§ 750.3 Review of license applications by BIS and other government agencies and departments.

* * * * *

(b) * * *

(2) * * *

(v) The Department of Justice is concerned with controls relating to encryption items and items primarily useful for the surreptitious interception of wire, oral, or electronic communications.

PART 752—[AMENDED]

■ 15. The authority citation for 15 CFR part 752 continues to read as follows:

Authority: 50 U.S.C. app. 2401 *et seq.*; 50 U.S.C. 1701 *et seq.*; E.O. 13020, 61 FR 54079, 3 CFR, 1996 Comp. p. 219; E.O. 13222, 66 FR 44025, 3 CFR, 2001 Comp., p. 783; Notice of August 3, 2006, 71 FR 44551 (August 7, 2006).

■ 16. Section 752.3 is amended by revising paragraph (a)(7) to read as follows:

§ 752.3 Eligible items.

(a) * * *

(7) Communications intercepting devices and related software and technology controlled by ECCN 5A980, 5D980, or 5E980 on the CCL;

* * * * *

PART 774—[AMENDED]

■ 17. The authority citation for 15 CFR part 774 is revised to read as follows:

Authority: 50 U.S.C. app. 2401 *et seq.*; 50 U.S.C. 1701 *et seq.*; 10 U.S.C. 7420; 10 U.S.C. 7430(e); 22 U.S.C. 287c, 22 U.S.C. 3201 *et seq.*, 22 U.S.C. 6004; 30 U.S.C. 185(s), 185(u); 42 U.S.C. 2139a; 42 U.S.C. 6212; 43 U.S.C. 1354; 46 U.S.C. app. 466c; 50 U.S.C. app. 5; Sec. 901–911, Pub. L. 106–387; Sec. 221, Pub. L. 107–56; E.O. 13026, 61 FR 58767, 3 CFR, 1996 Comp., p. 228; E.O. 13222, 66 FR 44025, 3 CFR, 2001 Comp., p. 783; Notice of August 3, 2006, 71 FR 44551 (August 7, 2006).

■ 18. In Supplement No. 1 to Part 774, the Commerce Control List, Category 5 (Telecommunications), is amended by revising the ''License Requirements'' section for Export Control Classification Number (ECCN) 5A980 to read as follows:

5A980 Devices primarily useful for the surreptitious interception of wire, oral, or electronic communications; and parts and accessories therefor.

License Requirements

Reason for Control: SL, AT.

Control(s): SL and AT apply to entire entry. A license is required for all destinations, as specified in § 742.13 of the EAR. Accordingly, a column specific to this control does not appear on the Commerce Country Chart (Supplement No. 1 to Part 738 of the EAR).

Note: This licensing requirement does not supersede, nor does it implement, construe or limit the scope of any criminal statute, including, but not limited to the Omnibus Safe Streets Act of 1968, as amended.

Note: These items are subject to the United Nations Security Council arms embargo against Rwanda described in § 746.8 of the EAR.

* * * * *

■ 19. In Supplement No. 1 to Part 774, the Commerce Control List, Category 5 (Telecommunications), is amended by adding new Export Control Classification Number (ECCN) 5D980 to read as follows:

5D980 Other ''software'', as follows (see List of Items Controlled).

License Requirements

Reason for Control: SL, AT.

Controls: SL and AT apply to entire entry. A license is required for all destinations, as specified in § 742.13 of the EAR. Accordingly, a column specific to this control does not appear on the Commerce Country Chart (Supplement No. 1 to Part 738 of the EAR).

Note: This licensing requirement does not supersede, nor does it implement, construe or limit the scope of any criminal statute, including, but not limited to the Omnibus Safe Streets Act of 1968, as amended.

Note: These items are subject to the United Nations Security Council arms embargo against Rwanda described in § 746.8 of the EAR.

License Exceptions

CIV: N/A.

TSR: N/A.

List of Items Controlled

Unit: $ value.

Related Controls: N/A.

Related Definitions: N/A.

Items:

a. ''Software'' primarily useful for the surreptitious interception of wire, oral, and electronic communications.

b. ''Software'' primarily useful for the ''development'', ''production'', or ''use'' of equipment controlled by 5A980.

■ 20. In Supplement No. 1 to Part 774, the Commerce Control List, Category 5 (Telecommunications), is amended by adding new Export Control Classification Number (ECCN) 5E980 to read as follows:

5E980 ''Technology'' primarily useful for the ''development'', ''production'', or ''use'' of equipment controlled by 5A980.

License Requirements

Reason for Control: SL, AT.

Controls: SL and AT apply to entire entry. A license is required for all destinations, as specified in § 742.13 of the EAR. Accordingly, a column specific to this control does not appear on the Commerce Country Chart (Supplement No. 1 to Part 738 of the EAR).

Note: These items are subject to the United Nations Security Council arms embargo against Rwanda described in § 746.8 of the EAR.

License Exceptions

CIV: N/A.

TSR: N/A.

List of Items Controlled

Unit: $ value.

Related Controls: N/A.

Related Definitions: N/A.

Items:

The list of items controlled is contained in the ECCN heading.

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Dated: November 13, 2006.

Christopher A. Padilla,

Assistant Secretary for Export Administration.

[FR Doc. E6–19509 Filed 11–17–06; 8:45 am]

BILLING CODE 3510–33–P

SOCIAL SECURITY ADMINISTRATION

20 CFR Part 404

[Docket No. SSA–2006–0098]

RIN 0960–AF34

Revised Medical Criteria for Evaluating Visual Disorders

AGENCY: Social Security Administration.

ACTION: Final rules.

SUMMARY: We are revising the criteria in the Listing of Impairments (the listings) that we use to evaluate claims involving visual disorders. We apply these criteria when you claim benefits based on disability under title II and title XVI of the Social Security Act (the Act). The revisions reflect our program experience and advances in medical knowledge, treatment, and methods of evaluating visual disorders.

DATES: These rules are effective February 20, 2007.

FOR FURTHER INFORMATION CONTACT: Michelle Hungerman, Social Insurance Specialist, Office of Disability and Income Security Programs, Social Security Administration, 100 Altmeyer Building, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–2289 or TTY (410) 966–5609 for information about these rules. For information on eligibility or filing for benefits, call our national toll-free number, 1–800–772–1213 or TTY 1–800–325–0778, or visit our Internet Web site, Social Security Online at *http://www.socialsecurity.gov.*

SUPPLEMENTARY INFORMATION:

Electronic Version

The electronic file of this document is available on the date of publication in the **Federal Register** at *http://www.gpoaccess.gov/fr/index.html.*

We are revising and making final the rules we proposed for evaluating visual disorders in the notice of proposed rulemaking (NPRM) published in the **Federal Register** on August 17, 2005 (70 FR 48342). We provide a summary of the provisions of the final rules below, with an explanation of the changes we have made from the text in the NPRM. We then provide summaries of the public comments and our reasons for adopting or not adopting the recommendations in those comments in the section ''Public Comments.'' The final rule language follows the Public Comments section.

What programs do these final regulations affect?

These final regulations affect disability and blindness determinations and decisions that we make under title II and title XVI of the Act. In addition, to the extent that Medicare entitlement and Medicaid eligibility are based on whether you qualify for disability or blindness benefits under title II or title XVI, these final regulations also affect the Medicare and Medicaid programs.

Who can get disability or blindness benefits?

Under title II of the Act, we provide for the payment of disability benefits, including disability benefits based on blindness if you are disabled and belong to one of the following three groups:

- Workers insured under the Act;
- Children of insured workers; and
- Widows, widowers, and surviving divorced spouses (see § 404.336) of insured workers.

Under title XVI of the Act, we provide for Supplemental Security Income (SSI) payments on the basis of disability or blindness if you are disabled or blind and have limited income and resources.

Is blindness treated differently under title II and title XVI?

Under title II, impairments that result in ''blindness'' are evaluated in the same way as other impairments. However, under title XVI, ''blindness'' is considered separately from other impairments under different eligibility requirements. In other words, under title XVI, you may qualify for benefits on the basis of ''blindness'' or on the basis of ''disability.''

How do we define blindness?

For both the title II and title XVI programs, the Act defines blindness as ''central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered * * * as having a central visual acuity of 20/200 or less.'' (Sections 216(i)(1) and 1614(a)(2) of the Act.) We refer to the Act's definition of blindness as ''statutory blindness.''

If you are seeking benefits under title II, your blindness generally must meet the 12-month statutory duration requirement. However, if you are seeking payments under title XVI of the Act based on blindness (rather than disability, as discussed below), your blindness need not meet the 12-month statutory duration requirement. Also, if you are seeking payments under title XVI of the Act based on blindness, there is no requirement that you be unable to do any substantial gainful activity (SGA). However, if you are working, we will consider your earnings to determine if you are eligible for SSI payments.

How do we define disability?

If your visual disorder does not meet our definition of blindness, you may still be eligible for disability benefits. Under both the title II and title XVI programs, disability must be the result of any medically determinable physical or mental impairment or combination of impairments that is expected to result in death or which has lasted or is expected to last for a continuous period of at least 12 months. Our definitions of disability are shown in the following table:

If you file a claim under * * *	And you are * * *	Disability means you have a medically determinable impairment(s) as described above that results in * * *
title II	an adult or a child	the inability to do any SGA.
title XVI	a person age 18 or older	the inability to do any SGA.
title XVI	a person under age 18	marked and severe functional limitations.

There is also an additional definition of disability if you are seeking benefits under title II of the Act, have attained age 55, and have blindness as defined in section 216(i)(1) of the Act: Disability means that the blindness has resulted in the inability to engage in SGA requiring skills or abilities comparable to those of any gainful activity in which you previously engaged with some regularity and over a substantial period of time. (See section 223(d)(1)(B) of the Act.)

How do we decide whether you are disabled?

If you are seeking benefits under title II of the Act, or if you are an adult seeking payments under title XVI of the Act, we use a five-step ''sequential evaluation process'' to decide whether you are disabled. We describe this five-step process in our regulations at §§ 404.1520 and 416.920. We follow the five steps in order and stop as soon as we can make a determination or decision. The steps are:

1. Are you working, and if so, is the work you are doing substantial gainful activity? If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled, regardless of your medical condition or your age, education, and work experience. If you are not, we will go on to step 2.

2. Do you have a ''severe'' impairment? If you do not have an impairment or combination of impairments that significantly limits your physical or mental ability to do basic work activities, we will find that you are not disabled. If you do, we will go on to step 3.

3. Do you have an impairment(s) that meets or medically equals the severity of an impairment in the listings? If you do, and the impairment(s) meets the duration requirement, we will find that you are disabled. If you do not, we will go on to step 4.

4. Do you have the residual functional capacity to do your past relevant work? If you do, we will find that you are not disabled. If you do not, we will go on to step 5.

5. Does your impairment(s) prevent you from doing any other work that exists in significant numbers in the national economy, considering your residual functional capacity, age,

education, and work experience? If it does, and it meets the duration requirement, we will find that you are disabled. If it does not, we will find that you are not disabled.

We use a different sequential evaluation process for children who apply for payments based on disability under title XVI of the Act. We describe that sequential evaluation process in § 416.924 of our regulations. If you are already receiving benefits, we also use a different sequential evaluation process when we decide whether your disability continues. See §§ 404.1594, 416.994, and 416.994a of our regulations. However, all of the processes include steps at which we consider whether your impairment(s) meets or medically equals one of our listings.

What are the listings?

The listings are examples of impairments that we consider severe enough to prevent you as an adult from doing any gainful activity. If you are a child seeking SSI payments based on disability, the listings describe impairments that we consider severe enough to result in marked and severe functional limitations. Although the listings are contained only in appendix 1 to subpart P of part 404 of our regulations, we incorporate them by reference in the SSI program in § 416.925 of our regulations, and apply them to claims under both title II and title XVI of the Act.

How do we use the listings?

The listings are in two parts. There are listings for adults (part A) and for children (part B). If you are an individual age 18 or over, we apply the listings in part A when we assess your claim, and we do not use the listings in part B.

