DATES: This deviation is effective from 5 a.m. on December 31, 2008, to 5 a.m. on January 2, 2009.

ADDRESSES: Documents indicated in this preamble as being available in the docket are part of docket USCG–2008–1090 and are available online at *www.regulations.gov.* They are also available for inspection or copying at two locations: the Docket Management Facility (M–30), U.S. Department of Transportation, West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays, and the Commander (dpb), Fifth Coast Guard District, Federal Building, 1st Floor, 431 Crawford Street, Portsmouth, VA 23704–5004 between 8 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice, call Mr. Bill H. Brazier, Bridge Management Specialist, Fifth Coast Guard District, at (757) 398–6422. If you have questions on viewing the docket, call Renee V. Wright, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION: The Norfolk Southern Corporation, who owns and operates this single-leaf bascule drawbridge, has requested a temporary deviation from the current operating regulations set out in 33 CFR 117.997(e) to facilitate structural repairs.

The Norfolk Southern #7 Bridge, at AIWW mile 5.8, across the Elizabeth River (Southern Branch) in Chesapeake, VA, has a vertical clearance in the closed position to vessels of 7 feet above mean high water.

To facilitate replacement of curved tread plates on the curved segmental girders of the lift span, the drawbridge will be maintained in the closed-to-navigation position from 5 a.m. on December 31, 2008, until and including 5 a.m. on January 2, 2009.

The Coast Guard will inform the users of the waterway through our Local and Broadcast Notices to Mariners of the opening restrictions of the draw span to minimize transiting delays caused by the temporary deviation.

In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the designated time period.

This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: October 30, 2008.

Waverly W. Gregory, Jr.,

Chief, Bridge Administration Branch, Fifth Coast Guard District.

[FR Doc. E8–26673 Filed 11–7–08; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2008–1046]

Drawbridge Operation Regulation: Upper Mississippi River, Clinton, Iowa, Activity Identifier; Repair and Maintenance

AGENCY: Coast Guard, DHS.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, Eighth Coast Guard District has issued a temporary deviation from the regulation governing the operation of the Clinton Railroad Drawbridge, across the Upper Mississippi River, mile 518.0, at Clinton, Iowa. The deviation is necessary to allow time for performing needed maintenance and repairs to the bridge. This deviation allows the bridge to open on signal if at least 24 hours advance notice is given from 12:01 a.m., December 15, 2008 until 9 a.m., March 15, 2009.

DATES: This temporary deviation is effective from 12:01 a.m., December 15, 2008 until 9 a.m., March 15, 2009.

ADDRESSES: Documents indicated in this preamble as being available in the docket are part of docket USCG–2008–1046 and are available online at *www.regulations.gov.* They are also available for inspection or copying at two locations: The Docket Management Facility (M–30), U.S. Department of Transportation, West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays, and the Robert A. Young Federal Building, Room 2.107F, 1222 Spruce Street, St. Louis, MO 63103–2832, between 8 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

FOR FUTHER INFORMATION CONTACT: If you have questions on this notice, call Roger K. Wiebusch, Bridge Administrator, (314) 269–2378. If you have questions on viewing the docket, call Renee V. Wright, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION: The Union Pacific Railroad Company requested a temporary deviation for the Clinton Railroad Drawbridge, across the Upper Mississippi, mile 518.0, at Clinton, Iowa to open on signal if at least 24 hours advance notice is given in order to facilitate needed bridge maintenance and repairs. The Clinton Railroad Drawbridge currently operates in accordance with 33 CFR 117.5, which states the general requirement that drawbridges shall open promptly and fully for the passage of vessels when a request to open is given in accordance with the subpart. In order to facilitate the needed bridge work, the drawbridge must be kept in the closed-to-navigation position. This deviation allows the bridge to open on signal if at least 24 hours advance notice is given from 12:01 a.m., December 15, 2008 until 9 a.m., March 15, 2009.

There are no alternate routes for vessels transiting this section of the Upper Mississippi River.

The Clinton Railroad Drawbridge, in the closed-to-navigation position, provides a vertical clearance of 18.7 feet above normal pool. Navigation on the waterway consists primarily of commercial tows and recreational watercraft. This temporary deviation has been coordinated with waterway users. No objections were received.

In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the designated time period. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: October 15, 2008.

Roger K. Wiebusch,

Bridge Administrator.

[FR Doc. E8–26671 Filed 11–7–08; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AH43

Schedule for Rating Disabilities; Eye

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the Department of Veterans Affairs (VA) Schedule for Rating Disabilities (Rating Schedule) by updating the portion of the schedule that addresses disabilities of the eye. These amendments ensure that the schedule uses current medical terminology, provides unambiguous criteria for evaluating disabilities, and

incorporates pertinent medical advances.

DATES: *Effective Date:* This amendment is effective December 10, 2008.

Applicability Date: These amendments shall apply to all applications for benefits received by VA on or after December 10, 2008.

FOR FURTHER INFORMATION CONTACT: Maya Ferrandino, Consultant, Policy and Regulations Staff (211D), Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC, 20420, (727) 319–5847. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: As part of its review of the Schedule for Rating Disabilities (38 CFR part 4), VA published a proposal to amend the portion of the schedule pertaining to the eye in the **Federal Register** of May 11, 1999 (64 FR 25246–25258). Interested persons were invited to submit written comments on or before July 12, 1999. We received comments from the Disabled American Veterans, the Blinded Veterans Association, and one other interested party.

Section 4.75 General Considerations for Evaluating Visual Impairment

We proposed to add paragraph (c) to § 4.75 to codify the longstanding VA practice that when visual impairment of only one eye is service-connected, either directly or by aggravation, the visual acuity of the nonservice-connected eye must be considered to be 20/40, subject to the provisions of 38 CFR 3.383(a). Section 3.383(a) 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 nonservice-connected disability, VA will pay compensation as if both were service-connected.

