

ineffective or unacceptable without a change.

Dated: September 15, 1995.

J.E. Shkor,

U.S. Coast Guard Chief Counsel.

FR Doc. 95-23518 Filed 9-21-95; 8:45 am]

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900-AF02

Schedule for Rating Disabilities; Hemic and Lymphatic Systems

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the Department of Veterans Affairs' (VA) Schedule for Rating Disabilities of the Hemic and Lymphatic Systems. The effect of this action is to update the hemic and lymphatic portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances that have occurred since the last review.

DATES: This amendment is effective October 23, 1995.

FOR FURTHER INFORMATION CONTACT:

Don England, Chief, Regulations Staff, Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 1800 G Street, Washington, DC, 20420, (202) 273-7210.

SUPPLEMENTARY INFORMATION: In the Federal Register of April 30, 1993, (58 FR 26080-83) VA published a proposal to amend the Schedule for Rating Disabilities of the hemic and lymphatic systems. Interested persons were invited to submit written comments, suggestions or objections on or before June 1, 1993. We received comments from the Veterans of Foreign Wars, the Disabled American Veterans, the Paralyzed Veterans of America and one comment from a concerned individual.

We proposed to reduce the evaluation for splenectomy, diagnostic code 7706, from 30 percent to 10 percent. Several commenters felt, for various reasons, that the evaluation for splenectomy should be more than 10 percent.

One commenter agreed that antibiotics may compensate for any increased susceptibility to infection, but was not persuaded that medical treatment is so effective that disabling consequences of splenectomy are nearly eliminated. He maintained that asplenic

patients require vigilant medical intervention to ward off infections. Another commenter suggested that after splenectomy, patients must carefully avoid activities that may result in trauma and avoid exposure to infection, and that these environmental restrictions substantially limit the range of vocational possibilities, resulting in industrial impairment greater than the 10 percent proposed for this disability. A third commenter stated that since he has undergone a splenectomy, employers have turned him down due to high risk and that his life insurance is more expensive.

On reconsideration, we have determined that an evaluation of 20 percent is warranted instead of 10 percent because of the many functions that the spleen performs in the areas of immune response, filtration of the blood, iron reutilization, blood volume regulation and others, and that splenectomy increases susceptibility to certain infections, such as those caused by encapsulated pneumococcus bacteria. This increased susceptibility requires that splenectomy patients restrict their activities, resulting in moderate industrial impairment, which we feel is consistent with the 20 percent level of disability. This level of disability is assigned throughout the rating schedule for "moderate" disability, for example, under the diagnostic codes for liver abscess (7313), pellagra (6315), resection of large intestine (7329) and erythromelalgia (7119).

One commenter stated that asplenia should be included in the evaluation criteria for sickle cell anemia. We do not agree. If removal of the spleen is necessary in the treatment of sickle cell anemia, the splenectomy will be evaluated separately under diagnostic code 7706, and combined.

One commenter assumed that complications of splenectomy such as anemia would be rated on the symptomatology demonstrated. He is correct and, for the sake of clarity, we have added a note instructing the rater to separately evaluate complications if they become manifest to a compensable degree.

One commenter felt that the 30 percent evaluation for splenectomy should be "grandfathered", and in fact it is. In section 103(a) of the Veterans' Benefits Programs Improvement Act of 1991 (Pub. L. 102-86) Congress modified 38 U.S.C. 1155 to provide that a readjustment to the rating schedule will not result in a reduction of any disability evaluation in effect on the date of the readjustment unless that disability has actually improved. Given

the permanent nature of a splenectomy, a 30 percent evaluation assigned under the prior rating schedule will be protected. The effect of this change is, therefore, prospective only.

One commenter felt that VA should contact all veterans who would be affected by the change in the evaluation of splenectomy, rather than requiring them to read the Federal Register.

Publication in the Federal Register is the legal means for any federal agency to notify the public of changes to regulations. Furthermore, since this change is prospective, taking the additional step of contacting asplenic veterans who are currently receiving benefits would serve no purpose since they will not be affected by this change in the regulation.