If you are an individual under age 18, we first use the criteria in part B of the listings. If the listings in part B do not apply, and your specific disease process(es) has a similar effect on adults and children, we then use the criteria in part A. (See §§ 404.1525 and 416.925.)

If your impairment(s) does not meet any listing, we will also consider whether it medically equals any listing; that is, whether it is as medically severe as an impairment in the listings. (See §§ 404.1526 and 416.926.)

What if you do not have an impairment(s) that meets or medically equals a listing?

We use the listings only to decide that you are disabled or that you are still disabled. We will not deny your claim because your impairment(s) does not meet or medically equal a listing. If you are not doing work that is substantial gainful activity, and you have a severe impairment(s) that does not meet or medically equal any listing, we may still find you disabled based on other rules in the ''sequential evaluation process'' described above. Likewise, we will not decide that your disability has ended only because your impairment(s) does not meet or medically equal a listing.

Also, when we conduct reviews to determine whether your disability continues, we will not find that your disability has ended because we have changed a listing. Our regulations explain that, when we change our listings, we continue to use our prior listings when we review your case, if you had qualified for disability benefits or SSI payments based on our determination or decision that your impairment(s) met or medically equaled the listings. In these cases, we determine whether you have experienced medical improvement, and if so, whether the medical improvement is related to the ability to work. If your condition(s) has medically improved so that you no longer meet or medically equal the prior listing, we evaluate your case further to determine whether you are currently disabled. We may find that you are currently disabled depending on the full circumstances of your case. (See §§ 404.1594(c)(3)(i) and 416.994(b)(2)(iv)(A).) If you are a child who is eligible for SSI payments, we follow a similar rule after we decide that you have experienced medical improvement in your condition(s). See § 416.994a(b)(2).

Why are we revising the listings for visual disorders?

We are making these revisions to update the medical criteria in the listings for visual disorders and to provide more information about how we evaluate visual disorders.

The listings for visual disorders, disturbances of labyrinthine-vestibular function, hearing impairments, and loss of speech are contained in listings for Special Senses and Speech. In these final rules, we are making changes only to the listings for visual disorders.

On April 24, 2002, we published final rules in the **Federal Register** (67 FR 20018) that included technical revisions to the listings for special senses and speech disorders. Prior to this, we published final rules that included revisions to the special senses and speech listings in the **Federal Register** on December 6, 1985 (50 FR 50068). We last published final rules making comprehensive revisions to the part A special senses and speech listings in the **Federal Register** on March 27, 1979 (44 FR 18170), and final rules making comprehensive revisions to the part B special senses and speech listings on March 16, 1977 (42 FR 14705). We intend to publish separately proposed rules that would update the criteria for the other disorders included in the Special Senses and Speech listings.

What do we mean by ''final rules'' and ''prior rules''?

Even though these rules will not go into effect until 90 days after publication of this notice, for clarity, we refer to the changes we are making here as the ''final rules'' and to the rules that will be changed by these final rules as the ''prior rules.''

When will we start to use these final rules?

We will start to use these final rules on their effective date. We will continue to use our prior rules until the effective date of these final rules. When the final rules become effective, we will apply them to new applications filed on or after the effective date of these rules and to claims pending before us, as we describe below.

As is our usual practice when we make changes to our regulations, we will apply these final rules on or after their effective date whenever we make a determination or decision, including in those claims in which we make a determination or decision after remand to us from a Federal court. With respect to claims in which we have made a final decision and that are pending judicial review in Federal court, we expect that the court's review of the Commissioner's final decision would be made in accordance with the rules in effect at the time the final decision of the Commissioner was issued. If a court reverses the Commissioner's final decision and remands the case for further administrative proceedings after the effective date of these final rules, we will apply the provisions of these final rules to the entire period at issue in the claim in our new decision issued pursuant to the court's remand.

How long will these final rules be effective?

These final rules will no longer be effective 8 years after the date on which they become effective, unless we extend them, or revise and issue them again.

How are we changing the introductory text to the special senses and speech listings for adults?

2.00 Special Senses and Speech

We are removing the following sections of prior 2.00:

- The last paragraph of 2.00A3, ''Field of vision.''
- Paragraph 2.00A4, ''Muscle function.''
- The first paragraph of 2.00A6, ''Special situations.''

The last paragraph of prior 2.00A3, ''Field of vision,'' explained that when the visual field loss was predominantly in the lower visual fields, a system such as the weighted grid scale for perimetric fields as described by B. Esterman in 1968 could be used for determining whether the visual field loss was comparable to that described in table 2 in section 2.00 of the listings. As this kind of scale is rarely used, we no longer need this guidance in the introductory text.

Prior 2.00A4, ''Muscle function,'' described the type of impairment evaluated under prior listing 2.06, ''Total bilateral ophthalmoplegia.'' (Ophthalmoplegia is paralysis of the eye muscles.) As the causes of this disorder are now more readily detectable and treatable, this disorder has become extremely rare. Therefore, we are removing both the prior listing and the guidance in the introductory text that addressed this disorder. Instead, we will evaluate total bilateral ophthalmoplegia and other eye muscle disorders by assessing the impact of such disorders on your visual efficiency under final listing 2.04, or based on your visual functioning.

The first paragraph of prior 2.00A6, ''Special situations,'' explained how we calculated visual acuity efficiency for individuals with aphakia (the absence of the anatomical lens of the eye). Advances in technology have led to the development of effective synthetic intraocular lenses. Also, contact lenses have been technically refined and may be used in those instances in which the anatomical lens is not replaced with a synthetic lens. Because the synthetic intraocular lens or the contact lens corrects both the visual acuity and the visual field, we compute the visual acuity efficiency or visual field efficiency as though your eye has an anatomical lens.

We are reorganizing and expanding the rest of the introductory text for visual disorders to provide additional guidance. The following is a detailed explanation of the final introductory text.

2.00A—How do we evaluate visual disorders?

This section corresponds to prior 2.00A, ''Disorders of Vision.'' We are clarifying the information in the prior section by reorganizing the material into eight subsections and by providing additional guidance as explained below.

2.00A1—What are visual disorders?

This section corresponds to prior 2.00A1, ''Causes of impairment.'' We are making nonsubstantive editorial changes for clarity.

2.00A2—How do we define statutory blindness?

This section revises prior 2.00A7, ''Statutory blindness,'' to include the statutory definition. In response to a public comment, we have added an explanation that we use your best-corrected visual acuity for distance in the better eye when we determine if you have statutory blindness based on visual acuity loss. We also clarify that you have statutory blindness only if your visual disorder meets the criteria of 2.02 or 2.03A. We further clarify that you do not have statutory blindness if your visual disorder medically equals the criteria of 2.02 or 2.03A, or if it meets or medically equals 2.03B, 2.03C, or 2.04. If your visual disorder medically equals the criteria of 2.02 or 2.03A, or if it meets or medically equals 2.03B, 2.03C, or 2.04, we will find that you have a disability if your visual disorder also meets the duration requirement.

In the NPRM, this section was headed ''What is statutory blindness?'' We are changing the heading to be consistent with other headings in this section.

2.00A3—What evidence do we need to establish statutory blindness under title XVI?

In this new section, we explain that when we make a determination or decision that you have statutory blindness under title XVI, we require evidence showing only that the statutory criteria are satisfied; we do not need evidence to document the visual disorder that causes the blindness. We also explain that there is no duration requirement for statutory blindness under title XVI.

We are adding this section because blindness is treated differently under title II and title XVI of the Act. Under title II, blindness is generally evaluated in the same way as other medical impairments. Under title XVI, blindness and disability are separate categories, and the requirements for eligibility based on blindness are different from the requirements for eligibility based on disability.

2.00A4—What evidence do we need to evaluate visual disorders, including those that result in statutory blindness under title II?

We are revising the last sentence of prior 2.00A1 to explain what evidence we need to evaluate a visual disorder. In response to public comments, we have revised proposed 2.00A4b to refer to a ''cortical visual disorder'' instead of ''cortical blindness'' and provided additional guidance on cortical visual disorders and how to document them.

2.00A5—How do we measure best-corrected visual acuity?

We are revising the guidance in the second sentence of prior 2.00A2, ''Visual acuity,'' by providing that, in addition to testing that uses Snellen methodology, we may also use visual acuity measurements obtained using another testing methodology that is comparable to Snellen methodology. We also clarify what constitutes best-corrected visual acuity.

In the NPRM, we proposed, in 2.00A5b(i), that we would not use the results of visual evoked response (VER) testing to determine best-corrected visual acuity. This guidance was questioned by several commenters who indicated that no response to VER testing demonstrates that an individual cannot see in that eye. We agree with these commenters, and have revised proposed 2.00A5b(i) to indicate that if you have an absent response to VER testing in an eye, we can use that result to determine that your visual acuity is 20/200 or less in that eye. However, we will not use a positive response to VER testing to determine best-corrected visual acuity. VER testing evaluates the function of the visual pathways from the retina, along the optic nerve and optic tract, to the vision cortex in the occipital lobe of the brain. While this testing can provide an estimate of visual acuity, it is not a direct measure of visual acuity.

We also provide that we will not use pinhole testing to determine best-corrected visual acuity. Pinhole testing is used to determine whether your visual acuity can be improved with a corrective lens. However, you may not achieve the same degree of correction with corrective lenses that you have with pinholes. Additionally, even when pinhole testing fails to show an improvement in your acuity, your acuity may improve with corrective lenses. Because pinhole testing may underestimate or overestimate your visual acuity, we will not use it to determine your best-corrected visual acuity.

In response to a public comment, we have also added guidance in final 2.00A5b(i) explaining that we will not use automated refraction acuity to determine your best-corrected visual acuity. An automated refractor is a machine that measures how light is changed as it enters the eye. It is used to provide an estimate of refractive error and the prescription for glasses. This estimate gives the clinician a place to start in determining the best-corrected visual acuity; it is not a direct measure of visual acuity.

In response to another public comment, we have added guidance in final 2.00A5b(ii) to explain that best-corrected visual acuity for distance is your best acuity at 20 feet, and to explain how we use visual acuity measurements obtained for other distances.

2.00A6—How do we measure visual fields?

This section replaces prior 2.00A3, ''Field of vision.'' Prior 2.00A3 indicated that we would use ''usual perimetric methods'' or other ''comparable perimetric devices'' to measure the size of the visual field. The Goldmann perimeter was cited as a comparable perimetric device.

The National Research Council (NRC), in its 2002 report, *Visual Impairments: Determining Eligibility for Social Security Benefits* (hereinafter, the ''NRC report''), recommended that ''the current SSA standard [for assessing visual field loss] should be revised so that disability determinations are based on the results of automated static projection perimetry rather than Goldmann (kinetic, nonautomated) visual fields.'' (Citations for the NRC report and other sources cited in this preamble are available in the NPRM (70 FR at 48348).) These final rules partially adopt this recommendation by providing that we will use visual field measurements obtained with an automated static threshold perimetry test performed on a perimeter that meets our requirements. However, we have decided that we will also continue to use visual field measurements obtained with Goldmann or other kinetic perimetry as these measurements are comparable to those obtained with automated static threshold perimetry.

In final 2.00A6a(i), we explain when we need visual field testing. In response to a public comment, we have deleted macular edema as an example of a visual disorder that could cause visual field loss.

In final 2.00A6a(ii), we explain that, when we need to measure the extent of your visual field loss, we will use visual field measurements obtained with an automated static threshold perimetry test performed on a perimeter that meets our requirements. We adopted as our requirements the criteria recommended in the NRC report. We cite the Humphrey Field Analyzer as an example of an acceptable perimeter because the NRC report cited it, and the Humphrey Field Analyzer is the most widely used automated perimeter in the United States to perform this type of test.

The NRC report also cited the Octopus perimeter as another example of an automated perimeter that meets the criteria set out in its recommendations. We have not included the Octopus perimeter as an example of an acceptable perimeter in final 2.00A6a(ii), because it is not our intention to list in these rules every acceptable automated perimeter and the Octopus perimeter is not widely used in the United States. However, we will accept findings from the Octopus perimeter or any other automated perimeter that satisfies the requirements of final 2.00A6a(ii).

