Paragraph 8. On page 13338 in amendatory instruction 23, paragraph (f)(6)(iii)(E) of § 31.303 was redesignated as paragraph (f)(6)(iii)(D) of § 31.303. Redesignated paragraph (f)(6)(iii)(D) is corrected to read as follows:

* * * * *

(f) * * *

(6) * * *

(iii) * * *

(D) *Waiver maximum.* A State may receive a waiver of termination of eligibility from the Administrator under paragraph (f)(6)(iii)(C) of this section for a combined maximum of four Formula Grant Awards through Fiscal Year 1993. No additional waivers will be granted.

* * * * *

John J. Wilson,

Deputy Administrator, Office of Juvenile Justice and Delinquency Prevention.

[FR Doc. 95–9826 Filed 4–20–95; 8:45 am]

BILLING CODE 4410–18–P

DEPARTMENT OF DEFENSE

Department of the Army

33 CFR Part 222

Periodic Inspection and Continuing Evaluation of Completed Civil Works Structures and Inspection and Evaluation of Corps of Engineers Bridges; Rescission

AGENCY: U.S. Army Corps of Engineers, DOD.

ACTION: Rescission of regulations.

SUMMARY: This final rule rescinds regulations concerning periodic inspection and continuing evaluation of completed civil works structures and inspection and evaluation of Corps of Engineers bridges. Both regulations are no longer required to be published in the Code of Federal Regulations because they are for ''in-house'' guidance only. This rule renumbers the remaining regulations in part 222.

EFFECTIVE DATE: March 20, 1995.

ADDRESSES: U.S. Army Corps of Engineers, Engineering Division, Directorate of Civil Works, Washington, DC 20314–1000.

FOR FURTHER INFORMATION CONTACT: Paul D. Barber or Yung Kuo, (202) 504–4533.

SUPPLEMENTARY INFORMATION:

List of Subjects in 33 CFR Part 222

Bridges, Dams, Reservoirs. Safety, Water resources.

For the reasons set forth in the preamble, 33 CFR part 222 is amended as follows:

PART 222—ENGINEERING AND DESIGN

1. The authority citations for part 222 continues to read as follows:

Authority: 23 U.S.C. 116(d); delegation in 49 CFR 1.45(b); 33 U.S.C. 467 et seq.; 33 U.S.C. 701, 701b, and 701c–1 and specific legislative authorization Acts and Public Laws listed in appendix E of § 222.7.

2. Sections 222.2 and 222.3 are removed and §§ 222.4 through 222.8 are redesignated as §§ 222.2 through 222.6.

Gregory D. Showalter,

Army Federal Register Liaison Officer.

[FR Doc. 95–9654 Filed 4–20–95; 8:45 am]

BILLING CODE 3710–92–M

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AE72

Schedule for Rating Disabilities; Gynecological Conditions and Disorders of the Breast

AGENCY: Department of Veterans Affairs.

ACTION: Final regulation.

SUMMARY: This document amends the section of the Department of Veterans Affairs (VA) Schedule for Rating Disabilities on Gynecological Conditions and Disorders of the Breast. This amendment is based on a General Accounting Office (GAO) study noting that there has been no comprehensive review of the rating schedule since 1945, and recommending that such a review be conducted. The intended effect of this action is to update the gynecological and breast disorders section of the rating schedule to ensure that it uses current medical terminology, unambiguous criteria, and that it reflects medical advances which have occurred since the last review.

EFFECTIVE DATE: This amendment is effective May 22, 1995.

FOR FURTHER INFORMATION CONTACT: Caroll McBrine, M.D., Consultant, Regulations Staff, Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, (202) 273–7210.

SUPPLEMENTARY INFORMATION: In December 1988, the General Accounting Office (GAO) recommended that VA prepare a plan for a comprehensive review of the rating schedule and, based on the results, revise the medical criteria accordingly. As part of the process to implement these recommendations, VA published in the **Federal Register** of March 26, 1992 (57 FR 10450–53) a proposal to amend 38 CFR 4.116 and 4.116a. Interested persons were invited to submit written comments, suggestions, or objections on or before April 27, 1992. We received comments from Disabled American Veterans, Veterans of Foreign Wars, Paralyzed Veterans of America, and from several VA employees.