We also proposed to remove current § 4.78, which provides a method of determining the level of disability when the visual impairment is aggravated during military service. As stated in the proposed rule, § 4.78 is not consistent with VA's method of evaluating visual impairment incurred in service in one eye only, nor is it consistent with VA's statutory scheme governing VA benefits. 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, which is not equitable. Section 4.78 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 nonservice-connected hand, subject to the provisions of § 3.383(a).

One commenter challenges the rule proposed in § 4.75(c) as contrary to legal authority and long-standing VA practice. According to the commenter, the proper rating of visual disability always considers: (1) The vision of each eye, regardless of whether the origin of the service-connected disability is one or both eyes and (2) the entire disability, regardless of whether service connection is based on incurrence or aggravation. The commenter stated that ''service connection is always bilateral in the legal sense.'' The commenter stated that VA used the term ''service connected'' in current § 4.78 in its literal sense and that the nonservice-connected visual impairment to which § 4.78 refers ''denotes the origin of the disability, not its legal status.'' The commenter further asserted that ''service connection attaches to the impairment of function or disability and not to the organ or body part per se'' and that ''service connection is accordingly established for visual impairment that is incurred in or aggravated by service and is not limited to the eye with the service-related disability.'' The commenter cited VA's Office of the General Counsel opinion VAOPGC 25–60 (9–13–60) and 38 U.S.C. 1160 in support of these assertions.

To an extent, the commenter is correct that the proper rating of visual disability always considers the vision of each eye, regardless of whether the origin of the service-connected disability is one or both eyes. However, if visual impairment of only one eye is service-connected, the vision in the other eye is considered to be normal, *i.e.*, 20/40. To do otherwise would violate 38 CFR 4.14, which provides that ''the use of manifestations not resulting from service-connected disease or injury in establishing the service-connected evaluation * * * [is] to be avoided.'' Proposed § 4.75(c) merely states long-standing VA practice in this regard.

The commenter is mistaken about the entire disability being considered, regardless of whether service connection is based on incurrence or aggravation. As 38 CFR 4.22 plainly states: ''In cases involving aggravation by active service, the rating will reflect only the degree of disability over and above the degree existing at the time of entrance into the active service * * *. It is necessary therefore, in all cases of this character[,] to deduct from the present degree of disability the degree, if ascertainable, of the disability existing at the time of entrance into active service. * * *''

Although there are certain specified exceptions (such as 38 U.S.C. 1151 and 1160), generally the statutes governing VA benefits authorize compensation for service-connected disability only. 38 U.S.C. 101(13), 1110, 1131. Only disabilities that result from injury or disease incurred or aggravated in service may be service connected. 38 U.S.C. 1110, 1131; 38 CFR 3.310(a). VAOPGC 25–60 addressed whether VA had authority to award a 100-percent disability rating for visual impairment where there is service-connected loss or loss of use of one eye and nonservice-connected loss or loss of use of the other eye arising after service. The opinion held that VA did not have statutory authority to compensate veterans for nonservice-connected visual disability arising after service. However, Congress later provided an exception in 38 U.S.C. 1160. If a veteran has visual impairment in one eye as a result of service-connected disability and visual impairment in the other eye as a result of nonservice-connected disability not the result of the veteran's own willful misconduct and either (1) the impairment of visual acuity in each eye is rated at a visual acuity of 20/200 or less or (2) the peripheral field of vision for each eye is 20 degrees or less, VA must pay compensation to the veteran as if the combination of both disabilities were the result of service-connected disability. 38 U.S.C. 1160(a). Thus, VA's authority to consider nonservice-connected visual disability for compensation purposes is limited to the circumstances described in section 1160(a). Absent the degree of visual impairment in both eyes prescribed in section 1160(a), nonservice-connected visual disability is not compensable and therefore not to be considered when rating service-connected disability. Where a claimant has a service-connected disability of only one eye and a nonservice-connected visual impairment but not of the degree prescribed by section 1160(a) in the other eye, deeming the nonservice-connected eye as having a visual acuity of 20/40 results in accurate evaluations that are based solely upon service-connected visual impairment. Our proposal to deem the nonservice-connected eye as having a visual acuity of 20/40 is consistent with current law. We make no change based upon this comment.

This commenter also asserted that VA should consider hearing loss less than total deafness and visual impairment less than blindness when evaluating impairment of the nonservice-connected ear and eye, respectively. The

commenter disagreed with VA's Office of the General Counsel opinion VAOPGCPREC 32–97, which interpreted the statutes governing compensation for service-connected disabilities and concluded that where a claimant has service-connected hearing loss in one ear and nonservice-connected hearing loss in the other ear, for purposes of evaluating the service-connected disability, the hearing in the ear with nonservice-connected hearing loss should be considered normal, unless the claimant is totally deaf in both ears. The issue raised by the commenter was mooted by the Veterans Benefits Act of 2002, Public Law 107–330, which authorized VA, when a veteran has compensable service-connected hearing loss in one ear and nonservice-connected deafness in the other ear, to assign an evaluation and pay compensation as though both ears were service-connected, and the Dr. James Allen Veteran Vision Equity Act of 2007, Public Law 110–157, which authorized VA, when a veteran has service-connected visual impairment in one eye and nonservice-connected visual impairment in the other eye of the degree described above, to assign an evaluation and pay compensation as though both eye disabilities were service connected. *See* 38 U.S.C. 1160(a)(1) and (3).

Further, while § 4.78 addressed aggravation, it is unnecessary to include this in this regulation as it is covered in 38 CFR 4.22. Section 4.78's discussion of aggravation was duplicative of § 4.22.

Proposed § 4.75(d) stated that the evaluation for visual impairment of one eye may be combined with evaluations for other disabilities that are not based on visual impairment and included disfigurement as an example. One commenter suggested that we evaluate phthisis bulbi (shrunken eyeball) or other serious cosmetic defect of the eyeball at 40 percent instead of referring the rater to diagnostic code 7800 (''Scars, disfiguring, head, face, or neck'') under the skin portion of the Rating Schedule. The commenter felt this would provide a standard evaluation for this problem.