In final 2.00A6a(iii), we describe the requirements of an acceptable automated static threshold perimetry test.

In final 2.00A6a(iv), we explain that we need a test that measures the central 24 to 30 degrees of the visual field to determine statutory blindness. We also provide examples of acceptable tests. In response to a public comment, we have added a reference to final listing 2.03A in this section.

In proposed 2.00A6a(v), we indicated that to determine if the criterion in listing 2.03B is met, we need a test performed on a Humphrey Field Analyzer that measures the central 30 degrees of the visual field. We also indicated that we could use comparable results from other acceptable perimeters. In response to a comment that these two statements were inconsistent with each other, we have clarified this section to explain that while the criterion in final listing 2.03B is based on using a test performed on a Humphrey Field Analyzer that measures the central 30 degrees of the visual field, we can also use comparable results from other acceptable perimeters. We also provide an example of a comparable result. Additionally, we explain that we cannot use tests that do not measure the central 30 degrees of the visual field, such as the Humphrey 24–2 test, to determine if your impairment meets or medically equals final listing 2.03B. The criterion we use in final listing 2.03B adopts the recommendation in the NRC report for determining that your visual field loss is disabling. That recommendation was based on the use of a test measuring the central 30 degrees of the visual field.

In final 2.00A6a(vi), we explain that we measure the extent of visual field loss by determining the portion of the visual field in which you can see a white III4e stimulus. This stimulus specification is the same as the specification in the second paragraph of prior 2.00A3.

In final 2.00A6a(vii), we explain that we need to determine the decibel (dB) level that corresponds to a 4e intensity for the particular perimeter being used. We further explain that we will then use the dB printout to determine which points would be seen at the 4e intensity level. We also give an example that explains that, for tests performed on Humphrey Field Analyzers, any point seen at 10 dB or higher is a point that would be seen with a 4e stimulus.

In final 2.00A6a(viii), we explain that we can also use visual field measurements obtained using kinetic perimetry, such as the Humphrey ''SSA Test Kinetic'' (a kind of automated kinetic perimetry) or Goldmann perimetry (a kind of manual kinetic perimetry). In response to a public comment, we have clarified this section to make it clear that this type of testing may be used instead of automated static threshold perimetry.

We contracted with West Virginia University to conduct research to determine whether the Humphrey ''SSA Test Kinetic'' is comparable to Goldmann perimetry. This research, which was completed in April 2000, showed that the Humphrey ''SSA Test Kinetic'' is comparable to Goldmann perimetry, except that the Humphrey ''SSA Test Kinetic'' does not identify scotomata, that is, non-seeing areas in the visual field surrounded by seeing areas. Therefore, in the NPRM, we proposed that if we needed additional information because your visual disorder had progressed to the point where it was likely to result in a significant limitation in the central visual field, such as a scotoma, we would supplement the automated kinetic perimetry with the results of a Humphrey 30–2 or comparable test. There were public comments questioning this guidance. In response to those comments, we have clarified this section to state that we will not use the results of automated kinetic testing to assess your visual field loss in this situation. Instead, we will assess your visual field loss with automated static threshold perimetry or with manual kinetic perimetry.

In final 2.00A6a(ix), we explain that we will not use the results of visual field screening tests, such as confrontation tests, tangent screen tests, or automated static screening tests, to determine that your impairment meets or medically equals a listing or to evaluate your residual functional capacity. We also explain that we can consider normal results from visual field screening tests to determine whether your visual disorder is severe when these results are consistent with the other evidence in your case record. We also list some circumstances under which we will not consider normal test results to be consistent with the other evidence in the file.

Consistent with our removal of the guidance on aphakia, we are removing the stimulus specifications used to test individuals with aphakia contained in the first two paragraphs of prior 2.00A3.

In final 2.00A6b, we revise the guidance in the first paragraph of prior 2.00A3 on the use of corrective lenses during visual field testing. We explain that eyeglasses must not be worn during the visual field examination because they limit your field of vision, but contact lenses or perimetric lenses may be used in order to obtain the most accurate visual field measurements. We also provide that, for this single purpose, you do not need to demonstrate that you have the ability to use the contact or perimetric lenses on a sustained basis.

2.00A7—How do we calculate visual efficiency?

In this section, we expand the guidance in prior 2.00A5, ''Visual efficiency,'' by explaining how we calculate visual acuity efficiency, visual field efficiency, and visual efficiency. The guidance in 2.00A7b is based on the first sentence of paragraph 2 of the explanatory text following Table 2 in the prior rules. We are deleting that sentence from the explanation of Table 2 because we are moving it here. The guidance in 2.00A7c is based on prior 2.00A5 and the parenthetical statement at the end of prior listing 2.04, which we are deleting because it is redundant. In response to a public comment, we are also adding an example to 2.00A7c to illustrate how visual efficiency is calculated.

2.00A8—How do we evaluate specific visual problems?

This section replaces prior 2.00A6, ''Special situations.'' In this section, we are adding guidance for evaluating specific visual problems. The following is a discussion of the section.

2.00A8a—Statutory blindness

In this section, we codify a longstanding procedure. The most commonly used visual acuity test charts are charts based on Snellen methodology. These charts usually do not have lines that measure visual acuity between 20/100 and 20/200. Therefore, if you are unable to read any of the letters on the 20/100 line on a test chart based on Snellen methodology, your visual acuity will be assessed as 20/200 or less.

There are newer test charts (not yet widely used, but comparable to charts based on Snellen methodology) that do have lines to measure visual acuity between 20/100 and 20/200. Based on medical literature, we know that if your visual acuity is between 20/100 and 20/200 as measured on those newer test charts, it would be 20/200 if it were measured using the more common chart based on Snellen methodology. We explain in this section that if your visual acuity is measured using one of these newer charts and you cannot read any of the letters on the 20/100 line, we will determine that you have statutory blindness based on a visual acuity of 20/200 or less. We also provide that, regardless of the type of test chart used, you do not have statutory blindness if you can read at least one letter on the 20/100 line. In response to a public comment, we have added examples of how we evaluate visual acuity measurements between 20/100 and 20/200.

2.00A8b—Blepharospasm

In the NPRM, we described the disorder and explained that we must consider how the involuntary blinking that characterizes it can affect your ability to maintain the measured visual acuities and visual fields over time. In response to a public comment, we have revised this section to refer to your ability to maintain visual functioning over time instead of your ability to maintain the measured visual acuities and visual fields over time. Also, as we reviewed this section to respond to the public comment, we realized that ''closure of the eyelids'' is a better descriptor of how the disease manifests than ''eye blinking,'' and have made this nonsubstantive change to more clearly describe the disorder. We have also made other nonsubstantive editorial changes for clarity.

2.00A8c—Scotoma

We define the term ''scotoma'' as a non-seeing area in the visual field surrounded by a seeing area. We also explain that when we measure your visual field, we will subtract the length of any scotoma, other than the normal blind spot, from the overall length of any diameter on which it falls.

2.00C—How do we evaluate impairments that do not meet one of the special senses and speech listings?

We are revising the guidance in the second paragraph of prior 2.00A6 by stating our basic adjudicative principle that if the impairment(s) does not meet or medically equal the criteria of a listing in this body system, we must consider whether it meets or medically equals the criteria of a listing in another body system. If not, we must continue the sequential evaluation process (see §§ 404.1520 and 416.920) to determine whether you are disabled or continue to be disabled (see §§ 404.1594, 416.994 and 416.994a). This new section applies to all the impairments in this body system, not just visual disorders.

How are we changing the criteria in the special senses and speech listings for adults?

2.01 Category of Impairments, Special Senses and Speech

We are removing the reservation for listing 2.05 because it is no longer needed. We are also removing prior listing 2.06, ''Total bilateral ophthalmoplegia,'' for the reasons cited in ''2.00 Special Senses and Speech'' above.

Listing 2.02—Loss of visual acuity

This final listing corresponds to prior listing 2.02, ''Impairment of visual acuity.'' We are changing the heading to be consistent with other language in these final rules.

Listing 2.03—Contraction of the visual field in the better eye

This final listing corresponds to prior listing 2.03, ''Contraction of peripheral visual fields in the better eye.'' We are removing prior listing 2.03A, which provided that an individual's visual field loss was of listing-level severity when the field was contracted to 10 degrees or less from the point of fixation. Prior listing 2.03B provided that an individual's visual field loss was of listing-level severity if that loss resulted in the widest diameter of the field subtending an angle no greater than 20 degrees. Any visual field loss that satisfied the criterion in prior listing 2.03A also satisfied the criterion in prior listing 2.03B. Therefore, prior listing 2.03A was unnecessary.

We are redesignating prior listing 2.03B as final listing 2.03A. In response to a public comment, we have added the phrase ''around the point of fixation'' to

make it clear that when we measure the widest diameter, the diameter must go through the point of fixation.

The NRC report contained a recommendation that a mean deviation (MD) of −22 or worse on an automated static threshold perimetry test measuring the central 30 degrees of the visual field ''would serve as a reasonable criterion for disability determination.'' We agree with the NRC and are adding this criterion as final listing 2.03B.

Final listing 2.03C corresponds to prior listing 2.03C. We are clarifying the criterion by indicating that a determination of visual field efficiency must be based on kinetic perimetry.

Listing 2.04—Loss of visual efficiency

This final listing corresponds to prior listing 2.04, ''Loss of visual efficiency.'' As already explained, we are removing the parenthetical statement at the end of the prior listing because it was redundant of information in proposed 2.00A7c. However, we are adding a reference to that section of the final introductory text as a reminder of where this guidance is contained.

Table 1—Percentage of Visual Acuity Efficiency Corresponding to the Best-Corrected Visual Acuity Measurement for Distance in the Better Eye

To be consistent with our removal of the introductory text on aphakia, we are removing the columns and guidance addressing aphakia from prior Table 1. We are also removing the entries for visual acuities worse than 20/100 for the reasons we gave under the explanation of final 2.00A8a. In response to a public comment, we are removing the entries for visual acuities of 20/32 and 20/64 and adding entries for visual acuities of 20/30, 20/60, and 20/70.

Table 2—Charts of Visual Fields

We are removing the first sentence of prior paragraph 2 in the explanation of how to use Table 2. That sentence provided instructions for calculating the percent of visual field efficiency, and we moved it to final 2.00A7b. We are also making nonsubstantive editorial changes for clarity.

How are we changing the introductory text to the special senses and speech listings for children?

102.00 Special Senses and Speech

Except for minor editorial changes, we have repeated much of the introductory text of final 2.00A in the introductory text to final 102.00A. This is because the same basic rules for establishing and evaluating the existence and severity of visual disorders in adults also apply to children. Because we have already described these provisions under the explanation of final 2.00A, the following discussions describe only those provisions that are unique to the childhood rules or that require further explanation specific to evaluating disability in children.

We are removing the second paragraph of prior 102.00A, ''Visual impairments in children.'' This paragraph indicated that the accommodative reflex is generally not present in children under 6 months of age (or, for a premature child, until 6 months of age plus the number of months the child is premature). It also provided that the absence of this reflex should be considered indicative of a visual impairment only in children above this age. We included this guidance in the prior rules to explain that it was not appropriate to use the criterion in prior listing 102.02B1 until the child reached the required age. However, in these final listings, we incorporated prior listing 102.02B1 into the more general category of abnormal anatomical findings evaluated under final listing 102.02B2. As the lack of the accommodative reflex is not considered an abnormal anatomical finding in very young children, its absence would not satisfy the final listing criterion. Therefore, we no longer need this explanation.

102.00A1—What are visual disorders?

In this section, we expand the guidance provided for adults in final 2.00A1 to indicate that in addition to limiting your ability to distinguish detail, read, and do fine work, a loss of visual acuity may affect your ability to perform other age-appropriate activities. We added this supplemental guidance to reflect the way we evaluate disability claims of children.

102.00A2—How do we define statutory blindness?

In this section, we repeat the guidance in final 2.00A2, but refer to the childhood listings that show statutory blindness.

102.00A4—What evidence do we need to evaluate visual disorders, including those that result in statutory blindness under title II?