Two commenters suggested that we revise the proposed criteria for rating endometriosis under diagnostic code (DC) 7629, placing the emphasis on pain and abnormal bleeding rather than on headaches.

Upon further review, VA concurs that symptoms such as headaches and muscle cramps are not the most appropriate criteria for evaluating endometriosis, and we have therefore modified the proposed criteria. At the 50 percent level, the proposed criteria specified endometriomas larger than 2×2 cm., ovary or tubes bound down or obstructed by adhesions, or obliteration of the cul-de-sac. These criteria have been modified to call for lesions involving the bladder or bowel confirmed by laparoscopy, pelvic pain or heavy or irregular bleeding not controlled by treatment, and bowel or bladder symptoms. The proposed 30 percent level called for several lesions or minimal adhesions with side effects such as headaches, muscle cramps, or edema despite treatment; but the schedule has been revised to require pelvic pain or heavy or irregular bleeding not controlled by treatment.

One commenter suggested that we include 10 percent and 100 percent levels for evaluation of endometriosis.

Upon further consideration we have added a 10 percent level for those cases in which pain or bleeding requires continuous treatment. However, endometriosis does not in our judgment reach the level of total disability. Some women have incapacitating symptoms, but on a cyclic basis related to their menstrual periods. Others have milder symptoms on a constant basis. Providing a 50 percent level recognizes the substantial level of disability that women may experience because of endometriosis, but we believe that, in general, the highest level of disability assigned for a condition should not exceed the evaluation for absence of the organ involved. In this case, 50 percent for removal of the uterus and both ovaries is the highest post-surgical evaluation.

One individual suggested that a convalescent period of six months at 100 percent should be provided for endometriosis following surgery or other corrective procedure.

VA does not concur. The most extensive surgery that is likely to be needed for endometriosis is a hysterectomy and bilateral salpingo-oophorectomy. Healing, convalescence, and residuals are likely to be similar to those after such surgery for other conditions. We have established a convalescent period for this type of surgery of three months, which is discussed in more detail below. More conservative surgery is often indicated, including some done on an outpatient basis. Recovery would be even more rapid in such cases and, in our judgment, six months of convalescence cannot be justified.

One commenter noted that 30–40 percent of patients with endometriosis become infertile and that 10–15 percent of infertile women have endometriosis.

While endometriosis may be associated with infertility, infertility is not itself a disability for VA rating purposes. It does not result in impairment of average earning capacity. If loss or loss of use of a creative organ is established as due to endometriosis, special monthly compensation under the provisions of 38 CFR 3.350(a) may be considered.

One commenter suggested a language change under the criteria for evaluation of prolapse of the uterus, DC 7621, from ''complete—through vulva'' to ''complete—through vagina and introitus.''

The language suggested by the commenter is more technically accurate and we have revised the language as suggested.

Four commenters expressed concern about a lack of clarity in the criteria for evaluating residuals of breast surgery under DC 7626. One said that the phrase ''following mastectomy or lumpectomy without significant alteration of size or form'' at the 0 percent level is confusing because literally ''mastectomy'' will result in significant alteration of size or form and that therefore ''biopsy'' should be substituted for ''mastectomy.'' Another said that it is impossible to remove the breast (i.e., perform a mastectomy) without significant alteration of size or form, and that therefore ''mastectomy'' should be replaced by ''lumpectomy.'' One felt that the phrase ''significant alteration of size or form'' is too subjective to be useful, and also that a mastectomy or lumpectomy which requires removal of some breast tissue together with supporting tissues will change the size and form of the breast and should be compensated at a 10 percent level.