The portion of the Rating Schedule that addresses the skin has been revised (67 FR 49590, July 31, 2002) since the comment was written. Diagnostic code 7800 is no longer limited to evaluation of scarring of the skin. The revised evaluation criteria include a 30-percent evaluation for gross distortion or asymmetry of a paired set of features with visible or palpable tissue loss. Since by definition, phthisis bulbi is a shrunken or atrophic eyeball, there would be visible or palpable tissue loss, and this level of evaluation under diagnostic code 7800 would apply. Any other cosmetic defect of the eyeball that meets the criteria for disfigurement could also be evaluated under diagnostic code 7800, with the level of evaluation based on application of the criteria for disfigurement. Therefore, we make no change based on this comment.

Proposed § 4.75(e) instructed adjudicators to increase evaluations by 10 percent in situations where a claimant has anatomical loss of one eye with inability to wear a prosthesis. One commenter suggested that 10 percent be added in the absence of anatomical loss but with deformity and inability to wear a prosthesis. The evaluation criteria of diagnostic code 7800 would apply in this situation. The level of evaluation for deformity and inability to wear a prosthesis could be more or less than 10 percent, depending on the extent of disfigurement. However, to avoid pyramiding under 38 CFR 4.14 (''the evaluation of the same manifestation under different diagnoses [is] to be avoided''), an evaluation under diagnostic code 7800 would preclude an additional 10 percent for the same deformity under § 4.75. We have decided to also specify in § 4.75(e) that the 10-percent increase in evaluation under that provision for anatomical loss of one eye with inability to wear a prosthesis precludes an evaluation under diagnostic code 7800 based on gross distortion or asymmetry of the eye.

We made nonsubstantive revisions to proposed § 4.75(b), (c), (d), (e), and (f) to improve clarity.

Section 4.76 Visual Acuity

We proposed to delete § 4.83, which stated that a person not able to read at any one of the scheduled steps or distances, but able to read at the ''next scheduled step or distance,'' is to be rated as reading at this latter step or distance. A commenter noted that this rule is vital for determining whether to select the higher or lower evaluation and recommended that we retain § 4.83. In our view, an adjudicator could simply refer to 38 CFR 4.7 to determine the correct evaluation. However, we will retain this instruction to promote consistency of evaluations. We have included the following language in § 4.76(b) at § 4.76(b)(4): ''To evaluate the impairment of visual acuity where a claimant has a reported visual acuity that is between two sequentially listed visual acuities, use the visual acuity which permits the higher evaluation.''

We proposed that visual acuity would generally be evaluated on the basis of corrected distance vision. One commenter suggested that because VA policy is to rate on central acuity, not eccentric viewing, we should revise the proposed language of § 4.76(b)(1) to clarify that even when a central scotoma is present, central visual acuity is evaluated based upon best corrected distance vision with central fixation. We agree that central visual acuity should be emphasized. To assure consistency of evaluation and eliminate the variability that could result if eccentric vision were tested, we have revised the language of proposed § 4.76(b)(1) according to the commenter's suggestion. For the sake of consistency, we have also added ''central'' to § 4.76(a) before ''*uncorrected* and *corrected* visual acuity''.

Another commenter asked how visual acuity is determined if central fixation is not possible. Visual acuity can be determined in these cases by optometrists and ophthalmologists, because they are routinely trained in special methods and techniques that allow them to assess visual acuity and/or function when there is loss of central fixation. Thus, central visual acuity can still be used to rate visual impairment, even if central fixation is impossible.

In § 4.76(b)(1), we proposed to amend how we evaluate visual acuity where there is a significant difference in the lens required to correct distance vision in the poorer eye compared to the lens required to correct distance vision in the better eye. We proposed to evaluate the visual acuity of the poorer eye using 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. This provision reduced the diopter difference required for application of this provision from the current requirement of more than four diopters to a requirement of more than three diopters. We proposed to reduce the diopter difference because at more than three diopters there is a significant possibility that a claimant will have visual difficulties. However, we have learned that even reducing the diopter difference required for application of this provision from more than four diopters to more than three diopters may still not assure that the individual's brain will be able to ''fuse'' the two differently sized images. The inability to do so results in an intolerable optical correction from clinically significant aniseikonia (where the ocular image of an object as seen by one eye differs in size and shape from that seen by the other).

Therefore, we have decided to remove the language ''by a lens that does not

differ by more than three diopters from the lens needed for correction of the other eye.'' By permitting evaluation based on either uncorrected vision or corrected vision without specifying the refractive power of the lens, we can accommodate both individuals who do experience visual difficulty when wearing such different lenses and individuals who do not experience visual difficulty.

Further, we have added to § 4.76(b)(1) language stating, ''and either the poorer eye or both eyes are service connected'' to emphasize VA's authority to service connect unilateral visual impairment. This additional language clarifies that VA evaluators must apply this provision whether disability of either only one eye (the poorer eye) or both eyes is service-connected.

We made nonsubstantive revisions to proposed § 4.76(a), (b)(1), (b)(2) and (b)(3) to improve clarity.

Section 4.76a Computation of Average Concentric Contraction of Visual Fields

We proposed to remove § 4.76a because directions for evaluating visual fields were revised and moved to § 4.77. The proposed rule did not make it clear whether or not Table III and Figure 1, which are part of § 4.76a, were to be retained. Table III lists the normal degrees of the visual field at the eight principal meridians and also gives an example of computing concentric contraction of abnormal visual fields. One commenter suggested that we retain the example of computing visual fields because it is useful for understanding the material on average concentric contraction. We agree, and although we have deleted from § 4.76a the text preceding Table III, we have retained Table III (including the example) and Figure 1 in the final rule.

Section 4.77 Visual Fields

Proposed § 4.77(a) stated that 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/4e)). It required that at least 16 meridians 221/2 degrees apart be charted for each eye. Table III listed the normal extent of the visual fields (in degrees) at the 8 principal meridians (45 degrees apart). It also stated that the examination must be supplemented by the use of a tangent screen when the examiner indicates it is necessary.