In this section, which is the same as final 2.00A4, we replace and expand the third paragraph of prior 102.00A.

102.00A5—How do we measure best-corrected visual acuity?

In this section, we revise the guidance in the first paragraph of prior 102.00A. In final 102.00A5a, we discuss comparable visual acuity testing for children who are unable to participate in testing using Snellen methodology, for example, because they are too young, and add guidance for how we evaluate children who are unable to participate in testing using Snellen methodology or other comparable testing. In response to a public comment, we have revised proposed 102.00A5b by adding examples of abnormal anatomical findings and abnormal neuroimaging of the cerebral cortex that would indicate a visual acuity of 20/200 or less.

102.00A6—How do we measure visual fields?

In this final section, we repeat the guidance in final 2.00A6 but in 102.00A6a(ix) refer to the way we evaluate disability in children.

102.00C—How do we evaluate impairments that do not meet one of the special senses and speech listings?

In this section, we repeat the guidance in final 2.00C, but include the definition of disability for children who are filing for or are receiving SSI payments.

How are we proposing to change the criteria in the special senses and speech listings for children?

102.01 Category of Impairments, Special Senses and Speech

We are adding new listings 102.03, ''Contraction of the visual field in the better eye,'' and 102.04, ''Loss of visual efficiency,'' because they apply to children as well as adults. Due to the addition of these listings, we are also adding Table 1, ''Percentage of Visual Acuity Efficiency Corresponding to the Best-Corrected Visual Acuity Measurements for Distance in the Better Eye,'' and Table 2, ''Charts of Visual Fields.''

These new listings and tables are identical to the corresponding adult listings and tables. Previously, we used prior listings 2.03 and 2.04 (and their corresponding tables) to evaluate children with visual field and visual efficiency impairments. With final listings 102.03 and 102.04 we will no longer need to refer to the listings in part A when we evaluate these impairments in children.

We are also making nonsubstantive editorial changes to the heading of this section to be consistent with the heading of 2.01.

Listing 102.02—Loss of visual acuity

This final listing corresponds to prior listing 102.02, ''Impairments of visual acuity.'' We are not making any changes to prior listing 102.02A.

We used prior listing 102.02B to evaluate loss of visual acuity in children below 3 years of age at the time of adjudication. We are removing the age criterion and instead will use final listing 102.02B to evaluate loss of visual acuity in any child who is unable to participate in testing using Snellen methodology or other comparable visual acuity testing and who has clinical findings that fixation and visual-following behavior are absent in the better eye.

The criteria in prior listing 102.02B were all examples of abnormal anatomical findings observable during a clinical eye examination. When present in the better eye, these abnormal anatomical findings would be expected to result in the absence of fixation and visual-following behavior, and would indicate a visual acuity of 20/200 or less. Rather than list each type of abnormal anatomical finding, we combined the prior criteria into a general category of abnormal anatomical findings in final listing 102.02B1. We used the phrase ''a visual acuity of 20/200 or worse'' in proposed listing 102.02B1. We have revised this phrase in final listing 102.02B1 to read ''a visual acuity of 20/200 or less'' to be consistent with the statutory language that defines blindness.

Final listings 102.02B2, 102.02B3, and 102.02B4 add criteria for impairments that generally are not observable during a clinical eye examination, but are diagnosed based on abnormal neuroimaging, an abnormal electroretinogram, or an absent response to VER testing. We did not propose the criterion in final listing 102.02B4, an absent response to VER testing in the better eye, in the NPRM. This criterion was added in response to a public comment.

Public Comments

In the NPRM we published in the **Federal Register** on August 17, 2005 (70 FR 48342), we provided the public with a 60-day comment period that ended on October 17, 2005. In addition to our notice to the public, we invited comments from national medical organizations and professionals who have expertise in the evaluation of visual disorders. As part of our outreach efforts, we also invited comments from advocacy groups and legal services organizations.

We received comments from 13 commenters. The commenters included advocacy groups, legal services organizations, State agencies that make disability determinations for us, medical organizations, ophthalmologists, and other individuals. We carefully considered all of the comments. Because some of the comments were long, we have condensed, summarized, and paraphrased them. We believe we have presented the commenters' views accurately, and have responded to all of the significant issues raised by the commenters that were within the scope of these rules.

Statutory Blindness

Comment: Two commenters suggested that we use the term ''blindness'' in the listings only to describe total vision loss or near-total vision loss; that is, situations in which the individual must rely primarily on vision substitution skills. They indicated that it is more appropriate to use the ranges of ''mild,'' ''moderate,'' ''severe,'' and ''profound'' vision loss as defined in the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* Fifth Edition (hereinafter, the ''AMA Guides'') for those individuals who have residual vision; that is, those that can still benefit from vision enhancement aids. As defined in the AMA Guides, the term ''severe vision loss'' reflects the statutory standard.

Response: We were not able to adopt this comment because we must follow the language of the Act. The definition of ''blindness'' in sections 216(i)(1) and 1614(a)(2) of the Act is:

> [C]entral visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered * * * as having a central visual acuity of 20/200 or less.

Comment: One commenter noted that the definition of blindness in proposed 2.00A2 and 102.00A2 contained the phrase ''with the use of a correcting lens.'' The commenter believed that this language can be taken to mean that any corrective lens will fulfill the requirement and recommended that the language be changed to read ''visual acuity of 20/200 or less in the better eye with the use of best possible corrective lens.''

Response: We partially adopted this comment. We have not deleted the phrase ''with the use of a correcting lens'' from the definition of blindness in final 2.00A2 and 102.00A2 as those sections reflect the statutory definition of blindness and the phrase is part of the statutory language. However, we have added a reference to sections 216(i)(1) and 1614(a)(2) of the Act in final sections 2.00A2 and 102.00A2 of the rules to make it clearer that we are providing the statutory definition. We also added guidance indicating that when we determine whether the statutory definition of blindness based on visual acuity is met, we use the best-corrected visual acuity for distance in the better eye.

Comment: One commenter suggested that we expand the definition of statutory blindness to include the criteria in proposed listings 2.03B and C and proposed listing 2.04. The commenter indicated that we can interpret the statute, and that the suggestion would be a reasonable interpretation.

Response: We did not adopt this comment. Although we agree that we have the authority to interpret the statute when necessary, the definition of blindness in the Act is clear and explicit, and there is nothing in the legislative history to suggest that Congress intended us to apply any standard other than the definitions in the statute, which are reflected in final listings 2.02 and 2.03A. (S. Rep. No. 90–744, at 7, 46–47 (1967), as reprinted in 1967 U.S.C.C.A.N. 2834, 2842, 2886–2887.)

Comment: We received several comments on our method for evaluating visual acuity measurements between 20/100 and 20/200 (proposed 2.00A8a and 102.00A8a). One commenter said that finding statutory blindness based on a visual acuity of 20/200 is a more liberal standard than that used in any other country, and that our proposal to treat visual acuity measurements between 20/100 and 20/200 as visual acuity of 20/200 would move us even further out of the global mainstream. This commenter stated we should instead use visual acuity that is worse than 20/160 as our standard, and indicated that when the clinician does not use a chart containing visual acuity measurements between 20/100 and 20/200, the clinician should measure best-corrected visual acuity from a distance of 10 feet instead of the usual 20 feet. Other commenters, including the American Optometric Association, indicated that our approach to interpreting visual acuity measurements between 20/100 and 20/200 is sensible because it does not adversely affect people who had previously been classified as disabled. Another commenter wondered whether an individual who can see only one letter on the 20/100 line of a visual acuity chart has functionally better vision than someone with best-corrected visual acuity of 20/200. However, this commenter did acknowledge that a line must be drawn somewhere.

Response: We did not adopt the recommendations to change our policy on evaluating visual acuity measurements between 20/100 and 20/

200. As we indicated in our explanation of proposed 2.00A8a in the NPRM (70 FR at 48346) and in our explanation of final 2.00A8a earlier in this preamble, the most commonly used visual acuity test charts are based on Snellen methodology and usually do not have lines that measure visual acuity between 20/100 and 20/200. While there are newer test charts that do provide such measurements, such as the Early Treatment Diabetic Retinopathy Study (ETDRS) chart, these charts are not widely used in clinical practice. Also, we know that if an individual's visual acuity is between 20/100 and 20/200 as measured on those newer charts, it would be 20/200 if measured using the most commonly used charts. Rather than evaluating the severity of a visual disorder based on the different types of charts used to test an individual's visual acuity, we have determined that it is more appropriate to assess visual acuity for all individuals using the same methodology—the one incorporated in the most commonly used test charts and the one contemplated in the statutory definition of blindness.

Moreover, we do not agree that requiring testing at 10 feet, instead of 20 feet, is a feasible alternative. The testing of visual acuity requires a specific optics setup in the clinician's office, and in most offices the optics setup is designed to obtain visual acuity measurements at a 20-foot working distance; that is, even when the testing lane is not 20 feet long, the optics setup is designed to give results comparable to those obtained at 20 feet. We believe that requiring best-corrected visual acuity measurements at a 10-foot working distance would greatly restrict our ability to use evidence provided by the individual's treating source(s) because we do not believe that clinicians would reconfigure the optics in their offices to obtain measurements that are not widely used in the medical community.

Also, we do not believe we should expand the standards for statutory blindness to encompass individuals who can read some, but not all, of the letters on the 20/100 line of the visual acuity chart. Such a standard would be more lenient than the 20/200 definition for blindness contained in the Act, even when measured on more commonly used visual acuity test charts. As we indicated above, there is nothing in the language of the statute or the legislative history to suggest that Congress intended that we apply any standard other than the strict definitions in the statute.

Comment: One commenter, who believed that we were expanding our definition of statutory blindness by providing that individuals who have visual acuity between 20/100 and 20/200 would meet the definition of statutory blindness, indicated that it was not obvious that the changes we proposed would have no cost. The commenter recommended that we do a field study to ascertain the fiscal impact of the proposed rules.

Response: As we indicated in our explanation of proposed 2.00A8a in the NPRM (70 FR at 48346) and in our explanation of final 2.00A8a earlier in this preamble, we are codifying in our regulations our longstanding procedure for evaluating visual acuity measurements between 20/100 and 20/200. We have used this procedure since 1991. Therefore, the proposed rules did not, and these final rules do not, change how we evaluate such clinical findings. We do not expect there will be any impact on program or administrative costs, and we do not agree that a field study is needed.

Comment: One commenter indicated that our policy on evaluating visual acuity measurements between 20/100 and 20/200 needed to be more clearly discussed and suggested that we add examples.

Response: We partially adopted this comment by adding examples in final 2.00A8a and 102.00A8a to illustrate how we use visual acuity measurements between 20/100 and 20/200 to determine whether an individual has statutory blindness.

Comment: Several commenters questioned the differences between the eligibility requirements for benefits based on blindness under title XVI and benefits based on disability under title II and title XVI. One commenter noted that individuals age 18 or older have to show an inability to do substantial gainful activity (SGA) to receive disability benefits, but that the inability to do SGA is not required for benefits based on blindness under title XVI. Three commenters noted that it is not necessary to establish the cause of the blindness in order to receive benefits based on blindness under title XVI, but it is necessary to establish the cause of any visual loss in order to receive disability benefits under either title XVI or title II, including disability benefits based on blindness under title II. One of these commenters indicated that these differences, as well as the fact that there is no duration requirement for benefits based on blindness under title XVI while there is such a requirement under title II, penalize individuals who receive title II disability benefits based on blindness. This commenter also recommended that if the title XVI eligibility requirements are statutory and cannot be changed, we should apply them when we determine whether individuals are disabled based on blindness under title II. Another commenter indicated that having different eligibility criteria could be confusing to our adjudicators.

Response: As we indicated in our explanation of proposed 2.00A3 in the NPRM (70 FR at 48345) and in our explanation of final 2.00A3 earlier in this preamble, these rules are required by the Act. ''Blindness'' and ''disability'' are separate categories under title XVI, whereas under title II blindness is considered a type of ''disability.'' The statutory requirements for eligibility based on blindness under title XVI are different from the statutory requirements for eligibility based on disability under title II and title XVI. As a matter of law, we cannot apply the title XVI eligibility requirements for statutory blindness to title II claims for disability.

