 20/40 (6/12)	20

GENERAL RATING FORMULA FOR DIAGNOSTIC CODES 6000 THROUGH 6009—Continued

	Rating
Vision in one eye 20/200 (6/60):	
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	40
In the other eye 20/50 (6/15)	30
In the other eye 20/40 (6/12)	20
Vision in one eye 20/100 (6/30):	
In the other eye 20/100 (6/30)	50
In the other eye 20/70 (6/21)	30
In the other eye 20/50 (6/15)	20
In the other eye 20/40 (6/12)	10
Vision in one eye 20/70 (6/21):	
In the other eye 20/70 (6/21)	30
In the other eye 20/50 (6/15)	20
In the other eye 20/40 (6/12)	10
Vision in one eye 20/50 (6/15):	
In the other eye 20/50 (6/15)	10
In the other eye 20/40 (6/12)	10
Vision in one eye 20/40 (6/12):	
In the other eye 20/40 (6/12)	0

[1] Review for entitlement to special monthly compensation under § 3.350 of this chapter.

RATINGS FOR IMPAIRMENT OF VISUAL FIELDS

	Rating
6080 Visual field defects:	
Homonymous hemianopsia	30
Loss of temporal half of visual field:	
Bilateral	30
Unilateral	10
Or rate each affected eye as 20/70 (6/21).	
Loss of nasal half of visual field:	
Bilateral	10
Unilateral	10
Or rate each affected eye as 20/50 (6/15).	
Loss of inferior half of visual field:	
Bilateral	30
Unilateral	10
Or rate each affected eye as 20/70 (6/21).	
Loss of superior half of visual field:	
Bilateral	10
Unilateral	10
Or rate each affected eye as 20/50 (6/15).	
Concentric contraction of visual field:	
With remaining field of 5 degrees[1]	
Bilateral	100
Unilateral	30
Or rate each affected eye as 5/200 (1.5/60).	
With remaining field of 6 to 15 degrees:	
Bilateral	70
Unilateral	20
Or rate each affected eye as 20/200 (6/60).	
With remaining field of 16 to 30 degrees:	
Bilateral	50
Unilateral	10
Or rate each affected eye as 20/100 (6/30).	
With remaining field of 31 to 45 degrees:	
Bilateral	30
Unilateral	10
Or rate each affected eye as 20/70 (6/21).	
With remaining field of 46 to 60 degrees:	
Bilateral	10
Unilateral	10
Or rate each affected eye as 20/50 (6/15).	
6081 Scotoma, unilateral:	
Minimum, with scotoma affecting at least one-quarter of the visual field (quadrantanopsia) or with centrally located scotoma of any size	10
Otherwise, evaluate on visual impairment.	

[1] Review for entitlement to special monthly compensation under § 3.350 of this chapter.

RATINGS FOR IMPAIRMENT OF MUSCLE FUNCTION

Degree of diplopia	Equivalent visual acuity
6090 Diplopia (double vision):	
(a) Central 20 degrees	5/200 (1.5/60)
(b) 21 degrees to 30 degrees:	
(1) Down	15/200 (4.5/60)
(2) Lateral	20/100 (6/30)
(3) Up	20/70 (6/21)
(c) 31 degrees to 40 degrees:	
(1) Down	20/200 (6/60)
(2) Lateral	20/70 (6/21)
(3) Up	20/40 (6/12)
6091 Symblepharon:	
Evaluate on visual impairment, lagophthalmos (diagnostic code 6022), disfigurement (diagnostic code 7800), etc., depending on particular findings in individual case.	

(Authority: 38 U.S.C 1155)

§§ 4.80, 4.83 and 4.84 [Removed and Reserved]

5. Sections 4.80, 4.83 and 4.84 are removed and reserved.

§§ 4.83a and 4.84a [Removed]

6. Sections 4.83a and 4.84a are removed.

[FR Doc 99–11771 Filed 5–10–99; 8:45 am]
BILLING CODE 8320–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 271

[FRL–6339–2]

New Jersey: Authorization of State Hazardous Waste Program

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: Pursuant to the Resource Conservation and Recovery Act, as amended, 42 U.S.C. 6901 *et seq.* (''RCRA''), and the regulations thereunder, the State of New Jersey (the ''State'') has applied for final authorization of its hazardous waste program adopted in October 1996. The Environmental Protection Agency, Region 2 (''EPA'') has reviewed the State's application and has made a decision, subject to EPA's receipt and evaluation of public comment, that the State's hazardous waste program satisfies all of the requirements necessary to qualify for final authorization. Accordingly, EPA proposes to approve and authorize the State's hazardous waste program.