The preamble to the proposed rule also stated that 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. One commenter suggested that VA's disability examination worksheet for the eye also specify the use of a Goldmann kinetic perimeter or equivalent kinetic examination method.

After the proposed rule was published, software programs for automated perimetry were developed that completely simulate results from Goldmann perimetry and can be charted on standard Goldmann charts. The Compensation and Pension Service, after consultation with the Veterans Health Administration's Chiefs of Ophthalmology and Optometry, sent a letter (FL06–21) on November 8, 2006, to the Veterans Benefits Administration regional offices stating that Humphrey Model 750, Octopus Model 101, and later versions of these perimetric devices with simulated kinetic Goldmann testing capability are acceptable devices for determining the extent of visual field loss for compensation and pension eye rating examinations.

Therefore, we have changed proposed § 4.77(a) to indicate that examiners must assess visual fields using either Goldmann kinetic perimetry or automated perimetry using Humphrey Model 750, Octopus Model 101, or later versions of these perimetric devices with simulated kinetic Goldmann testing capability. We also clarified the directions about the Goldmann equivalent that must be used for phakic (normal), aphakic, and pseudophakic individuals. The content of the disability examination worksheets is beyond the scope of this rulemaking, and we make no change based on the comment about the worksheet.

We proposed to evaluate visual fields by using a Goldmann kinetic perimeter or equivalent kinetic method, using a standard target size and luminance (Goldmann's equivalent (III/4e)). That Goldmann equivalent is useful for evaluating visual fields except in certain cases where a larger equivalent size is needed. We have therefore clarified the use of Goldmann equivalents in the final rule by revising proposed § 4.77(a) to state that, for phakic (normal) individuals, as well as for pseudophakic or aphakic individuals who are well adapted to intraocular lens implant or contact lens correction, visual field examinations must be conducted using a standard target size and luminance, which is Goldmann's equivalent III/4e. For aphakic individuals not well adapted to contact lens correction or pseudophakic individuals not well adapted to intraocular lens implant, visual field examinations must be conducted using Goldmann's equivalent IV/4e.

Proposed § 4.77(a) stated that ''[a]t least two recordings of visual fields must be made'' for purposes of VA's disability evaluations. We have learned from vision specialists that this is not necessary and is not standard procedure, since the visual field outline is determined by testing multiple objects along each meridian. Therefore, we have removed the language requiring ''two recordings'' as unnecessary. In conjunction with this change, we have also removed the proposed statement that the confirmed visual fields must be made a part of the examination report. Instead, we have stated in § 4.77(a) that in all cases, the results of visual field examinations must be recorded on a standard Goldmann chart. We additionally require that the Goldmann chart be included with the examination report.

Proposed § 4.77(a) also said that the examination must be supplemented by the use of a tangent screen when the examiner indicates it is necessary. We have determined that a 30-degree threshold visual field with the Goldmann III stimulus size could be used in lieu of a tangent screen. This test provides information similar to the tangent screen. For this reason, the final rule provides that adjudicators must consider either of these two tests when additional testing of visual fields becomes necessary, and requires that the examination report include either the tracing of the tangent screen or the tracing of the 30-degree threshold visual field.

We made further nonsubstantive revisions to proposed § 4.77(a), (b), and (c) to improve clarity.

Section 4.78 Muscle Function

In proposed § 4.78(b)(1), we provided guidance concerning the evaluation of diplopia, and proposed that adjudicators assign an evaluation for diplopia for only one eye. Further, we proposed that where a claimant has both diplopia and decreased visual acuity or a visual field defect, the corrected visual acuity for the poorer eye (or the affected eye, if only one eye is service-connected) is deemed to be, depending on the severity of the diplopia, between one and three steps poorer, provided that the adjusted level of corrected visual acuity does not exceed 5/200. Using the adjusted visual acuity for the poorer eye (or the affected eye) and the corrected visual acuity for the better eye, we proposed that the claimant's visual impairment be evaluated under diagnostic codes 6064 through 6066.

Proposed diagnostic code 6064 refers to light perception only (LPO), which exceeds a visual acuity level of 5/200. Hence, an evaluation under diagnostic code 6064 is not permitted under § 4.78(b). Therefore, in § 4.78(b)(1) we have omitted reference to diagnostic code 6064.

We proposed not to retain in § 4.78(b)(1) the rule from former § 4.77 (Examination of muscle function) which stated that ''[d]iplopia which is only occasional or correctable is not considered a disability,'' since it pertains to the issue of service connection rather than evaluation. Section 4.78(b)(1) addresses evaluation of muscle function rather than service connection. One commenter stated that this rule provides useful guidance to adjudicators considering claims for service connection for diplopia. In response to this comment, and because disease of or injury to one or more extraocular eye muscles may cause diplopia which is occasional or correctable, rather than including this language in § 4.78(b)(1), we have added a note under diagnostic code 6090 (diplopia) stating that in accordance with 38 CFR 4.31, diplopia that is occasional or that is correctable with spectacles is evaluated at 0 percent. This would clarify how to evaluate diplopia with these characteristics.

In order to remove any doubt about the difference between § 4.78(b)(2), which explains how to evaluate diplopia that is present in more than one quadrant or range of degrees, and § 4.78(b)(3), which explains how to evaluate diplopia that exists in two separate areas of the same eye, we have changed the language of § 4.78(b)(2) from ''[w]hen diplopia is present in more than one quadrant,'' as proposed, to ''[w]hen diplopia extends beyond more than one quadrant''. This is similar to the language in the current rating schedule and will ensure a clear distinction between these provisions.

We made nonsubstantive revisions to proposed § 4.78 (a) and (b) to improve clarity.

Section 4.79 Schedule of Ratings—Eye

We proposed to evaluate angle-closure glaucoma (diagnostic code 6012), which often presents as a red, painful eye, sometimes accompanied by nausea and vomiting, either on the basis of visual impairment or on the basis of incapacitating episodes, whichever results in a higher evaluation. We proposed to evaluate open-angle glaucoma (diagnostic code 6013), which generally presents as painless, chronic, progressive loss of vision, solely on the basis of visual impairment because open-angle glaucoma is unlikely to result in incapacitating episodes.