We do not believe that our adjudicators will be confused by the different eligibility criteria in these final rules because we have been following these different rules for adjudicating blindness under title II and title XVI since the SSI program began in 1974. Therefore, our adjudicators have long been aware of these differences.

Visual Acuity

Comment: One commenter noted that there are some visual acuity tests used in low vision clinics that use a testing distance of 10 feet. The commenter suggested that the regulation explain how to interpret these results.

Response: In response to this comment, we expanded our guidance in proposed 2.00A5b(ii) and 102.00A5b(ii) to address this issue.

Comment: One commenter suggested that we revise proposed 2.00A5b(i) and 102.00A5b(i) to add ''automated refraction acuity'' as an example of a type of visual acuity testing that cannot be used to determine best-corrected visual acuity.

Response: We adopted this comment.

Comment: Two commenters noted that while proposed 2.00A5b(i) and 102.00A5b(i) clarified that VER testing cannot be used to measure best-corrected visual acuity, the proposed rules did not describe how VER testing should be used. The commenters indicated that VER testing can be useful in many situations, such as ascertaining whether a non-verbal individual is able to see, diagnosing cortical visual disorders, and evaluating cases in which malingering is suspected. One commenter asked how we evaluate

cases of young children in which neuroimaging results are not obtainable, but in which the treating source has diagnosed a cortical visual disorder, there is an absent response to VER testing, and fixation and following behavior are absent.

Response: We agree with the commenters that when there is an absent response to VER testing in an eye, we can use that result to determine that the visual acuity is 20/200 or less in that eye, and we are adding this guidance to proposed 2.00A5b and 102.00A5b. We are also revising proposed 2.00A4b and 102.00A4b to indicate that we will request a copy of VER testing results if this testing was performed to help diagnose a cortical visual disorder. Lastly, we are adding an absent response to VER testing as a criterion in final listing 102.02B.

We also agree that VER testing has other uses in clinical practice. However, VER testing is one tool among many that clinicians use to assess the degree of visual loss, and it is beyond the scope of these listings to explain how tools such as VER testing are used by clinicians in making their assessments.

Comment: One commenter noted that proposed 2.05A and 102.05A provided that we will use visual acuity testing that was carried out using Snellen methodology or any other testing methodology that is comparable to Snellen methodology. The commenter indicated that there is no generally agreed on definition of Snellen methodology, and suggested we use ''letter chart testing'' instead of ''Snellen methodology.''

Response: We did not adopt the comment. The term ''Snellen methodology'' is well recognized by the medical community as meaning a chart on which there is one large letter for 20/200 and below it rows of letters in progressively smaller sizes that reflect the distance at which a normal eye would be able to see the letters in that row.

Measuring Visual Acuity in Children

Comment: One commenter noted that proposed listing 102.02A requires best-corrected visual acuity at distance. The commenter also noted that paragraph 102.00A5a(iii) provides that if a child is unable to participate in visual acuity testing, fixation and following behavior will be considered. The commenter indicated that some children retain the ability to fix and follow at short distances, such as three feet, but not at far distances. The commenter asked how we assess visual acuity for these individuals if neuroimaging is not available.

Response: A child has statutory blindness based on visual acuity loss if his or her visual acuity is 20/200 or less in the better eye with the use of a correcting lens. For children who can participate in visual acuity testing, we determine whether the child has statutory blindness by assessing the child's best-corrected visual acuity for distance in the better eye.

However, not all children can participate in visual acuity testing. For these children, we developed alternative criteria in final listing 102.02B for determining if their visual acuity loss has resulted in statutory blindness. One of the requirements of that listing is that the visual disorder results in the absence of fixation and visual-following behavior. The listing contemplates that this behavior will be assessed at short distances; that is, within a few feet, because that is how this behavior is assessed in clinical practice. If a child can use the better eye to fixate and visually follow at short distances, his or her impairment does not meet the listing. We will then evaluate the visual disorder to determine if it medically equals a listing or functionally equals the listings.

Comment: One commenter noted that proposed listing 102.02B required clinical findings that fixation and visual-following behavior be absent in the better eye and indicated that the phrase ''in the better eye'' is unnecessary. The commenter remarked that if the better eye cannot fix and follow, the lesser eye certainly cannot.

Response: We did not delete the phrase ''in the better eye'' from final listing 102.02B because we believe it is necessary to the meaning of the rule. If we did not have it, the listing could be met if a child could not fixate and visually follow in the lesser eye but could in the better eye.

Comment: One commenter noted that proposed 102.00A5b(i) provided that visual acuity measurements obtained with a specialized lens can be used only if the child has demonstrated the ability to use the lens on a sustained basis. It also provided that telescopic lenses cannot be used because they significantly reduce the visual fields. The commenter wanted to know how visual acuity is assessed if the child is too young to wear specialized lenses on a sustained basis and telescopic lenses cannot be used.

Response: If the child can participate in visual acuity testing, his or her visual acuity will be assessed through refraction, and we will use the best-corrected visual acuity for distance that the child will have with regular glasses. If the child cannot participate in visual acuity testing, we will assess his or her ability with the better eye to fixate and visually follow. If fixation and visual following are absent, we will look at anatomical findings, or the results of neuroimaging, electroretinography, or VER testing, if any of these have been done, to determine if they are consistent with a finding of visual acuity of 20/200 or less. If they are not consistent with such a finding, we will evaluate the visual disorder to determine whether there is medical or functional equivalence.

Comment: Two commenters indicated we should expand the introductory text to provide examples of abnormal anatomical findings that would indicate a visual acuity of 20/200 or worse in the better eye. One commenter indicated the examples could include bilateral optic atrophy, bilateral optic pallor with specific cup-to-disc size detailed, findings of bilateral congenital cataracts, or presence of Stage III or worse retinopathy of prematurity despite surgical intervention. One of the commenters also asked for examples of abnormal neuroimaging of the cerebral cortex that would indicate a visual acuity of 20/200 or worse in the better eye.

Response: In response to these comments we added final 102.00A5b(iii) to provide examples of abnormal anatomical findings and abnormal neuroimaging documenting damage to the cerebral cortex that would indicate best-corrected visual acuity of 20/200 or less. We did not include bilateral optic pallor with specific cup-to-disc size detailed or findings of bilateral congenital cataracts as examples of abnormal anatomical findings that would indicate a visual acuity of 20/200 or less in the better eye because we do not believe that these findings are always indicative of that level of visual acuity loss.

Visual Fields

Comment: One commenter objected to several of our requirements for acceptable perimeters in proposed 2.00A6a(ii) and 102.00A6a(ii) which can be used to perform automated static threshold testing. The commenter believed that the requirements seemed to be dictated more by a desire to promote the Humphrey Field Analyzer than by the requirements of disability evaluation. The commenter stated that our requirements that the perimeter have an internal normative database, a statistical analysis package, and demonstrate the ability to correctly detect visual field loss and correctly identify normal visual fields were unnecessary. The commenter also

indicated that these requirements would not permit the use of Goldmann perimeters.

Response: As we indicated in our explanation of proposed 2.00A6a in the NPRM (70 FR at 48345) and in our explanation of final 2.00A6a earlier in this preamble, we adopted the criteria recommended in the NRC report as our requirements for perimeters used to perform automated static threshold perimetry. We agree with the NRC that all the criteria should be satisfied.

In final 2.00A6a(ii) and 102.00A6a(ii) we cite the Humphrey Field Analyzer as an example of an acceptable perimeter. We cite only the Humphrey Field Analyzer because it is not our intention to list in these rules every acceptable automated perimeter, and the Humphrey Field Analyzer is the most widely used automated perimeter in the United States.

Goldmann perimeters are manual kinetic perimeters. The requirements listed in final 2.00A6a(ii) and 102.00A6a(ii) are for perimeters used to perform automated static threshold testing; therefore, they are not applicable to Goldmann perimeters. However, as we indicated in our explanation of 2.00A6a in the NPRM (70 FR at 48345) and in our explanation of final 2.00A6a earlier in this preamble, we will continue to use visual field measurements obtained with kinetic perimetry such as Goldmann perimetry.

Comment: Several commenters noted that proposed 2.00A6a(iv) and 102.00A6a(iv) appeared to conflict with proposed 2.00A6a(v) and 102.00A6a(v) and requested that we clarify this guidance. One commenter indicated that we should require a 30-degree test for all situations. Another suggested that we add a reference to listing 2.03A in proposed 2.00A6a(iv).

Response: We clarified the rules in response to the comments. Proposed 2.00A6a(iv) and 102.00A6a(iv) described the automated static threshold testing needed to determine if an individual's visual field loss resulted in statutory blindness; that is, whether the widest diameter of the visual field subtended an angle no greater than 20 degrees and thus satisfied the criterion in proposed listing 2.03A or 102.03A. Proposed 2.00A6a(v) and 102.00A6a(v) described the automated static threshold testing needed to determine if an individual's visual field loss satisfied the criterion in proposed listing 2.03B or 102.03B. The criterion in proposed listing 2.03B or 102.03B did not represent statutory blindness. Therefore, the fact that there were different documentation requirements was not a conflict. However, in response to these comments, we added a reference to final listing 2.03A in final 2.00A6a(iv) and a reference to final listing 102.03A in final 102.00A6a(iv).

We did not adopt the comment to require a 30-degree test to determine if an individual has statutory blindness based on visual field loss. If a 24-degree test shows this degree of limitation, we believe it is not necessary to obtain a 30-degree test.

Comment: One commenter questioned the NRC's recommendations for visual field testing. The commenter believed that, while visual field tests that measure the central 30 degrees of the visual field are valuable for diagnostic purposes, the NRC report failed to provide evidence that they would also be appropriate for disability evaluation; that is, for determining the consequences of a visual disorder. The commenter indicated that evaluation of reading and mobility would be better measures of visual disability. The commenter also suggested that instead of adopting the NRC recommendation, we should evaluate visual field loss using the method described in the AMA Guides, Fifth Edition.

Response: We did not adopt the comment. The NRC report recommended that we use a mean deviation of -22, determined by an automated static threshold perimetry test of the central 30 degrees of the visual field, as an indicator of disability. The NRC explained that this mean deviation corresponds to an individual having normal vision within the central 10-degree radius of the visual field and no vision outside this radius. The NRC indicated, and we agree, that this mean deviation represents extensive visual field loss, and we believe that this degree of visual field loss is of listing-level severity.

The NRC also looked at using reading and mobility as indicators of visual disability and found that use of these measures was not viable. Additionally, the NRC recommended we not use ''the visual field scoring procedures recently published by the American Medical Association (1993). The AMA guidelines are not based on empirical data, the procedures have not been validated, and their properties are largely unknown.''

Comment: One commenter noted that proposed 2.00A6a(v) and 102.00A6a(v) indicated that we need results from a Humphrey Field Analyzer but also provided that we could use comparable results from other acceptable perimeters. The commenter believed this language was inconsistent.

Response: In response to this comment, we revised proposed 2.00A6a(v) and 102.00A6a(v) to indicate that, while the criterion in final listings 2.03B and102.03B is based on the use of a test performed on a Humphrey Field Analyzer, we can also use comparable results from other acceptable perimeters.

Comment: One commenter noted that our explanation of proposed 2.00A6 indicated that the NRC report recommended that disability determinations be based on visual fields obtained by automated static threshold perimeters rather than by kinetic perimeters. The commenter noted that while automated static threshold perimetry can be used to determine if the visual disorder meets listing 2.03B, it cannot be used to determine the percentage of residual field efficiency. Two commenters believed that the fact that determinations under proposed listing 2.03C required kinetic testing contradicted the statement that either automated static threshold testing or kinetic testing could be used. One of these commenters believed that the regulations could be interpreted as requiring both automated static threshold testing and kinetic testing, and that such a requirement would increase costs for SSA.