One commenter believed that there should be a note following the evaluation formula for anemia, diagnostic code 7700, instructing the rater to evaluate chronic residuals of the disease separately.

We agree and have added a note following the rating criteria for diagnostic code 7700, anemias, to instruct the rater to evaluate the complications of pernicious anemia, such as dementia or peripheral neuropathy, separately. These complications occur often enough that this instruction is warranted to ensure consistent evaluations. Furthermore, the note is consistent with instructions for other conditions throughout the schedule, such as lupus erythematosus, (diagnostic code 6350), leprosy (Hansen's Disease), (6302), and rheumatoid arthritis, (5002), which instruct the rater to evaluate residuals separately.

The proposed levels of evaluations for anemia, diagnostic code 7700, were based solely on hemoglobin levels. One commenter noted that the key determination in evaluating the degree of disability is not the laboratory value, but the primary diagnosis and compensatory level of the cardiovascular system. He felt, therefore, that the purely objective criteria of hemoglobin levels are inadequate for rating anemia unless clinical findings are also considered.

The normal level of hemoglobin differs by sex, with men having a higher level, on the average, than women. Individuals also vary in the possible compensatory mechanisms, such as tachycardia, brought to bear when anemia develops. Along with the level of hemoglobin, the speed of onset of the anemia helps determine the symptoms. We agree, therefore, that levels of hemoglobin in combination with clinical findings will allow a better

assessment of disability than either alone. We have revised the criteria to include clinical findings such as a weakness, easy fatigability, headaches, lightheadedness, or shortness of breath on mild exertion. We have also added a 10 percent evaluation because there are patients with a hemoglobin level of 10gm/100ml or less who also have symptoms such as weakness, easy fatigability or headaches. Those with a hemoglobin level of 10gm/100ml or less who are asymptomatic will be assigned a zero percent evaluation. This provides a clear separation between the requirements for the 10% and 0% levels since they require the same hemoglobin levels.

The proposed evaluation formulas for agranulocytosis, diagnostic code 7702, and aplastic anemia, diagnostic code 7716, provided for 100, 50 and zero percent evaluations. One commenter suggested that there should be a 60 percent evaluation level.

We have reviewed the proposed evaluation criteria for agranulocytosis (diagnostic code 7702) and aplastic anemia (diagnostic code 7716) and agree that a wider range of evaluation levels is warranted because of the range of possible manifestations of the conditions. We have, therefore, redesignated the evaluations proposed as 50 percent disabling for both of these disabilities as 60 percent disabling, and added 30 percent and 10 percent evaluation levels. The 30 percent levels are based on the number of transfusions required or infections that occur, and the 10 percent levels are based on the need for continuous medication for control. We have removed the 0 percent evaluation level because a noncompensable evaluation can always be assigned under § 4.31 of this section whenever the residuals required for a compensable evaluation are not shown. Retaining the 0 percent evaluation level would be redundant. These changes provide a realistic range of evaluations and clear guidelines for assigning those evaluations.

The proposed regulation provided an indefinite total evaluation for aplastic anemia, diagnostic code 7716, following bone marrow transplant, with mandatory VA examination six months following hospital discharge, with any change based on that examination subject to the provisions of § 3.105(e). This is consistent with other diseases of this type, such as malignancies, leukemia and anemia.

One commenter stated that the post-hospital stabilization period for aplastic anemia, diagnostic code 7716, should be one year, not six months. We do not concur. A person who has required

hospitalization for aplastic anemia would not be discharged unless stable, and it is reasonable to examine the patient six months thereafter to verify that the condition has indeed stabilized. The purpose of the VA examination six months after hospital discharge is to gather medical information regarding the actual level of disability. Therefore, there would be no possibility of an immediate reduction. Should the examination demonstrate that the condition remains totally disabling, the evaluation will not be changed.