One commenter questioned why angle-closure glaucoma based on incapacitating episodes does not include a 10-percent evaluation for incapacitating episodes of at least 1 week, but less than 2 weeks total duration per year, when diagnostic codes 6000 through 6009 provide for such an evaluation. Under the proposed rule, a minimum evaluation of 10 percent would be assigned for angle-closure glaucoma if continuous medication is required. In our view, virtually all claimants with symptomatic angle-closure glaucoma would require continuous medication, which would entitle them to a minimum 10-percent evaluation. Therefore, we did not propose a 10-percent evaluation based on incapacitating episodes. We make no change based upon this comment.

One commenter suggested that we evaluate both angle-closure and open-angle glaucoma on the basis of visual field loss or central visual acuity impairment, whichever results in a higher evaluation. Section 4.75(a) states that the evaluation of visual impairment is based on impairment of visual acuity (excluding developmental errors of refraction), visual field, and muscle function. All three elements of visual impairment may be present in glaucoma, although visual field loss is most common. Not only would the commenter's suggestion limit the rating possibilities to two of the three elements of visual impairment, it also would not allow for evaluation of angle-closure glaucoma based on incapacitating episodes. Section 4.75(b) states that eye examinations must be conducted by a licensed optometrist or ophthalmologist, and such specialists are unlikely to overlook a visual field defect or any other type of visual impairment in an individual with glaucoma. In our judgment, allowing evaluation to be based on any of the three elements of visual impairment or on incapacitating episodes is a fair way to assess glaucoma and to assure that the veteran is evaluated based on the disabling effects that provide the higher benefit. We have therefore not adopted the commenter's suggestion.

We proposed that certain eye disabilities be evaluated either on visual impairment or on incapacitating episodes, whichever results in a higher evaluation. We proposed to define an incapacitating episode as a period of acute symptoms severe enough to require bed rest and treatment by a physician or other healthcare provider.

One commenter suggested that the rating formula based on incapacitating episodes—60 percent if there are incapacitating episodes of at least 6 weeks total duration per year, 40 percent if there are incapacitating episodes of at least 4 weeks, but less than 6 weeks, total duration per year, etc.—is miserly because a veteran will be compensated only for visual impairment or periods of incapacitation, but not both, and with less than bedrest, the veteran receives nothing.

In most eye diseases, visual impairment will be the major problem and therefore the more common basis of evaluation. With modern medical and surgical treatment, few patients require bedrest of any duration for eye disease. However, an evaluation based on incapacitating episodes might be higher in those few cases in which bedrest might be required, e.g., angle-closure glaucoma with severe pain, nausea, and vomiting. If bedrest is not required, evaluation is based on visual impairment. The evaluations based on visual impairment and those based on incapacitating episodes are both meant to account for the average occupational impairment. Providing alternative criteria allows the rater to evaluate using the set of criteria more favorable to the veteran.

The same commenter asked why there is a maximum evaluation of 60 percent for incapacitating episodes.

As stated above, with modern medical and surgical treatment, very few, if any, veterans will experience incapacitating episodes of more than 6 weeks total duration per year due to eye disease. However, for any who do, 38 CFR 4.16(a), which provides for a total evaluation based on individual unemployability, and 38 CFR 3.321(b)(1), which provides for extra-schedular evaluations in cases where an evaluation is inadequate because the condition presents such an unusual disability picture that applying the regular schedular standards would be impractical, provide reasonable alternatives for assigning an evaluation greater than 60 percent. In our judgment, the range of evaluations we have provided based on incapacitating episodes of eye disease will adequately compensate veterans, and a 100-percent evaluation level based on incapacitating episodes is not warranted.

Conditions evaluated on the basis of incapacitating episodes are entitled to a 60-percent evaluation when the claimant has experienced at least 6 weeks of incapacitating episodes over the preceding 12 months. One commenter suggested that, in some cases, an adjudicator would not be able

to assign the maximum 60-percent evaluation until after the passage of an entire year, and felt that evaluations based upon incapacitating episodes should be retroactive to the date of the first incapacitating episode, regardless of when it occurred.

By statute (38 U.S.C. 5110(a)), except as otherwise provided, the effective date of an award of compensation will be fixed in accordance with the facts but not before the date of receipt of the claim. Furthermore, an award of increased compensation will be effective the earliest date it is ascertainable that an increase in disability occurred if application is received within 1 year of that date. 38 U.S.C. 5110(b)(2). Otherwise, the effective date is the date the claim was received. 38 CFR 3.400(o)(2). We are aware of no special provisions that would apply to the evaluation of incapacitating episodes of the eye. Under governing law, entitlement to a 60-percent rating would not arise until 6 weeks of incapacitating episodes have taken place, and the effective date could not be established before then. Once the claimant has experienced 6 weeks of incapacitating episodes, the 60-percent evaluation will be assigned, even if the evaluation occurs within several months of the initial incapacitating episode. In cases where it takes the entire 12-month period for a claimant to experience 6 weeks of incapacitating episodes, the 60-percent evaluation will be assigned at that time. However, during the interim, a rating corresponding to the total duration of incapacitating episodes already experienced may be assigned. That is to say, once 1 week of incapacitating episodes is experienced, a 10-percent rating may be assigned; once 2 weeks of incapacitating episodes are experienced, a 20-percent rating may be assigned; etc. We make no change based on this comment.

The proposed criteria based on incapacitating episodes referred to the total duration of incapacitating episodes ''per year''. To clarify that we mean during the preceding 12-month period, and not the calendar year, we have changed this language to refer to incapacitating episodes ''during the past 12 months''. This language is consistent with other provisions in the rating schedule that evaluate incapacitating episodes (e.g., diagnostic code 5243, intervertebral disc syndrome, and diagnostic code 7354, hepatitis C). We are also adding language to indicate that bed rest must be prescribed by a physician to the notes following diagnostic codes 6000 through 6009 and diagnostic code 6012 of the rating schedule. This clarifies VA's intent in the proposed rule and makes a nonsubstantive change for clarification purposes.