In response to these comments, VA has simplified the criteria for evaluating breast surgery residuals and has clarified them by adding a note defining the terms used for the various types of breast surgery specified at each level of evaluation. At the 0 percent level, we have replaced the words ''mastectomy or lumpectomy'' with ''wide local excision,'' a term that we also define for VA purposes in the note. Since the commenters did not offer alternative language for us to consider, however, we have retained the phrase ''significant alteration of size or form.'' We believe the term is objective enough to be useful since it requires a substantial, as opposed to a subtle or minimal, alteration in the normal size or form of the breast. Furthermore, a mastectomy or lumpectomy or any other wide local excision that significantly alters the size or form of the breast will be compensated, not at 10 percent, but at 30 percent. For degrees of alteration that are not significant, a 10 percent evaluation is not warranted because there is no industrial impairment and little or no cosmetic deformity.

Two commenters suggested that there be major and minor evaluations for breast surgery under DC 7626, comparable to muscle loss under DC 5302, extrinsic muscles of shoulder girdle.

VA does not concur. Muscle loss is not the only disability that results from a radical mastectomy. There are two additional disabling aspects: removal of the breast and removal of lymphatic tissue. The residuals of removal of a breast include pain and deformity, each of variable extent, and a 30 percent level of disability has been established for removal of one breast without involvement of muscle or lymphatic tissue. Disability of the pectoral muscle under DC 5302 is assessed solely on loss of function, and complete removal warrants an evaluation of 30 percent or 40 percent, depending on whether it is on the major or minor side. Residuals from the removal of lymphatic tissue during a radical mastectomy may be as mild in degree as minimal deformity or pain or as severe as massive lymphedema of an arm. Thus the residual disability from each of the three elements has a range of severity, and it is the combination of the three that we have taken into account in assigning a level of disability following breast surgery. Considering all of these facets of disability, we do not believe that the difference between muscle loss on the major and on the minor side significantly influences the overall disability from a radical mastectomy. Fifty percent was the assigned level of impairment for a unilateral radical mastectomy in the 1945 rating schedule. In our judgment this is a reasonable assessment, and we have retained it in this revision. In other than radical breast surgery there is no muscle impairment at all, so the comment on major and minor evaluations is not applicable.

One commenter, stating that there is no industrial impairment following mastectomy with significant alteration of size or form but without removal of axillary lymph nodes unless there are painful scars, suggested that the proposed evaluation of 50 percent for both and 30 percent for one should be lower.

VA does not agree with the commenter. Residuals of mastectomy may include pain, deformity, and sense of loss with psychological distress. Any of these may have an effect on an individual's functioning and can occur regardless of whether or not the external appearance of the clothed individual is altered. We are retaining the current evaluations because the residuals remain essentially the same as they have been for many years, and, in our judgment, result in residual disability consistent with the levels currently assigned.

We proposed to retain § 4.116 of the 1945 rating schedule intact with only minor changes, but one commenter criticized that section as ambiguous and confusing, particularly the part which indicates that removal of uterus, ovaries, etc., is considered disabling, but only prior to the natural menopause.

VA agrees that the implied distinction of surgery before or after the natural menopause is not warranted. The rating schedule spells out, without qualification or restriction, the evaluations to be assigned following the removal of female reproductive organs once the convalescent period has ended. The surgical residuals from the anatomic removal of an organ or organs do not differ depending on whether or not natural, surgical, or any other type of menopause has occurred. The last sentence of § 4.116 has therefore been deleted.

We have also removed the sentences addressing congenital malformations and new growths. They are redundant since they state principles stated elsewhere, specifically in § 4.9, covering congenital or developmental defects as applied to the entire rating schedule, in § 4.10, covering functional impairment in general, and in the criteria under DC's 7627 and 7628, covering evaluation of neoplasms.

Finally, the first two sentences of § 4.116, ''[i]n rating disability from gynecological conditions the following will not be considered as ratable conditions: (a) The natural menopause, (b) amenorrhea, when this is based upon

developmental defect or abnormality, and (c) pregnancy and childbirth and their incidents, except surgical complications under certain circumstances'' and ''The surgical complications of pregnancy will not be held the result of service except when additional disability resulted from treatment therein or they are otherwise attributable to unusual circumstances of service,'' have been changed. The second sentence contains unclear remarks about the surgical complications of pregnancy, seemingly restricting service connection for many of them. Chronic disabilities resulting from pregnancy, whether medical or surgical, are subject to service connection if incurred during service, as with other chronic disabilities. Since this sentence is not only ambiguous but offers no specific information that would aid in evaluation of disabilities, it has been deleted.