The proposed evaluation formula for leukemia, diagnostic code 7703, includes instructions to otherwise rate as anemia (code 7700) or aplastic anemia (code 7716), whichever would result in the greater benefit, and a note instructing the rater to continue the 100 percent evaluation indefinitely following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedures, with a mandatory BA examination six months following hospital discharge.

One commenter stated that evaluations less than 100 percent for leukemia should not be based on diagnostic codes 7700 or 7716.

We do not agree. Using the evaluation criteria from other codes is common in the rating schedule and this is consistent with that practice. The symptoms and treatments in the criteria for anemia and aplastic anemia are the same as those for leukemia and the percentage levels reflect the amount of disability.

One commenter pointed out an inconsistency between the proposed criteria for a 100 percent evaluation and the NOTE: the NOTE establishes the length of time that a 100 percent evaluation will continue after surgery or the termination of radiation, chemotherapy or other therapeutic procedure, whereas the criteria for a 100 percent evaluation require "intensive treatment" such as periodic irradiation or transfusion. The language in the evaluation criteria was retained from the 1945 rating schedule. Since "intensive treatment" might be construed as being more restrictive than the language of the NOTE—an effect we did not intend—we have revised that language to indicate that a 100 percent evaluation will be assigned while the disease is active or during a treatment phase. That language not only eliminates the perceived disparity between the evaluation criteria and the Note under diagnostic code 7703, it is also consistent with the language in the evaluation criteria for Hodgkin's disease (diagnostic code 7709) and non-Hodgkin's lymphoma (7715).

We have reworded the NOTE following code 7703, leukemia, for clarity. No substantive change is intended.

One commenter stated that polycythemia vera, code 7704, warrants a higher evaluation than 40 percent if myelosuppressive therapy is necessary.

Polycythemia vera is a readily managed disorder in most patients that can remain asymptomatic for long periods. Although inadequate management of the red cell mass can result in both thrombotic and hemorrhagic complications, control of blood volume and viscosity with the use of phlebotomy, supplemented when indicated with the use of myelosuppression, can ensure most patients with polycythemia vera a prolonged period of relatively symptom-free survival. (*Cecil, Textbook of Medicine*, 19th edition, 1992, pages 925–29.) On the other hand, certain myelosuppressants, such as P32 and chlorambucil, can have severe side effects and possibly lead to the development of leukemia in polycythemia patients. On the basis of this comment, we have revised the evaluation criteria for polycythemia by adding a 100 percent evaluation during periods of myelosuppressive therapy and for three months after completion of the therapy. Further, we have revised the proposed criteria for the 40 percent evaluation, which will now be assigned when the condition is controlled by phlebotomy, and added a 10 percent evaluation. As a result, a total evaluation will be assigned when the disease is active and the patient is being treated with myelosuppressants, a 40 percent evaluation will be assigned when the disease is controlled with phlebotomy, and a 10 percent evaluation will be assigned when the condition is stabilized with or without medication. We have removed the 0 percent level since a noncompensable evaluation can be assigned under § 4.31 of this section at any time when required residuals are not shown. Retaining the 0 percent evaluation level would be redundant. In our judgment, these changes will provide evaluations which accurately reflect the levels of this disability.

The same commenter suggested that the frequency of phlebotomies should be evaluated the same as the frequency of blood transfusions for aplastic anemia (diagnostic code 7716).

Phlebotomy, the removal of blood, is a different procedure than transfusion, the injection of blood. Different risks are involved and the amount of time before symptoms are resolved is dramatically different. Phlebotomy provides rapid

remission of symptoms. Transfusions, on the other hand, may have to be repeated several times before the desired results are attained, and even then it may be days or weeks before symptoms completely disappear. For these reasons, we do not believe that phlebotomy warrants an evaluation equivalent to that assigned based on transfusions.

One commenter noted that hypertension and gout are common complications of polycythemia vera and suggested that in the note following the evaluation formula they be mentioned along with stroke and thrombotic disease as complications to be rated separately.

We agree and have included these additional conditions in the note following diagnostic code 7704, polycythemia vera.