DATES: Comments on this proposed rule must be received by the close of business on June 10, 1999.

ADDRESSES: Written comments should be sent to Ms. Kathleen C. Callahan, Director, Division of Environmental Planning and Protection, U.S. EPA, Region II, 290 Broadway, New York, New York 10007–1866, (212) 637–3724.

Copies of the State's application for authorization are available for inspection and copying as follows:

The New Jersey Department of Environmental Protection (''NJDEP'')
Address: Public Access Center, NJDEP, 401 East State Street, 1st Floor, Trenton, NJ 08625
Hours: Monday through Friday (excluding holidays), 8:30AM–1:00PM, 2:00PM–4:30PM
Telephone: (609) 777–3373

EPA
Address: EPA's Library, 16th Floor, 290 Broadway, New York, NY 10007–1866
Hours: Monday through Thursday (excluding holidays), 9:00AM–4:30PM, Friday (excluding holidays), 9:00AM–1:00PM
Telephone: (212) 637–3185

FOR FURTHER INFORMATION CONTACT: Call Elizabeth Butler at (212) 637–4163.

Summary

I. State Authorization Under RCRA

Pursuant to section 3006 of RCRA, 42 U.S.C. 6926, EPA may, upon application by a state, authorize the applicant state's hazardous waste program to operate in the state in lieu of the federal hazardous waste program. The federal hazardous waste program (the ''Federal Program'') is comprised of the regulations published in Title 40 of the Code of Federal Regulations under the authority of RCRA. To qualify for final authorization, a state's hazardous waste program must: (1) be equivalent with the Federal Program; (2) be consistent with the Federal Program; and (3) provide for adequate enforcement. RCRA section 3006(b), 42 U.S.C. 6926(b).

II. Background—History of RCRA Authorization Within the State

In 1985, the State was granted final authorization by EPA for the RCRA base program, effective February 21, 1985 (50 FR 5260, 2/7/85). At that time the base program covered the essential core of the Federal Program as reflected in the initial enactment of RCRA prior to its amendment by the Hazardous and Solid Waste Amendments of 1984. In 1988 and 1993 EPA authorized the State for a small number of additional regulations (53 FR 30054, 8/10/88, and 58 FR 59370, 11/9/93).

On October 21, 1996, the State repealed its then existing hazardous waste program, including the authorized provisions, and adopted a new program (N.J.A.C. 7:26G–1.1 *et seq.*, 28 New Jersey Register 4606, 10/21/96). As part of this October 21, 1996 adoption, the State adopted, with certain exceptions and modifications, 40 CFR parts 124, 260–266, 268 and 270 as set forth in the July 1, 1993 CFR, by incorporation by reference, and designated these provisions N.J.A.C. 7:26G–4 through N.J.A.C. 7:26G–13, inclusive. (28 New Jersey Register 4652–4668, 10/21/96. N.J.A.C. 7:26G–4 through N.J.A.C. 7:26G–13 are referred to below as the ''State Program''). Under cover of a letter dated January 13, 1999, the State submitted an application meeting the requirements of 40 CFR part 271, requesting authorization of the State Program.[1]

[1] The State's redesignation of the Parts of the Federal Program adopted by incorporation by reference on October 21, 1996, and comprising the State Program, is as follows: N.J.A.C. 7:26G–4 (40 CFR part 260); N.J.A.C. 7:26G–5 (40 CFR part 261); N.J.A.C. 7:26G–6 (40 CFR part 262); N.J.A.C. 7:26G–7 (40 CFR part 263); N.J.A.C. 7:26G–8 (40 CFR part 264); N.J.A.C. 7:26G–9 (40 CFR part 265); N.J.A.C.