One commenter asked for clarification as to whether the absence of light perception is to be evaluated as anatomical loss of one eye (diagnostic code 6063) or light perception only (diagnostic code 6064).

Section 4.75(d) states that the evaluation for visual impairment of one eye must not exceed 30-percent unless there is anatomical loss of the eye. This is clear and straightforward and names no exceptions. Therefore, in evaluating visual acuity of one eye, no light perception is evaluated the same as light perception only. To avoid confusion, we have revised the titles of diagnostic codes 6062 to ''No more than light perception in both eyes'' and 6064 to ''No more than light perception in one eye.''

As previously discussed under one of the comments about diplopia, we have added a note to diagnostic code 6090 stating that occasional or correctable diplopia will be evaluated as 0-percent disabling.

One commenter asked that we clarify whether the use of an eye patch for diplopia warrants special monthly compensation (SMC) (*see* 38 CFR 3.350) for loss or loss of use of an eye. Since the eye is present when an eye patch is used for diplopia, SMC for loss of an eye is not warranted. Visual impairment due to diplopia is determined without the eye patch, and it could be at any level of severity, so SMC for loss of use of an eye is also not warranted. The fact that the eye is not being used when it is patched does not necessarily mean it cannot be used, which would be required for loss of use.

We use the word ''alternatively'' instead of the proposed ''otherwise'' in diagnostic code 6011 for clarity and add ''if this would result in a higher evaluation'' for further guidance. We use similar language in diagnostic code 6081 for the same purpose. We additionally edited the proposed criteria for evaluating malignant neoplasms of the eyeball (diagnostic code 6014) for the sake of clarity.

VA appreciates the comments submitted in response to the proposed rule. Based on the rationale stated in the proposed rule and in this document, the proposed rule is adopted as final with the changes noted.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any year. This final rule would have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

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

Executive Order 12866

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). The Executive Order classifies a ''significant regulatory action,'' requiring review by the Office of Management and Budget (OMB) unless OMB waives such review, as any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

The economic, interagency, budgetary, legal, and policy implications of this final rule has been examined, and it has been determined to be a significant regulatory action under the Executive Order because it is likely to result in a rule that may raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This final rule would not affect any small entities. Only VA beneficiaries could be directly

affected. Therefore, pursuant to 5 U.S.C. 605(b), this final rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance Numbers and Titles

The Catalog of Federal Domestic Assistance program numbers and titles are 64.104, Pension for Non-Service-Connected Disability for Veterans, and 64.109, Veterans Compensation for Service-Connected Disability.

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

Approved: August 6, 2008.

Gordon H. Mansfield,

Deputy Secretary of Veterans Affairs.

■ For the reasons set out in the preamble, 38 CFR part 4, subpart B, 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, unless otherwise noted.

Subpart B—Disability Ratings

■ 2. Section 4.75 is 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.* The examination must be conducted by a licensed optometrist or by a licensed ophthalmologist. The examiner must identify the disease, injury, or other pathologic process responsible for any visual impairment found. Examinations 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. Unless medically contraindicated, the fundus must be examined with the claimant's pupils dilated.

(c) *Service-connected visual impairment of only one eye.* Subject to the provisions of 38 CFR 3.383(a), if visual impairment of only one eye is service-connected, the visual acuity of the other eye will be considered to be 20/40 for purposes of evaluating the service-connected visual impairment.

(d) *Maximum evaluation for visual impairment of one eye.* The evaluation for visual impairment of one eye must not exceed 30 percent unless there is anatomical loss of the eye. Combine the evaluation for visual impairment of one eye with evaluations for other disabilities of the same eye that are not based on visual impairment (e.g., disfigurement under diagnostic code 7800).

(e) *Anatomical loss of one eye with inability to wear a prosthesis.* When the claimant has anatomical loss of one eye and is unable to wear a prosthesis, increase the evaluation for visual acuity under diagnostic code 6063 by 10 percent, but the maximum evaluation for visual impairment of both eyes must not exceed 100 percent. A 10-percent increase under this paragraph precludes an evaluation under diagnostic code 7800 based on gross distortion or asymmetry of the eye but not an evaluation under diagnostic code 7800 based on other characteristics of disfigurement.

(f) *Special monthly compensation.* When evaluating visual impairment, refer to 38 CFR 3.350 to determine whether the claimant 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. 1114 and 1155)

■ 3. Section 4.76 is revised to read as follows:

§ 4.76 Visual acuity.

(a) *Examination of visual acuity.* Examination of visual acuity must include the central *uncorrected* and *corrected* visual acuity for *distance* and *near* vision using Snellen's test type or its equivalent.

(b) *Evaluation of visual acuity.* (1) Evaluate central visual acuity on the basis of corrected distance vision with central fixation, even if a central scotoma is present. 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), and either the poorer eye or both eyes are service connected, evaluate the visual acuity of the poorer eye using either its uncorrected or corrected visual acuity, whichever results in better combined visual acuity.

(2) Provided that he or she customarily wears contact lenses, 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 an explanation of the reason for the difference. In these cases, evaluate based on corrected distance vision adjusted to one step poorer than measured.

(4) To evaluate the impairment of visual acuity where a claimant has a reported visual acuity that is between two sequentially listed visual acuities, use the visual acuity which permits the higher evaluation.

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

■ 4. In § 4.76a, remove the introductory text, retain Table III—Normal Visual Field Extent at 8 Principal Meridians, retain Figure 1. Chart of visual field showing normal field right eye and abnormal contraction visual field left eye and the text and table following Figure 1, and add an authority citation at the end of the section to read as follows.

§ 4.76a Computation of average concentric contraction of visual fields.