One commenter, noting that the criteria for non-total ratings for thrombocytopenia under diagnostic code 7705 specify that there be no bleeding, suggested that the 100 percent evaluation be assigned during periods of active bleeding.

We agree and have revised the criteria for the 100 percent evaluation to require that there be active bleeding. When a patient with thrombocytopenia is actively bleeding, he or she would be under close medical supervision, unable to work and totally disabled. Requiring that there be active bleeding for the 100 percent evaluation level clearly separates the total evaluation from lower evaluations, which specifically require no bleeding.

One commenter suggested that there should be a total rating assigned for thrombocytopenia during an appropriate stabilization and observation period, with an examination to follow.

We do not concur. The periods of thrombocytopenic bleeding are relatively short, but require aggressive medical management. If the veteran requires prolonged hospitalization (over 21 days), a total evaluation would be assigned under the provisions of § 4.29. If medically indicated, a period of convalescence would be assigned under the provisions of § 4.30. Since an exacerbation of this severity is closely followed by a medical professional, records of observation and treatment which are normally available are adequate to evaluate any progression of the disease. If they are not, an examination would be requested.

One commenter stated that the convalescence periods for Hodgkin's disease, diagnostic code 7709, and non-Hodgkin's lymphoma, diagnostic code

7715, should not be reduced to six months.

The commenter appears to have misinterpreted the proposed rule to mean that a convalescent evaluation will be terminated six months after treatment has ceased. However, under the proposed change there cannot be a reduction at six months because the process of re-evaluation does not begin until that time. First, there must be a VA examination six months after completion of treatment. Then, if the results of that or any subsequent examination warrant a reduction in evaluation, the reduction will be implemented under the provisions of 38 CFR 3.105(e), which requires 60 days notice before VA reduces an evaluation and an additional 60 days notice before the reduced evaluation takes effect. The revision not only provides for a current examination to assure that all residuals are noted, but also offers the veteran more contemporaneous notice of any proposed action and expands the veteran's opportunity to present evidence shown that the proposed action should not be taken. In our judgment this method will better ensure that actual side-effects and recuperation times are taken into account because they will be noted on the required VA exam.

One commenter stated that the provisions for an examination six months after cessation of treatment as in Hodgkin's and non-Hodgkin's lymphoma should be applied under malignant neoplasms of the genitourinary system (code 7528) and the gynecological system (code 7627). The revisions of these systems have been made since this comment was received and the rating procedure of evaluating malignancies of these systems based on an examination six months following cessation of treatment was implemented.

We have made a number of editorial changes, primarily of syntax and punctuation, throughout the final rule. These changes are intended to clarify the rating criteria and represent no substantive amendment.

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. 601(b), this amendment is exempt from the initial and final regulatory flexibility

analysis requirements of sections 603 and 604.

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

List of Subjects in 38 CFR Part 4

Persons with Disabilities, Pensions, Veterans.

Approved: June 13, 1995.

Jesse Brown,

Secretary of Veterans Affairs.

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

PART 4—SCHEDULE FOR RATING DISABILITIES

1. The authority citation for part 4 is revised to read as follows:

Authority: 38 U.S.C. 1155.

Subpart B—Disability Ratings

2. Section 4.117 is revised to read as follows:

§ 4.117 Schedule of ratings—hemic and lymphatic systems.

	<i>Rating</i>
7700 Anemia, hypochromic-microcytic and megaloblastic, such as iron-deficiency and pernicious anemia:	
Hemoglobin 5gm/100ml or less, with findings such as high output congestive heart failure or dyspnea at rest	100
Hemoglobin 7gm/100ml or less, with findings such as dyspnea on mild exertion, cardiomegaly, tachycardia (100 to 120 beats per minute) or syncope (three episodes in the last six months)	70
Hemoglobin 8gm/100ml or less, with findings such as weakness, easy fatigability, headaches, lightheadedness, or shortness of breath	30
Hemoglobin 10gm/100ml or less with findings such as weakness, easy fatigability or headaches	10
Hemoglobin 10gm/100ml or less, asymptomatic	0

Rating

Note: Evaluate complications of pernicious anemia, such as dementia or peripheral neuropathy, separately.