The first sentence has been shortened and the type of amenorrhea that is not considered a ratable condition clarified as ''primary'' amenorrhea. This remaining sentence would serve better as a note, and we have deleted § 4.116 in its entirety and retained this sentence as part of Note (1) at the beginning of this portion of the rating schedule. We have also added a sentence to the note stating that chronic residuals of medical or surgical complications of pregnancy may be disabilities for rating purposes. Since § 4.116 has been deleted, § 4.116a has been redesignated as § 4.116.

One commenter felt that the rating schedule should include rating criteria for cervical dysplasia.

VA does not concur. Cervical dysplasia is neither disease nor injury, but a cellular abnormality of the cervix revealed by a Pap smear. It may resolve without residuals or it may represent a premalignant condition which is a forerunner of carcinoma or carcinoma in situ of the cervix. If carcinoma develops in service, whether or not preceded by cervical dysplasia, it will be service-connected. If carcinoma develops after service, the diagnosis of cervical dysplasia in service may or may not be a factor in establishing service connection, which will be determined under either presumptive provisions of 38 CFR 3.309(a) or the general principles relating to service connection in 38 CFR 3.303 *et seq.* Since cervical dysplasia is not itself a disability, it does not in our judgment warrant inclusion in the rating schedule.

One commenter objected to the retention of separate sections for genitourinary conditions and gynecological conditions, calling this a remnant of antiquated prejudices.

VA does not concur. In fact, the separation of these disciplines is standard throughout modern medicine, with separate specialists, textbooks, medical school and hospital departments, etc. Urology has developed as a specialty that includes both the urinary tract and the male genital tract because these two systems share some common anatomy. This is not the case in females, however, where the genital tract is independent of the urinary tract and is the focus of the separate specialty of gynecology. Combining these systems would be contrary to a major focus of the current revision, which is to bring the rating schedule in line with current medical practice, and would be of no discernible advantage to veterans or to those using the rating schedule.

The same commenter asserted that conditions of the gynecological system, especially the loss of procreative organs, do not cause impairment of earning capacity and should therefore not be compensated. A second commenter suggested that our proposed method of evaluating disabilities of the gynecological system based on the need for or response to treatment is inappropriate because it is not based on impairment of earning capacity as required by 38 U.S.C. 1155. A third related comment was an objection that the proposed evaluations covering disease, injury, or adhesions of the female reproductive organs (DC 7610–7615) were based on optimum success in overcoming the effects of disease and the results of surgery rather than the resultant average impairment.

VA disagrees with the three commenters. The conditions in this system may cause pain, abnormal bleeding, incontinence, etc., and such symptoms undoubtedly cause women to lose time from work, which affects the ability to obtain and retain employment, and thus affects income. In addition, loss of procreative organs may affect endocrine function, renal function, psychological function, etc., any of which may affect the ability to work. How well a patient feels, which often relates to how well or how poorly a disease or injury has responded to treatment, is a significant factor in employment. A person who requires continuous treatment is more disabled than one who does not, and one who has symptoms despite continuous treatment is even more impaired. Since evaluation criteria for conditions in other body systems (e.g., malaria (DC 9304), leukemia (DC 7703), and hypo- and hyper-thyroidism (DC 7900 and DC 7903)) take into account the need for treatment, the evaluation criteria which we proposed under DC's 7610 through 7615 are also consistent with other portions of the rating schedule. Our method of evaluating many of these conditions based on response to treatment is therefore appropriate because it assigns those who have symptoms despite treatment the highest level of evaluation because they are the ones who will suffer the most adverse effects on employment.

One commenter suggested that we not compensate pelvic inflammatory disease, which he states is most often a sexually transmitted disease, because, short of tertiary complications of syphilis, male veterans are not compensated for sexually transmitted diseases. He stated that the proposed rule retains disparate ratings for the same type of disability affecting male and female veterans.