Response: As we indicated in our explanation of proposed 2.00A6 in the NPRM (70 FR at 48345) and in our explanation of final 2.00A6 earlier in this preamble, we partially adopted the NRC recommendation. We will use results of automated static threshold perimetry to determine the degree of visual field loss, but we will also continue to use comparable visual field measurements obtained with kinetic perimetry. Because we allow for different types of testing, final listings 2.03 and 102.03 provide criteria that can be used with the different types of test results. As the results of these tests are comparable, only one type of testing is needed. Therefore, in response to the second comment, we clarified proposed 2.00A6a(viii) and 102.00A6a(viii) to state that kinetic perimetry may be used instead of automated static threshold perimetry.

Comment: One commenter noted that proposed 2.00A6a(viii) and 102.00A6a(viii) indicated that automated kinetic testing may need to be supplemented with a Humphrey 30–2 or comparable test if the visual disorder has progressed to the point where it is likely to result in a significant scotoma. The commenter asked if this meant that we should merge the test result obtained from the SSA test kinetic with the results of the automated static threshold testing when there is a significant scotoma present

and if there is a methodology that we want our adjudicators to follow for combining these tests. Another commenter suggested we revise proposed 2.00A6(viii) and 102.00A6a(viii) to indicate that automated kinetic testing needs to be supplemented when there is the likelihood of a significant limitation in the central or mid-peripheral visual field. The commenter believed we should add a reference to the mid-peripheral field as this is important in conditions such as retinitis pigmentosa, but also noted that such a limitation might be missed by a Humphrey 30–2 or comparable test.

Response: In response to these comments, we revised the guidance in proposed 2.00A6a(viii) and 102.00A6a(viii) to indicate that we will not use automated kinetic perimetry to assess visual field loss if the visual disorder has progressed to the point where it is likely to result in a significant limitation in the central visual field. In these situations, we will use automated static threshold testing or manual kinetic perimetry to evaluate the visual field loss.

We did not adopt the comment that asked us to add a reference to the mid-peripheral field. As we indicate below, we believe that measuring the central 30 degrees of the visual field will provide sufficient information to determine disability or blindness.

Comment: One commenter noted that the Goldmann and Humphrey kinetic tests, which measure to the periphery, used in conjunction with the 30–2 would give a better picture of the visual field than the 30–2 alone.

Response: While we agree with the commenter, we believe that a visual field test that measures the central 30 degrees of the visual field will provide sufficient information to determine blindness or disability.

Comment: One commenter suggested that we revise the language in proposed 2.00A6a(ix) and 102.00A6a(ix) to state that we can use normal test results to determine that the visual field loss is not severe.

Response: In response to this comment, we have clarified proposed 2.00A6a(ix) and 102.00A6a(ix) to state that we can consider normal results from visual field screening tests to determine whether the visual disorder is severe.

Comment: One commenter suggested we add the words ''around fixation'' to proposed listing 2.03A, the listing for contraction of the visual field in the better eye, with the widest diameter subtending an angle no greater than 20 degrees.

Response: We have adopted this comment by adding the phrase ''around the point of fixation'' in final listings 2.03A and 102.03A. This will clarify that, when we measure the widest diameter, the diameter must go through the point of fixation.

Comment: One commenter suggested we add a chart showing how the length of a scotoma is subtracted from the overall length of any diameter in which it falls.

Response: We did not adopt this comment. However, we plan to issue a Social Security Ruling to explain the procedural aspects of measuring the visual field, and we will explain how to deduct the length of a scotoma in that ruling.

Comment: Two commenters noted that proposed 2.00A6a(i) cited macular edema as an example of a disorder that could result in visual field loss in adults but this disorder was not cited in proposed 102.00A6a(i). One of these commenters suggested that macular edema not be included as an example of a disorder that could result in visual field loss as it does not result in more than minimal field loss. The other commenter indicated that macular edema should be added to proposed 102.00A6a(i) as the condition does occur in children.

Response: We agree that macular edema generally does not result in significant visual field loss; therefore, we removed the example in response to the comment that asked us to do that. Final 2.00A6a(i) and 102.00A6a(i) are now the same in this regard.

Visual Efficiency

Comment: Two commenters recommended that we change the way we calculate visual efficiency to use the functional vision score (FVS) as described in the AMA Guides.

Response: We did not adopt this comment. The FVS is based on an assessment of visual acuity and visual fields. The visual acuity assessment requires the use of an ETDRS-type chart which is the preferred visual acuity chart for research purposes, but is not commonly used in clinical practice. Additionally, this visual acuity assessment requires a measurement of binocular visual acuity, and this measurement usually is not performed as part of a routine eye examination.

Also, as we indicated above, the NRC report recommended that we not use the visual field scoring procedures published by the AMA.

Comment: Three commenters asked that we add an example to proposed 2.00A7 and 102.00A7 to clarify how we compute visual efficiency. One of these commenters also suggested that we add the phrase ''and expressing the product in decimals converted to a percentage'' to the end of proposed 2.00A7c and 102.00A7c.

Response: In response to this comment, we added an example of a visual efficiency calculation and the phrase ''and converting the decimal to a percentage'' to proposed 2.00A7c and 102.00A7c.

Comment: Two commenters recommended that we revise proposed Table 1 to show visual acuity efficiency ratings for the visual acuities of 20/30, 20/60, and 20/70 instead of the visual acuities of 20/32 and 20/64. One of these commenters also suggested we add ''aphakic with a contact lens'' to the heading of the last column in Table 1.

Response: In response to this comment we revised proposed Table 1 to show visual acuity efficiency for the visual acuities of 20/30, 20/60, and 20/70 (and their metric equivalents) instead of the visual acuities of 20/32 and 20/64. We did not adopt the second comment because we removed the heading in the last column of proposed Table 1 as these rules do not differentiate between an eye that is phakic, pseudophakic, or aphakic.

Binocular Vision

Comment: One commenter suggested we use binocular vision instead of vision in the better eye when we evaluate blindness or disability.

Response: We did not adopt this comment. The Act specifies that we use the vision in the better eye, that is, monocular vision, to determine blindness. Additionally, binocular visual acuity is often not measured during a routine eye examination. Lastly, there are no commonly used procedures to measure binocular visual fields directly or to derive a binocular visual field from monocular visual fields.

Specific Visual Disorders

Comment: One commenter questioned the removal of the guidance in prior 2.00A4, ''Muscle function.'' The commenter indicated that, although total bilateral ophthalmoplegia is very rare, paralysis of individual eye muscles or groups of eye muscles may cause a totally debilitating condition. The commenter noted that this type of impairment was not addressed in the proposed rules. Another commenter suggested that we add guidance on how to evaluate nystagmus.

Response: We did not adopt these comments as eye muscle disorders usually do not result in a listing-level loss of visual acuity or visual fields. As

we indicated in our explanation of the proposed changes to 2.00 in the NPRM (70 FR at 48344) and in our explanation of the final changes to 2.00 earlier in this preamble, we will evaluate ophthalmoplegia and other eye muscle disorders (such as nystagmus) by assessing the impact of the disorder on visual efficiency or on the individual's visual functioning.

Comment: Two commenters asked that we provide additional guidance on how to evaluate the effect of the involuntary blinking involved in blepharospasm on the ability to maintain measured visual acuity and visual fields over time. One of these commenters also suggested that we change the phrase ''maintain measured visual acuities and visual fields over time'' in the last sentence of section 2.00A8b to ''maintain function over time'' as blepharospasm does not cause a decrease in measured acuities or fields.

Response: In response to this comment, we revised proposed 2.00A8b and 102.00A8b to refer to visual functioning instead of visual acuities and visual fields. Additionally, as we reviewed this section to respond to this comment, we realized that we should have referred to ''closure of your eyelids'' instead of ''eye blinking,'' and have made this and other nonsubstantive editorial changes for clarity. We have not provided additional guidance on how to evaluate the effect of the involuntary eyelid closure. This assessment requires medical judgment and must be made on a case-by-case basis.

Comment: Two commenters expressed concern that deleting our prior guidance for evaluating aphakia will disadvantage those few individuals who are unable to obtain or use synthetic intraocular lenses or contact lenses.

Response: As we discussed in our explanation of the proposed changes to 2.00 in the NPRM (70 FR at 48344) and in our explanation of the final changes to 2.00 earlier in this preamble, we deleted the guidance on aphakia as this condition is effectively treated with synthetic intraocular lenses or contact lenses. We do not agree that the very few individuals who are unable to obtain or use these treatments will be adversely affected. If an individual with aphakia does not have an impairment that meets a listing, we can consider the effects of aphakia when we determine whether the impairment medically equals a listing or when determining residual functional capacity or, in children, functional equivalence.

Comment: One commenter suggested we add guidance about pseudophakia to proposed 2.00A8 and 102.00A8.

Response: We did not adopt this comment as these final rules do not differentiate between an eye that is phakic, pseudophakic, or aphakic.

Comment: One commenter suggested that we change the phrase ''cortical blindness'' used in proposed 2.00A4b and 102.00A4b to ''cortical visual impairment.'' The commenter also provided language that describes a cortical visual impairment and suggested we add the language to proposed 2.00A8 and 102.00A8. Another commenter noted that proposed 2.00A4b cited stroke as an example of a catastrophic event that can cause cortical blindness in adults. The commenter recommended that we include the same example in proposed 102.00A4b for children.

Response: In response to these comments, we changed the phrase ''cortical blindness'' to ''cortical visual disorder'' and expanded the discussion of cortical visual disorders in proposed 2.00A4b and 102.00A4b. Our expanded discussions include stroke as an example of a cause of cortical visual disorders in children.

Comment: One commenter requested clarification of what is needed to document a catastrophic event that causes blindness. The commenter asked if mention of the specific event as part of the medical history would be sufficient, or whether copies of the actual hospitalization, operative report, or pertinent lab studies would be required.

Response: The mention of a specific event as part of a medical history would be an allegation that the event took place; it would not be documentation of the event. To document the catastrophic event, we need medical records showing the treatment for the event.

Other Comments

Comment: One commenter noted that our reference to the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* Fifth Edition, cited pages 252 and 287–295. The commenter indicated that he believed we never consulted the fifth edition as the page numbers are wrong and the content is not used.

Response: We did reference the fifth edition of the AMA Guides. The reference to page 252 was an editing error. The section of the AMA Guides on impairment of visual field is on pages 287–295. Although we consulted this reference, we decided not to adopt the AMA's procedures for evaluating visual field loss for reasons we have already given.

Comment: A number of commenters suggested minor editorial changes and additions. For example, one commenter suggested we add the word ''impairments'' to the heading of this body system. Another commenter suggested we add the acronym ''VTAP'' after the word ''Humphrey'' in the last sentence of proposed 2.00A6a(iv) and 102.00A6a(iv). Another commenter suggested we change the heading of proposed 2.08 and 102.08.

Response: We did not adopt these suggestions. In some cases, we did not think they were necessary. In others, we did not think that they clarified the issues.

Comment: One commenter asked us to clarify the reporting requirements under the Paperwork Reduction Act.

Response: The Paperwork Reduction Act (PRA) of 1995, Public Law 104–13, requires Federal Government agencies that intend to collect information from 10 or more members of the public to seek comment on such information collections prior to obtaining Office of Management and Budget approval. The purpose in seeking public comment is to reduce to the extent practicable and appropriate the burden imposed on the public. Sections 2.00A and 102.00A discuss evidentiary reports, such as reports of eye examinations that we obtain from providers of medical evidence. The evidentiary reporting requirements are covered by the PRA; therefore; we provide an opportunity for the public to comment via the PRA notice shown in the preamble to the proposed rules.

Regulatory Procedures

Executive Order 12866

We have consulted with the Office of Management and Budget (OMB) and determined that these final rules meet the requirements for a significant regulatory action under Executive Order 12866, as amended by Executive Order 13258. Thus, they were subject to OMB review.

Regulatory Flexibility Act

We certify that these final rules do not have a significant economic impact on a substantial number of small entities because they affect only individuals. Thus, a regulatory flexibility analysis as provided in the Regulatory Flexibility Act, as amended, is not required.