7702 Agranulocytosis, acute:
 Requiring bone marrow transplant, or; requiring transfusion of platelets or red cells at least once every six weeks, or; infections recurring at least once every six weeks 100
 Requiring transfusion of platelets or red cells at least once every three months, or; infections recurring at least once every three months 60
 Requiring transfusion of platelets or red cells at least once per year but less than once every three months, or; infections recurring at least once per year but less than once every three months 30
 Requiring continuous medication for control 10

Note: The 100 percent rating for bone marrow transplant shall be assigned as of the date of hospital admission and shall continue with a mandatory VA examination six months following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

7703 Leukemia:
 With active disease or during a treatment phase 100
 Otherwise rate as anemia (code 7700) or aplastic anemia (code 7716), whichever would result in the greater benefit.

Note: The 100 percent rating shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. 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 recurrence, rate on residuals.

7704 Polycythemia vera:
 During periods of treatment with myelosuppressants and for three months following cessation of myelosuppressant therapy 100
 Requiring phlebotomy 40
 Stable, with or without continuous medication 10

Note: Rate complications such as hypertension, gout, stroke or thrombotic disease separately.

Rating

7705 Thrombocytopenia, primary, idiopathic or immune:
 Platelet count of less than 20,000, with active bleeding, requiring treatment with medication and transfusions 100
 Platelet count between 20,000 and 70,000, not requiring treatment, without bleeding 70
 Stable platelet count between 70,000 and 100,000, without bleeding 30
 Stable platelet count of 100,000 or more, without bleeding 0

7706 Splenectomy 20

Note: Rate complications such as systemic infections with encapsulated bacteria separately.

7707 Spleen, injury of, healed.
 Rate for any residuals.

7709 Hodgkin's disease:
 With active disease or during a treatment phase 100

Note: The 100 percent rating shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. 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.

7710 Adenitis, tuberculous, active or inactive.
 Rate under §§ 4.88c or 4.89 of this part, whichever is appropriate.

7714 Sickle cell anemia:
 With repeated painful crises, occurring in skin, joints, bones or any major organs caused by hemolysis and sickling of red blood cells, with anemia, thrombosis and infarction, with symptoms precluding even light manual labor 100
 With painful crises several times a year or with symptoms precluding other than light manual labor 60
 Following repeated hemolytic sickling crises with continuing impairment of health 30
 Asymptomatic, established case in remission, but with identifiable organ impairment 10

Note: Sickle cell trait alone, without a history of directly attributable pathological findings, is not a ratable disability. Cases of symptomatic sickle cell trait will be forwarded to the Director, Compensation and Pension Service, for consideration under § 3.321(b)(1) of this chapter.

Rating

7715 Non-Hodgkin's lymphoma:
 With active disease or during a treatment phase 100

Note: The 100 percent rating shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. 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.

7716 Aplastic anemia:
 Requiring bone marrow transplant, or; requiring transfusion of platelets or red cells at least once every six weeks, or; infections recurring at least once every six weeks 100
 Requiring transfusion of platelets or red cells at least once every three months, or; infections recurring at least once every three months 60
 Requiring transfusion of platelets or red cells at least once per year but less than once every three months, or; infections recurring at least once per year but less than once every three months 30
 Requiring continuous medication for control 10

Note: The 100 percent rating for bone marrow transplant shall be assigned as of the date of hospital admission and shall continue with a mandatory VA examination six months following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

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ENVIRONMENTAL PROTECTION AGENCY
40 CFR Part 228
[FRL-5300-4]
Ocean Dumping; Site Modifications and Site Dedesignation; Charleston, South Carolina
AGENCY: Environmental Protection Agency (EPA).
ACTION: Final rule.

SUMMARY: EPA today modifies the designation of an Ocean Dredged Material Disposal Site (ODMDS) and dedesignates another ODMDS in the