VA again disagrees. The provisions of 38 CFR 3.301(c)(1) specifically permit consideration of service connection for residuals of venereal disease if the initial infection occurred during active service. The commenter's statement that males are not compensated for residuals of venereal disease is inaccurate. Urethral strictures, for example, which in some cases represent residuals of venereal disease, may be compensable disabilities. We would also point out that venereal disease presents differently, both acutely and chronically, in males and females, and that rating criteria and entitlement to compensation are based on disability, not on etiology. For these reasons, we find that the inclusion of pelvic inflammatory disease in the rating schedule does not represent disparate evaluations of similar disabilities for males and females, and the commenter's statements do not, in our judgment, establish a rational basis for deleting this condition from the rating schedule.

We proposed changing the convalescent periods for Ovary, removal of (DC 7619) and Uterus and both ovaries, removal of (DC 7617) from six months to three months, and two commenters objected. One stated that by reducing certain evaluations and periods of convalescence, VA was exceeding the GAO mandate to review the rating schedule to update medical terminology and evaluation criteria, and that a statistical study of impairment in earning capacity should be done. The other said that removal of both uterus and ovaries is a far more significant surgical procedure than the removal of the uterus alone or ovary alone and there is a basis for continuation of the six-month convalescent period.

VA disagrees. A convalescent period of three months after removal of the

uterus and/or ovaries is regarded as adequate for most patients because of improvements in surgical techniques and in postoperative care, including the practice of early ambulation. The average convalescent period is actually shorter than three months, with most patients requiring no more than six to eight weeks to convalesce. VA's mandate to readjust the schedule does not derive from GAO but from 38 U.S.C. 1155, which instructs the Secretary to revise the schedule ''in accord with experience.'' A need for shorter periods of convalescence represents a significant medical advance since the last revision, and changes in the rating schedule to reflect this are appropriate.

Three commenters objected to the proposal concerning the period of total evaluation following the completion of therapy for malignancy, citing the wide variety of possible side effects, the varying individual time requirements for convalescence, and the complexity of certain medical procedures.

VA does not concur with the objections. The commenters appear 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 the end of six months because the process of reevaluation 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 require a 60-day notice before VA can reduce an evaluation and an additional 60-day notice before the reduced evaluation takes effect. The revision not only requires a current examination to assure that all residuals are documented, but also offers the veteran more contemporaneous notice of any proposed action and expands the veteran's opportunity to present evidence showing 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. Based on commenters' concerns, however, we have revised the note under this code so that it cannot be misinterpreted as requiring a reduction six months after treatment is terminated. We have also added to the note a direction to rate on residuals, if there has been no local recurrence or metastasis, in order to make these provisions consistent with those we provided for malignancies of the revised genitourinary system. This is not a substantive change, but has been made to provide further clarity, as well as internal consistency within the rating schedule.

Two commenters urged us to retain a minimum evaluation of 10 percent following surgery or the completion of therapy for malignancy.

VA does not agree. Residuals following the medical or surgical treatment of malignancy are common, but vary widely in type and severity, and a specified arbitrary level of residual disability cannot be assumed to be present in every case. As previously discussed, we will be requiring a VA examination for each individual before adjusting the convalescent evaluation, and that examination will also ensure that actual residual disabilities will be documented and assigned an accurate evaluation, which may be more or less than 10 percent.

Two commenters suggested that we retain the evaluation for removal of one ovary with or without partial removal of the other at 10 percent rather than changing it to 0 percent. Another stated that removal of one ovary is analogous to atrophy of both ovaries and should therefore be rated at 20 percent.

VA does not concur. One ovary or even part of an ovary produces sufficient hormone to maintain normal reproductive and endocrine functions without hormonal replacement therapy. The ultimate test of ovarian hormonal function is the ability to support a pregnancy, and it is a well-established medical fact that one ovary is sufficient to support a pregnancy. This is significantly different from complete atrophy of both ovaries (DC 7620), where there would be no hormonal output, and replacement therapy would be necessary.