Paperwork Reduction Act

The Paperwork Reduction Act (PRA) of 1995 says that no persons are required to respond to a collection of

information unless it displays a valid OMB control number. In accordance with the PRA, SSA is providing notice that OMB has approved the information collection requirements contained in Part A, 2.00 and Part B, 102.00 of these final rules. The OMB Control Number for this collection is 0960–0642, expiring March 31, 2008.

(Catalog of Federal Domestic Assistance Program Nos. 96.001, Social Security—Disability Insurance; 96.002, Social Security—Retirement Insurance; 96.004, Social Security—Survivors Insurance; and 96.006, Supplemental Security Income)

List of Subjects in 20 CFR Part 404

Administrative practice and procedure, Blind, Disability benefits, Old-Age, Survivors, and Disability Insurance, Reporting and recordkeeping requirements, Social Security.

Dated: August 2, 2006.

Jo Anne B. Barnhart,

Commissioner of Social Security.

■ For the reasons set forth in the preamble, we are amending subpart P of part 404 of chapter III of title 20 of the Code of Federal Regulations as set forth below:

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950–)

■ 1. The authority citation for subpart P of part 404 continues to read as follows:

Authority: Secs. 202, 205(a), (b), and (d)–(h), 216(i), 221(a) and (i), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405(a), (b), and (d)–(h), 416(i), 421(a) and (i), 422(c), 423, 425, and 902(a)(5)); sec. 211(b), Pub. L. 104–193, 110 Stat. 2105, 2189.

Appendix 1 to Subpart P of Part 404—[Amended]

■ 2. Appendix 1 to subpart P of part 404 is amended as follows:

■ a. Item 3 of the introductory text before part A of appendix 1 is amended by revising the expiration date.

■ b. Section 2.00A of part A of appendix 1 is revised.

■ c. Section 2.00C is added to part A of appendix 1.

■ d. Listing 2.02 of part A of appendix 1 is revised.

■ e. Listing 2.03 of part A of appendix 1 is revised.

■ f. Listing 2.04 of part A of appendix 1 is revised.

■ g. The reservation for listing 2.05 is removed.

■ h. Listing 2.06 of part A of appendix 1 is removed.

■ i. Tables 1 and 2 of section 2.00 of part A of appendix 1 are revised.

■ j. Section 102.00A of part B of appendix 1 is revised.

■ k. Section 102.00C is added to part B of appendix 1.

■ l. Listing 102.01 of part B of appendix 1 is revised.

■ m. Listing 102.02 of part B of appendix 1 is revised.

■ n. Listing 102.03 is added to part B of appendix 1.

■ o. Listing 102.04 is added to part B of appendix 1.

■ p. Tables 1 and 2 are added to section 102.00 of part B of appendix 1.

The revised text is set forth as follows:

Appendix 1 to Subpart P of Part 404—Listing of Impairments

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3. Special Senses and Speech (2.00 and 102.00): February 20, 2015.

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Part A

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2.00 SPECIAL SENSES AND SPEECH

A. *How do we evaluate visual disorders?*

1. *What are visual disorders?* Visual disorders are abnormalities of the eye, the optic nerve, the optic tracts, or the brain that may cause a loss of visual acuity or visual fields. A loss of visual acuity limits your ability to distinguish detail, read, or do fine work. A loss of visual fields limits your ability to perceive visual stimuli in the peripheral extent of vision.

2. *How do we define statutory blindness?* Statutory blindness is blindness as defined in sections 216(i)(1) and 1614(a)(2) of the Social Security Act (the Act). The Act defines blindness as visual acuity of 20/200 or less in the better eye with the use of a correcting lens. We use your best-corrected visual acuity for distance in the better eye when we determine if this definition is met. The Act also provides that an eye that has a visual field limitation such that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered as having visual acuity of 20/200 or less. You have statutory blindness only if your visual disorder meets the criteria of 2.02 or 2.03A. You do not have statutory blindness if your visual disorder medically equals the criteria of 2.02 or 2.03A, or if it meets or medically equals 2.03B, 2.03C, or 2.04. If your visual disorder medically equals the criteria of 2.02 or 2.03A, or if it meets or medically equals 2.03B, 2.03C, or 2.04, we will find that you have a disability if your visual disorder also meets the duration requirement.

3. *What evidence do we need to establish statutory blindness under title XVI?* For title XVI, the only evidence we need to establish statutory blindness is evidence showing that your visual acuity in your better eye or your visual field in your better eye meets the criteria in 2.00A2, provided that those measurements are consistent with the other evidence in your case record. We do not need to document the cause of your blindness. Also, there is no duration requirement for statutory blindness under title XVI (see §§ 416.981 and 416.983).

4. *What evidence do we need to evaluate visual disorders, including those that result in statutory blindness under title II?*

a. To evaluate your visual disorder, we usually need a report of an eye examination that includes measurements of the best-corrected visual acuity or the extent of the visual fields, as appropriate. If there is a loss of visual acuity or visual fields, the cause of the loss must be documented. A standard eye examination will usually reveal the cause of any visual acuity loss. An eye examination can also reveal the cause of some types of visual field deficits. If the eye examination does not reveal the cause of the visual loss, we will request the information that was used to establish the presence of the visual disorder.

b. A cortical visual disorder is a disturbance of the posterior visual pathways or occipital lobes of the brain in which the visual system does not interpret what the eyes are seeing. It may result from such causes as traumatic brain injury, stroke, cardiac arrest, near drowning, a central nervous system infection such as meningitis or encephalitis, a tumor, or surgery. It can be temporary or permanent, and the amount of visual loss can vary. It is possible to have a cortical visual disorder and not have any abnormalities observed in a standard eye examination. Therefore, a diagnosis of a cortical visual disorder must be confirmed by documentation of the cause of the brain lesion. If neuroimaging or visual evoked response (VER) testing was performed, we will request a copy of the report or other medical evidence that describes the findings in the report.

c. If your visual disorder does not satisfy the criteria in 2.02, 2.03, or 2.04, we will also request a description of how your visual disorder impacts your ability to function.

5. *How do we measure best-corrected visual acuity?*

a. *Testing for visual acuity.* When we need to measure your best-corrected visual acuity, we will use visual acuity testing that was carried out using Snellen methodology or any other testing methodology that is comparable to Snellen methodology.

b. *Determining best-corrected visual acuity.* (i) Best-corrected visual acuity is the optimal visual acuity attainable with the use of a corrective lens. In some instances, this assessment may be performed using a specialized lens; for example, a contact lens. We will use the visual acuity measurements obtained with a specialized lens only if you have demonstrated the ability to use the specialized lens on a sustained basis. However, we will not use visual acuity measurements obtained with telescopic lenses because they significantly reduce the visual field. If you have an absent response to VER testing in an eye, we can determine that your best-corrected visual acuity is 20/200 or less in that eye. However, if you have a positive response to VER testing in an eye, we will not use that result to determine your best-corrected visual acuity in that eye. Additionally, we will not use the results of pinhole testing or automated refraction acuity to determine your best-corrected visual acuity.

(ii) We will use the best-corrected visual acuity for distance in your better eye when we determine whether your loss of visual acuity satisfies the criteria in 2.02. The best-corrected visual acuity for distance is usually measured by determining what you can see from 20 feet. If your visual acuity is measured for a distance other than 20 feet, we will convert it to a 20-foot measurement. For example, if your visual acuity is measured at 10 feet and is reported as 10/40, we will convert this to 20/80.

6. *How do we measure visual fields?*

a. *Testing for visual fields.*

(i) We generally need visual field testing when you have a visual disorder that could result in visual field loss, such as glaucoma, retinitis pigmentosa, or optic neuropathy, or when you display behaviors that suggest a visual field loss.

(ii) When we need to measure the extent of your visual field loss, we will use visual field measurements obtained with an automated static threshold perimetry test performed on a perimeter, like the Humphrey Field Analyzer, that satisfies all of the following requirements:

A. The perimeter must use optical projection to generate the test stimuli.

B. The perimeter must have an internal normative database for automatically comparing your performance with that of the general population.

C. The perimeter must have a statistical analysis package that is able to calculate visual field indices, particularly mean deviation.

D. The perimeter must demonstrate the ability to correctly detect visual field loss and correctly identify normal visual fields.

E. The perimeter must demonstrate good test-retest reliability.

F. The perimeter must have undergone clinical validation studies by three or more independent laboratories with results published in peer-reviewed ophthalmic journals.

(iii) The test must use a white size III Goldmann stimulus and a 31.5 apostilb (10 cd/m^2) white background. The stimuli locations must be no more than 6 degrees apart horizontally or vertically. Measurements must be reported on standard charts and include a description of the size and intensity of the test stimulus.

(iv) To determine statutory blindness based on visual field loss (2.03A), we need a test that measures the central 24 to 30 degrees of the visual field; that is, the area measuring 24 to 30 degrees from the point of fixation. Acceptable tests include the Humphrey 30–2 or 24–2 tests.

(v) The criterion in 2.03B is based on the use of a test performed on a Humphrey Field Analyzer that measures the central 30 degrees of the visual field. We can also use comparable results from other acceptable perimeters, for example, a mean defect of 22 on an acceptable Octopus test, to determine that the criterion in 2.03B is met. We cannot use tests that do not measure the central 30 degrees of the visual field, such as the Humphrey 24–2 test, to determine if your impairment meets or medically equals 2.03B.

(vi) We measure the extent of visual field loss by determining the portion of the visual field in which you can see a white III4e stimulus. The ''III'' refers to the standard Goldmann test stimulus size III, and the ''4e'' refers to the standard Goldmann intensity filters used to determine the intensity of the stimulus.

(vii) In automated static threshold perimetry, the intensity of the stimulus varies. The intensity of the stimulus is expressed in decibels (dB). We need to determine the dB level that corresponds to a 4e intensity for the particular perimeter being used. We will then use the dB printout to determine which points would be seen at a 4e intensity level. For example, in Humphrey Field Analyzers, a 10 dB stimulus is equivalent to a 4e stimulus. A dB level that is higher than 10 represents a dimmer stimulus, while a dB level that is lower than 10 represents a brighter stimulus. Therefore, for tests performed on Humphrey Field Analyzers, any point seen at 10 dB or higher is a point that would be seen with a 4e stimulus.

(viii) We can also use visual field measurements obtained using kinetic perimetry, such as the Humphrey ''SSA Test Kinetic'' or Goldmann perimetry, instead of automated static threshold perimetry. The kinetic test must use a white III4e stimulus projected on a white 31.5 apostilb (10 cd/m^2) background. In automated kinetic tests, such as the Humphrey ''SSA Test Kinetic,'' testing along a meridian stops when you see the stimulus. Because of this, automated kinetic testing does not detect limitations in the central visual field. If your visual disorder has progressed to the point at which it is likely to result in a significant limitation in the central visual field, such as a scotoma (see 2.00A8c), we will not use automated kinetic perimetry to evaluate your visual field loss. Instead, we will assess your visual field loss using automated static threshold perimetry or manual kinetic perimetry.

(ix) We will not use the results of visual field screening tests, such as confrontation tests, tangent screen tests, or automated static screening tests, to determine that your impairment meets or medically equals a listing or to evaluate your residual functional capacity. However, we can consider normal results from visual field screening tests to determine whether your visual disorder is severe when these test results are consistent with the other evidence in your case record. (See §§ 404.1520(c), 404.1521, 416.920(c), and 416.921.) We will not consider normal test results to be consistent with the other evidence if either of the following applies:

A. The clinical findings indicate that your visual disorder has progressed to the point that it is likely to cause visual field loss, or

B. You have a history of an operative procedure for retinal detachment.

b. *Use of corrective lenses.* You must not wear eyeglasses during the visual field examination because they limit your field of vision. Contact lenses or perimetric lenses may be used to correct visual acuity during the visual field examination in order to obtain the most accurate visual field measurements. For this single purpose, you do not need to demonstrate that you have the ability to use the contact or perimetric lenses on a sustained basis.