* * * * *

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

■ 5. Section 4.77 is amended by:
■ a. Revising the section heading.
■ b. Removing the introductory text and adding, in its place, paragraphs (a), (b), and (c).
■ c. Retaining Figure 2. Goldmann Perimeter Chart.
■ d. Adding an authority citation at the end of the section.

The additions read as follows:

§ 4.77 Visual fields.

(a) *Examination of visual fields.* Examiners must use either Goldmann kinetic perimetry or automated perimetry using Humphrey Model 750, Octopus Model 101, or later versions of these perimetric devices with simulated kinetic Goldmann testing capability. For phakic (normal) individuals, as well as for pseudophakic or aphakic individuals who are well adapted to intraocular lens implant or contact lens correction, visual field examinations must be conducted using a standard target size

and luminance, which is Goldmann's equivalent III/4e. For aphakic individuals not well adapted to contact lens correction or pseudophakic individuals not well adapted to intraocular lens implant, visual field examinations must be conducted using Goldmann's equivalent IV/4e. In all cases, the results must be recorded on a standard Goldmann chart (see Figure 1), and the Goldmann chart must be included with the examination report. The examiner must chart at least 16 meridians 22½ degrees apart for each eye and indicate the Goldmann equivalent used. See Table III for the normal extent (in degrees) of the visual fields at the 8 principal meridians (45 degrees apart). When the examiner indicates that additional testing is necessary to evaluate visual fields, the additional testing must be conducted using either a tangent screen or a 30-degree threshold visual field with the Goldmann III stimulus size. The examination report must then include the tracing of either the tangent screen or of the 30-degree threshold visual field with the Goldmann III stimulus size.

(b) *Evaluation of visual fields.* Determine the average concentric contraction of the visual field of each eye 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 and are service connected, separately evaluate the visual acuity and visual field defect (expressed as a level of visual acuity), and combine them under the provisions of § 4.25.

* * * * *

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

■ 6. Section 4.78 is revised to read as follows:

§ 4.78 Muscle function.

(a) *Examination of muscle function.* The examiner must use a Goldmann perimeter chart that identifies the four major quadrants (upward, downward, left and right lateral) and the central field (20 degrees or less) (see Figure 2). The examiner must chart the areas of diplopia and include the plotted chart with the examination report.

(b) *Evaluation of muscle function.* (1) An evaluation for diplopia will be assigned to only one eye. When a claimant has both diplopia and decreased visual acuity or visual field defect, assign a level of corrected visual acuity for the poorer eye (or the affected eye, if disability of 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; or three steps poorer if the evaluation under diagnostic code 6090 is 5/200. This adjusted level of corrected visual acuity, however, must not exceed a level of 5/200. Use the adjusted visual acuity for the poorer eye (or the affected eye, if disability of only one eye is service-connected), and the corrected visual acuity for the better eye (or visual acuity of 20/40 for the other eye, if only one eye is service-connected) to determine the percentage evaluation for visual impairment under diagnostic codes 6065 through 6066.

(2) When diplopia extends beyond more than one quadrant or range of degrees, evaluate diplopia based on the quadrant and degree range that provides the highest evaluation.

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

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

■ 7. Section 4.79 is revised to read as follows:

§ 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	
Evaluate on the basis of either visual impairment due to the particular condition or on incapacitating episodes, whichever results in a higher evaluation.	
With incapacitating episodes having a total duration of at least 6 weeks during the past 12 months	60
With incapacitating episodes having a total duration of at least 4 weeks, but less than 6 weeks, during the past 12 months	40
With incapacitating episodes having a total duration of at least 2 weeks, but less than 4 weeks, during the past 12 months	20
With incapacitating episodes having a total duration of at least 1 week, but less than 2 weeks, during the past 12 months	10
Note: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician or other healthcare provider.	
6010 Tuberculosis of eye:	
Active	100
Inactive: Evaluate 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
Alternatively, evaluate based on visual impairment due to retinal scars, atrophy, or irregularities, if this would result in a higher evaluation.	
6012 Angle-closure glaucoma:	
Evaluate on the basis of either visual impairment due to angle-closure glaucoma or incapacitating episodes, whichever results in a higher evaluation.	
With incapacitating episodes having a total duration of at least 6 weeks during the past 12 months	60

DISEASES OF THE EYE—Continued

	Rating
With incapacitating episodes having a total duration of at least 4 weeks, but less than 6 weeks, during the past 12 months	40
With incapacitating episodes having a total duration of at least 2 weeks, but less than 4 weeks, during the past 12 months	20
Minimum evaluation if continuous medication is required	10
Note: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician or other healthcare provider.	
6013 Open-angle glaucoma:	
Evaluate based on visual impairment due to open-angle glaucoma.	
Minimum evaluation if continuous medication is required	10
6014 Malignant neoplasms (eyeball only):	
Malignant neoplasm of the eyeball that 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	100
Note: Continue the 100-percent rating 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 will be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination will be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, evaluate based on residuals.	
Malignant neoplasm of the eyeball that does not require therapy comparable to that for systemic malignancies:	
Separately evaluate visual impairment and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations.	
6015 Benign neoplasms (of eyeball and adnexa):	
Separately evaluate visual impairment and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations.	
6016 Nystagmus, central	10
6017 Trachomatous conjunctivitis:	
Active: Evaluate based on visual impairment, minimum	30
Inactive: Evaluate based 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 based on residuals, such as visual impairment and disfigurement (diagnostic code 7800).	
6019 Ptosis, unilateral or bilateral:	
Evaluate based on visual impairment or, in the absence of visual impairment, 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.):	
Bilateral	20
Unilateral	10
6026 Optic neuropathy:	
Evaluate based on visual impairment.	
6027 Cataract of any type:	
Preoperative:	
Evaluate based on visual impairment.	
Postoperative:	
If a replacement lens is present (pseudophakia), evaluate based on visual impairment. If there is no replacement lens, evaluate based on aphakia.	
6029 Aphakia or dislocation of crystalline lens:	
Evaluate based 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 (cranial nerve III)).	20
6032 Loss of eyelids, partial or complete:	
Separately evaluate both visual impairment due to eyelid loss and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations.	
6034 Pterygium:	
Evaluate based on visual impairment, disfigurement (diagnostic code 7800), conjunctivitis (diagnostic code 6018), etc., depending on the particular findings.	
6035 Keratoconus:	
Evaluate based on impairment of visual acuity.	
6036 Status post corneal transplant:	
Evaluate based on visual impairment.	
Minimum, if there is pain, photophobia, and glare sensitivity	10
6037 Pinguecula:	
Evaluate based on disfigurement (diagnostic code 7800).	