Two commenters requested that we annotate certain diagnostic codes in this section to indicate entitlement to special monthly compensation (SMC) under 38 U.S.C. 1114(k) for loss of a creative organ. One suggested annotating DC's 7617, 7618, 7619, and 7626, and the other suggested annotations ''where appropriate.''

Because the statutory requirements for SMC are very complicated and in some cases involve more than one body system, it is impractical to provide detailed information at every location in the rating schedule where the potential for entitlement to SMC might arise. Rating specialists must be aware of the need to refer to 38 CFR 3.350, the governing regulation, in every instance where the veteran has a condition which potentially establishes eligibility for SMC. To that end, we have added a note at the beginning of § 4.116 requiring rating specialists to refer to § 3.350 any time they evaluate a claim involving loss or loss of use of one or more creative organs. In view of the comments received, we have also placed footnotes after diagnostic codes 7617 (removal of uterus and both ovaries), 7618 (removal of uterus), 7619 (removal of ovary), and 7620 (complete atrophy of both ovaries) instructing raters to review for entitlement to SMC. While the conditions we have annotated clearly call for review for entitlement to SMC, almost any condition in this section might, under certain circumstances, establish entitlement to SMC. The note at the beginning of § 4.116 makes it clear that it is the responsibility of the rating specialist to recognize those circumstances and assign SMC when warranted. The lack of a footnote does not relieve rating specialists of that responsibility.

Viewing the rating schedule as a whole, we are concerned that if there are footnotes only for obvious grants of SMC, individual veterans entitled to SMC in less obvious situations will be disadvantaged if rating specialists fail to recognize potential entitlement because they have not been prompted to do so by a footnote. We believe that the combination of the regulatory requirement in the note and the footnotes is the best method of making sure that potential entitlement to SMC is considered.

On further review, we have made some additional changes to the proposed revisions for the sake of clarity and objectivity. The title of DC 7627 has been changed from ''Breast, removal of'' to ''Breast, surgery of,'' since surgery often stops short of removal of a breast.

In order to eliminate the need to search in other sections of the rating schedule for criteria to evaluate DC 7625, Fistula, urethrovaginal, (which in the proposed rule was to be rated as voiding dysfunction under the genitourinary schedule), we have provided the criteria for voiding dysfunction (continual urine leakage, post surgical urinary diversion, urinary incontinence, or stress incontinence subset of criteria) under DC 7625. The only difference is that we changed the word urethroperineal to urethrovaginal, as being more specific to this system.

Similarly, we proposed that Fistula, rectovaginal (DC 7624) be evaluated as DC 7332, rectum and anus, impairment of sphincter control (in the digestive system section of the rating schedule). In response to a general comment on the proposed rating schedule revisions of a number of body systems, which strongly

favored the elimination of subjectivity and urged its extension, we removed terms such as ''extensive leakage'' and ''fairly frequent'', which are part of the criteria for DC 7332, in favor of criteria that are more precise, but still based on the extent of fecal leakage and the necessity for wearing a pad.

We made one additional minor technical change under DC 7628, Benign neoplasms of the gynecological system or breast. The word ''genitourinary'' has been replaced by the word ''urinary'' as being more specific to this system.

VA appreciates the comments submitted in response to the proposed rule, which is now adopted with the amendments noted above.

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 (RFA), 5 U.S.C. 601–612. The reason for this certification is that this amendment would not directly affect any small entities. Only VA beneficiaries could be directly affected. Therefore, pursuant to 5 U.S.C. 605(b), this amendment is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

This regulatory amendment has been reviewed by the Office of Management and Budget under the provisions of Executive Order 12866, Regulatory Planning and Review, dated September 30, 1993.

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

List of Subjects in 38 CFR Part 4

Individuals with disability, Pensions, Veterans.

Approved: December 22, 1994.

Jesse Brown,

Secretary of Veterans Affairs.

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

PART 4—SCHEDULE FOR RATING DISABILITIES

Subpart B—Disability Ratings

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

Authority: 38 U.S.C. 1155.

2. The undesignated center heading appearing before § 4.116 is revised to read as follows:

Gynecological Conditions and Disorders of the Breast

3. Section 4.116 is removed.

4. Section 4.116a is redesignated as § 4.116 and its heading and text are revised to read as follows:

§ 4.116. Schedule of ratings—gynecological conditions and disorders of the breast.

	Rating
Note 1: Natural menopause, primary amenorrhea, and pregnancy and childbirth are not disabilities for rating purposes. Chronic residuals of medical or surgical complications of pregnancy may be disabilities for rating purposes.	
Note 2: When evaluating any claim involving loss or loss of use of one or more creative organs, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, almost any condition in this section might, under certain circumstances, establish entitlement to special monthly compensation.	
7610 Vulva, disease or injury of (including vulvovaginitis).	
7611 Vagina, disease or injury of.	
7612 Cervix, disease or injury of.	
7613 Uterus, disease, injury, or adhesions of.	
7614 Fallopian tube, disease, injury, or adhesions of (including pelvic inflammatory disease (PID)).	
7615 Ovary, disease, injury, or adhesions of.	
General Rating Formula for Disease, Injury, or Adhesions of Female Reproductive Organs (diagnostic codes 7610 through 7615):	
Symptoms not controlled by continuous treatment	30
Symptoms that require continuous treatment	10
Symptoms that do not require continuous treatment	0
7617 Uterus and both ovaries, removal of, complete:	
For three months after removal	[1] 100
Thereafter	[1] 50
7618 Uterus, removal of, including corpus:	
For three months after removal	[1] 100
Thereafter	[1] 30
7619 Ovary, removal of:	
For three months after removal	[1] 100
Thereafter:	
Complete removal of both ovaries	[1] 30
Removal of one with or without partial removal of the other	[1] 0
7620 Ovaries, atrophy of both, complete	[1] 20
7621 Uterus, prolapse:	
Complete, through vagina and introitus	50
Incomplete	30
7622 Uterus, displacement of:	
With marked displacement and frequent or continuous menstrual disturbances	30
With adhesions and irregular menstruation	10
7623 Pregnancy, surgical complications of:	
With rectocele or cystocele	50
With relaxation of perineum	10
7624 Fistula, rectovaginal:	
Vaginal fecal leakage at least once a day requiring wearing of pad	100
Vaginal fecal leakage four or more times per week, but less than daily, requiring wearing of pad	60
Vaginal fecal leakage one to three times per week requiring wearing of pad	30
Vaginal fecal leakage less than once a week	10
Without leakage	0
7625 Fistula, urethrovaginal:	
Multiple urethrovaginal fistulae	100
Requiring the use of an appliance or the wearing of absorbent materials which must be changed more than four times per day	60
Requiring the wearing of absorbent materials which must be changed two to four times per day	40
Requiring the wearing of absorbent materials which must be changed less than two times per day	20
7626 Breast, surgery of:	
Following radical mastectomy:	
Both	80
One	50
Following modified radical mastectomy:	
Both	60
One	40
Following simple mastectomy or wide local excision with significant alteration of size or form:	
Both	50
One	30
Following wide local excision without significant alteration of size or form:	
Both or one	0
Note: For VA purposes:	
(1) *Radical mastectomy* means removal of the entire breast, underlying pectoral muscles, and regional lymph nodes up to the coracoclavicular ligament.	

	Rating
(2) *Modified radical mastectomy* means removal of the entire breast and axillary lymph nodes (in continuity with the breast). Pectoral muscles are left intact.	
(3) *Simple (or total) mastectomy* means removal of all of the breast tissue, nipple, and a small portion of the overlying skin, but lymph nodes and muscles are left intact.	
(4) *Wide local excision* (including partial mastectomy, lumpectomy, tylectomy, segmentectomy, and quadrantectomy) means removal of a portion of the breast tissue.	
7627 Malignant neoplasms of gynecological system or breast	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
7628 Benign neoplasms of the gynecological system or breast. Rate according to impairment in function of the urinary or gynecological systems, or skin.	
7629 Endometriosis:	
Lesions involving bowel or bladder confirmed by laparoscopy, pelvic pain or heavy or irregular bleeding not controlled by treatment, and bowel or bladder symptoms	50
Pelvic pain or heavy or irregular bleeding not controlled by treatment	30
Pelvic pain or heavy or irregular bleeding requiring continuous treatment for control	10
Note: Diagnosis of endometriosis must be substantiated by laparoscopy.	