DISEASES OF THE EYE—Continued

	Rating
Impairment of Central Visual Acuity	
6061 Anatomical loss of both eyes [1]	100
6062 No more than light perception 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 No more than light perception 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
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 38 CFR 3.350.

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 evaluate each affected eye as 20/70 (6/21).	
Loss of nasal half of visual field:	
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15).	
Loss of inferior half of visual field:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21).	
Loss of superior half of visual field:	
Bilateral	10
Unilateral	10
Or evaluate 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 evaluate each affected eye as 5/200 (1.5/60).	
With remaining field of 6 to 15 degrees:	
Bilateral	70
Unilateral	20
Or evaluate each affected eye as 20/200 (6/60).	
With remaining field of 16 to 30 degrees:	
Bilateral	50
Unilateral	10
Or evaluate each affected eye as 20/100 (6/30).	
With remaining field of 31 to 45 degrees:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21).	
With remaining field of 46 to 60 degrees:	
Bilateral	10
Unilateral	10
Or evaluate 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
Alternatively, evaluate based on visual impairment due to scotoma, if that would result in a higher evaluation.	

[1] Review for entitlement to special monthly compensation under 38 CFR 3.350.

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)
Note: In accordance with 38 CFR 4.31, diplopia that is occasional or that is correctable with spectacles is evaluated at 0 percent.	
6091 Symblepharon:	
Evaluate based on visual impairment, lagophthalmos (diagnostic code 6022), disfigurement (diagnostic code 7800), etc., depending on the particular findings.	

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

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

■ 8. Sections 4.80, 4.83, and 4.84 are removed and reserved.

§§ 4.83a and 4.84a [Removed]

■ 9. Sections 4.83a and 4.84a are removed.

[FR Doc. E8–26304 Filed 11–7–08; 8:45 am]

BILLING CODE 8320–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R03–OAR–2008–0068; FRL–8738–3]

Approval and Promulgation of Air Quality Implementation Plans; Delaware; Control of Stationary Combustion Turbine Electric Generating Unit Emissions

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is approving a State Implementation Plan (SIP) revision submitted by the State of Delaware. This revision pertains to controlling nitrogen oxides (NO_X) emissions from stationary combustion turbine (CT) electric generating units (EGUs). EPA is approving this SIP revision in accordance with the Clean Air Act (CAA).

DATES: *Effective Date:* This final rule is effective on December 10, 2008.

ADDRESSES: EPA has established a docket for this action under Docket ID Number EPA–R03–OAR–2008–0068. All documents in the docket are listed in the *http://www.regulations.gov* Web site. Although listed in the electronic docket, some information is not publicly available, i.e., confidential business information (CBI) or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through *http://www.regulations.gov* or in hard copy for public inspection during normal business hours at the Air Protection Division, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103. Copies of the State submittal are available at the Delaware Department of Natural Resources & Environmental Control, 89 Kings Highway, P.O. Box 1401, Dover, Delaware 19903.

FOR FURTHER INFORMATION CONTACT: Gerallyn Duke (215) 814–2084, or by e-mail at *duke.gerallyn@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

On July 14, 2008 (73 FR 40228), EPA published a notice of proposed rulemaking (NPR) for the State of Delaware. The NPR proposed approval of the Regulation 1148—Control of Stationary Combustion Turbine Electric Generating Unit Emissions. The formal SIP revision was submitted by the State of Delaware on September 11, 2007.

II. Summary of SIP Revision

Regulation 1148 requires that an owner or operator of an existing stationary combustion turbine electric generating unit located in Delaware with a base-load nameplate capacity of 1 megawatt (MW) or greater must, by May 1, 2009, either demonstrate that the existing stationary combustion turbine generating unit meets the emission limits listed below or must install NO_X emission controls designed to meet these limits:

- For CTs that burn gaseous fuel—42 parts per million volume (ppmv) NO_X.
- For CTs that burn liquid fuel—88 ppmv NO_X.

Design of these limits was based on anticipated NO_X emissions if water injection pollution control equipment were installed. The six CTs affected by this regulation operate without any NO_X pollution control equipment, although they are subject to regulations designed to control NO_X emissions. Delaware determined that the six sources could achieve significant reductions in their NO_X emissions through the use of water injection equipment. EPA has previously recognized this equipment and technology as reasonably available control technology (RACT). Water injection is a proven, feasible technology that has been used in other states to reduce NO_X emissions.

This revision will reduce NO_X emissions from CTs by 40 percent, or by 0.88 tons per day to approximately 1.33 tons per day. Such a reduction will significantly improve air quality, particularly on days when CTs normally operate, i.e., hot humid days and when weather conditions are conducive to forming ground-level ozone, and is one of the many regulatory steps taken to allow Delaware to attain the National Ambient Air Quality Standards (NAAQS) by 2010.

Other specific requirements of Regulation 1148 and the rationale for EPA's proposed action are explained in the NPR and will not be restated here. No public comments were received on the NPR.

III. Final Action

EPA is approving Regulation 1148—Control of NO_X Emissions from Stationary Combustion Turbine Electric Generating Units as a revision to the Delaware SIP.

IV. Statutory and Executive Order Reviews

A. General Requirements

Under the Clean Air Act, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. Accordingly, this action merely approves state law as meeting Federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this action:

- Is not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et. seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et. seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the Clean Air Act; and
- Does not provide EPA with the discretionary authority to address, as