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

[FR Doc. 95–9714 Filed 4–20–95; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 440 and 441

[MB–41–F]

RIN 0938–AF12

Medicaid Program; Required Coverage of Nurse Practitioner Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule stipulates the requirements for coverage of and payment for pediatric and family nurse practitioner services under the Medicaid program. The coverage of these additional services under the Medicaid program increases the availability and accessibility of medical care for specified Medicaid recipients.

This final rule adds to the Medicaid regulations provisions of sections 1902(a)(10)(A) and 1905(a)(21) of the Social Security Act, as amended by section 6405 of the Omnibus Budget Reconciliation Act of 1989.

EFFECTIVE DATE: These regulations are effective May 22, 1995.

FOR FURTHER INFORMATION CONTACT: Robert Wardwell, (410) 966–5659.

SUPPLEMENTARY INFORMATION:

I. General Background

Title XIX of the Social Security Act (the Act) authorizes States to establish Medicaid programs to provide medical assistance to needy individuals. Section 1902(a)(10) of the Act describes the two broad classifications of most individuals to whom medical assistance may be provided: The categorically needy (section 1902(a)(10)(A)) and the medically needy (section 1902(a)(10)(C)). Section 1905 of the Act defines medical assistance for purposes of the Medicaid program and specifies the services that constitute medical assistance.

Section 6405 of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Public Law 101–239, enacted on December 19, 1989, redesignated section 1905(a)(21) as section 1905(a)(22) and added a new section 1905(a)(21) to the Act to include services furnished by certified pediatric nurse practitioners (CPNPs) and by certified family nurse practitioners (CFNPs) in the definition of ''medical assistance.'' Section 1905(a)(21) describes the added services as those that a nurse practitioner is legally authorized to perform under State law, whether or not the nurse practitioner is under the supervision of, or associated with, a physician or other health care provider.

In addition, section 6405 of OBRA '89 amended section 1902(a)(10)(A) to include the nurse practitioner services listed in section 1905(a)(21) of the Act as services that must be made available to categorically needy recipients. Nurse practitioner services can be provided to medically needy recipients at the option of the State Medicaid agency.

Program instructions to help States implement the provisions of section 6405 of OBRA '89 were initially published in the State Medicaid Manual, Part 4, Services, in August 1990 (Transmittal Number 48). As a result, since July 1, 1990, States have been required to provide for direct payment to nurse practitioners for their services if the services are not billed by an employing provider (for example, a hospital clinic). These instructions included an administratively imposed requirement that CPNPs and CFNPs must be certified by national accrediting bodies.

II. Notice of Proposed Rulemaking

On December 23, 1991, we published in the **Federal Register** (56 FR 66392) a proposed rule to include in the Medicaid regulations coverage of and payment for services furnished by CPNPs and CFNPs, as provided by section 6405 of OBRA '89.

The proposed rule included revisions to 42 CFR parts 440 and 441 to define nurse practitioner services for purposes of this benefit, to set out the requirements for CPNPs and CFNPs, and to describe the permissible methods of payment for services. Under proposed § 440.166(a), we defined nurse practitioner services as services furnished within the scope of practice authorized by State law or regulations, by a practitioner who meets the requirements for a CPNP or a CFNP, regardless of whether the nurse practitioner is under the supervision of, or associated with, a physician or other health care provider.

In § 440.166(b), we proposed that a CPNP must—

- Be a registered professional nurse;
- Be currently licensed to practice in the State as a registered professional nurse;
- Meet the State requirements for qualification of pediatric nurse practitioners or nurse practitioners in the State in which he or she furnishes the services; and
- Be currently engaged in a pediatric nurse practice within the scope of applicable State law.