7. *How do we calculate visual efficiency?*

a. *Visual acuity efficiency.* We use the percentage shown in Table 1 that corresponds to the best-corrected visual acuity for distance in your better eye.

b. *Visual field efficiency.* We use kinetic perimetry to calculate visual field efficiency by adding the number of degrees seen along the eight principal meridians in your better eye and dividing by 500. (See Table 2.)

c. *Visual efficiency.* We calculate the percent of visual efficiency by multiplying the visual acuity efficiency by the visual field efficiency and converting the decimal to a percentage. For example, if your visual acuity efficiency is 75 percent and your visual field efficiency is 64 percent, we will multiply 0.75×0.64 to determine that your visual efficiency is 0.48, or 48 percent.

8. *How do we evaluate specific visual problems?*

a. *Statutory blindness.* Most test charts that use Snellen methodology do not have lines that measure visual acuity between 20/100 and 20/200. Newer test charts, such as the Bailey-Lovie or the Early Treatment Diabetic Retinopathy Study (ETDRS), do have lines that measure visual acuity between 20/100 and 20/200. If your visual acuity is measured with one of these newer charts, and you cannot read any of the letters on the 20/100 line, we will determine that you have statutory blindness based on a visual acuity of 20/200 or less. For example, if your best-corrected visual acuity for distance in the better eye was determined to be 20/160 using an ETDRS chart, we will find that you have statutory blindness. Regardless of the type of test chart used, you do not have statutory blindness if you can read at least one letter on the 20/100 line. For example, if your best-corrected visual acuity for distance in the better eye was determined to be 20/125+1 using an ETDRS chart, we will find that you do not have statutory blindness as you are able to read one letter on the 20/100 line.

b. *Blepharospasm.* This movement disorder is characterized by repetitive, bilateral, involuntary closure of the eyelids. If you have this disorder, you may have measurable visual acuities and visual fields that do not satisfy the criteria of 2.02 or 2.03. Blepharospasm generally responds to therapy. However, if therapy is not effective, we will consider how the involuntary closure of your eyelids affects your ability to maintain visual functioning over time.

c. *Scotoma.* A scotoma is a non-seeing area in the visual field surrounded by a seeing area. When we measure the visual field, we subtract the length of any scotoma, other than the normal blind spot, from the overall length of any diameter on which it falls.

* * * * *

C. *How do we evaluate impairments that do not meet one of the special senses and speech listings?*

1. These listings are only examples of common special senses and speech disorders that we consider severe enough to prevent an individual from doing any gainful activity. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. If you have a medically determinable impairment(s) that does not meet a listing, we will determine whether the impairment(s) medically equals a listing. (See §§ 404.1526 and 416.926.) If you have an impairment(s) that does not meet or medically equal a listing, you may or may not have the residual functional capacity to engage in substantial gainful activity. Therefore, we proceed to the fourth, and if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920. When we decide whether you continue to be disabled, we use the rules in §§ 404.1594, 416.994, or 416.994a, as appropriate.

2.01 Category of Impairments, Special Senses and Speech

2.02 *Loss of visual acuity.* Remaining vision in the better eye after best correction is 20/200 or less.

2.03 *Contraction of the visual field in the better eye,* with:

A. The widest diameter subtending an angle around the point of fixation no greater than 20 degrees;

OR

B. A mean deviation of –22 or worse, determined by automated static threshold perimetry as described in 2.00A6a(v);

OR

C. A visual field efficiency of 20 percent or less as determined by kinetic perimetry (see 2.00A7b).

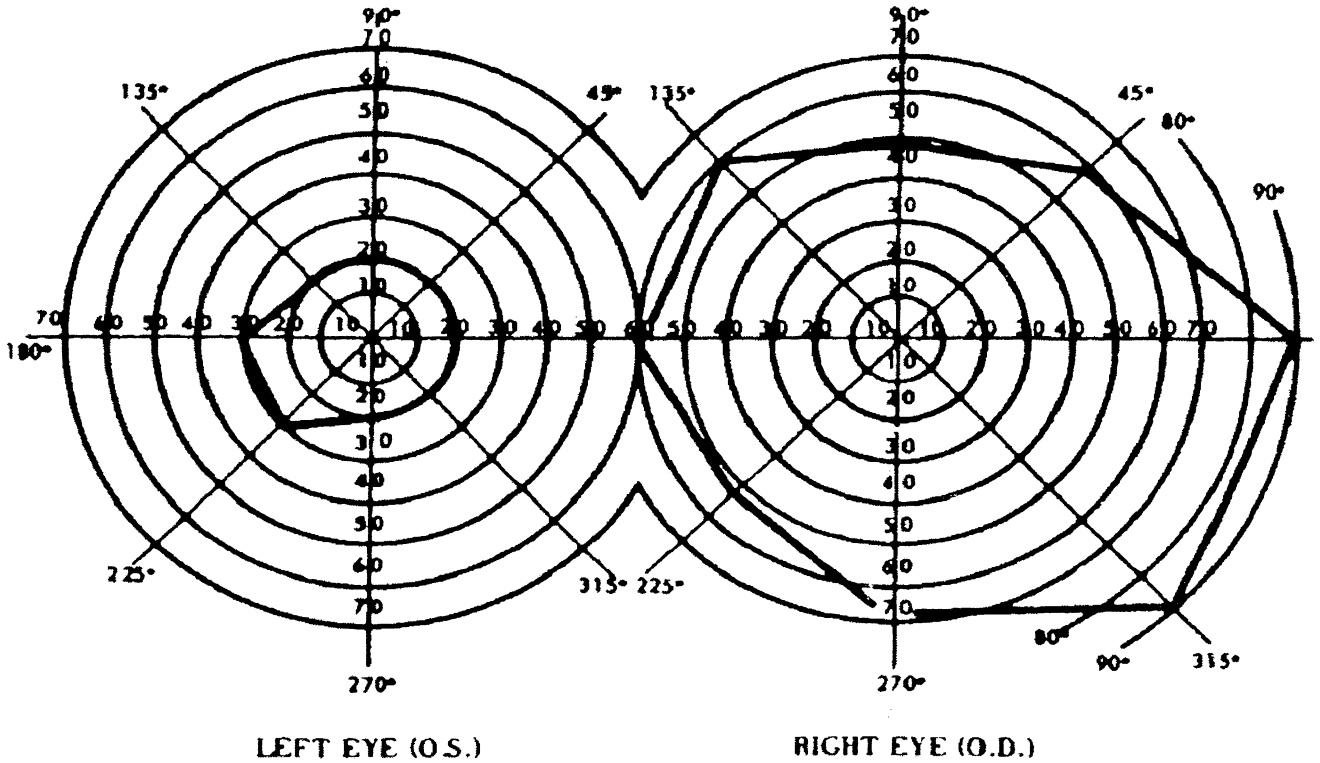
2.04 *Loss of visual efficiency.* Visual efficiency of the better eye of 20 percent or less after best correction (see 2.00A7c).

* * * * *

TABLE 1.—PERCENTAGE OF VISUAL ACUITY EFFICIENCY CORRESPONDING TO THE BEST-CORRECTED VISUAL ACUITY MEASUREMENT FOR DISTANCE IN THE BETTER EYE

Snellen		Percent visual acuity efficiency
English	Metric	
20/16	6/5	100
20/20	6/6	100
20/25	6/7.5	95
20/30	6/9	90
20/40	6/12	85
20/50	6/15	75
20/60	6/18	70
20/70	6/21	65
20/80	6/24	60
20/100	6/30	50

TABLE 2.—CHART OF VISUAL FIELDS



1. The diagram of the right eye illustrates the extent of a normal visual field as measured with a III4e stimulus. The sum of the eight principal meridians of this field is 500 degrees.

2. The diagram of the left eye illustrates a visual field contracted to 30 degrees in two meridians and to 20 degrees in the remaining six meridians. The percent of visual field efficiency of this field is: $(2 \times 30) + (6 \times 20) = 180 \div 500 = 0.36$ or 36 percent visual field efficiency.

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Part B

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102.00 SPECIAL SENSES AND SPEECH

A. *How do we evaluate visual disorders?*

1. *What are visual disorders?* Visual disorders are abnormalities of the eye, the optic nerve, the optic tracts, or the brain that may cause a loss of visual acuity or visual fields. A loss of visual acuity limits your ability to distinguish detail, read, do fine work, or perform other age-appropriate activities. A loss of visual fields limits your ability to perceive visual stimuli in the peripheral extent of vision.

2. *How do we define statutory blindness?* Statutory blindness is blindness as defined in sections 216(i)(1) and 1614(a)(2) of the Social Security Act (the Act). The Act defines blindness as visual acuity of 20/200 or less in the better eye with the use of a correcting lens. We use your best-corrected visual acuity for distance in the better eye when we determine if this definition is met. The Act also provides that an eye that has a visual field limitation such that the widest diameter of the visual field subtends an angle no

greater than 20 degrees is considered as having visual acuity of 20/200 or less. You have statutory blindness only if your visual disorder meets the criteria of 102.02 or 102.03A. You do not have statutory blindness if your visual disorder medically equals the criteria of 102.02 or 102.03A, or if it meets or medically equals 102.03B, 102.03C, or 102.04. If your visual disorder medically equals the criteria of 102.02 or 102.03A, or if it meets or medically equals 102.03B, 102.03C, or 102.04, we will find that you have a disability if your visual disorder also meets the duration requirement.

3. *What evidence do we need to establish statutory blindness under title XVI?* For title XVI, the only evidence we need to establish statutory blindness is evidence showing that your visual acuity in your better eye or your visual field in your better eye meets the criteria in 102.00A2, provided that those measurements are consistent with the other evidence in your case record. We do not need to document the cause of your blindness. Also, there is no duration requirement for statutory blindness under title XVI (see §§ 416.981 and 416.983).

4. W*hat evidence do we need to evaluate visual disorders, including those that result in statutory blindness under title II?*

a. To evaluate your visual disorder, we usually need a report of an eye examination that includes measurements of the best-corrected visual acuity or the extent of the visual fields, as appropriate. If there is a loss of visual acuity or visual fields, the cause of the loss must be documented. A standard eye examination will usually reveal the cause of any visual acuity loss. An eye examination can also reveal the cause of some types of visual field deficits. If the eye examination does not reveal the cause of the visual loss, we will request the information that was used to establish the presence of the visual disorder.

b. A cortical visual disorder is a disturbance of the posterior visual pathways or occipital lobes of the brain in which the visual system does not interpret what the eyes are seeing. It may result from such causes as traumatic brain injury, stroke, cardiac arrest, near drowning, a central nervous system infection such as meningitis or encephalitis, a tumor, or surgery. It can be temporary or permanent, and the amount of visual loss can vary. It is possible to have a cortical visual disorder and not have any abnormalities observed in a standard eye examination. Therefore, a diagnosis of a cortical visual disorder must be confirmed by documentation of the cause of the brain lesion. If neuroimaging or visual evoked response (VER) testing was performed, we will request a copy of the report or other medical evidence that describes the findings in the report.

c. If your visual disorder does not satisfy the criteria in 102.02, 102.03, or 102.04, we will also request a description of how your visual disorder impacts your ability to function.

5. *How do we measure best-corrected visual acuity?*

a. *Testing for visual acuity.*

(i) When we need to measure your best-corrected visual acuity, we will use visual acuity testing that was carried out using Snellen methodology or any other testing methodology that is comparable to Snellen methodology.

(ii) We consider tests such as the Landolt C test or the tumbling-E test, which are used to evaluate young children who are unable to participate in testing using Snellen methodology, to be comparable to testing using Snellen methodology. These alternate methods for measuring visual acuity should be performed by specialists with expertise in assessment of childhood vision.

(iii) If you are unable to participate in testing using Snellen methodology or other comparable testing, we will consider your fixation and visual-following behavior. If both these behaviors are absent, we will consider the anatomical findings or the results of neuroimaging, electroretinogram, or VER testing when this testing has been performed.

b. Determining best-corrected visual acuity.

(i) Best-corrected visual acuity is the optimal visual acuity attainable with the use of a corrective lens. In some instances, this assessment may be performed using a specialized lens; for example, a contact lens. We will use the visual acuity measurements obtained with a specialized lens only if you have demonstrated the ability to use the specialized lens on a sustained basis. However, we will not use visual acuity measurements obtained with telescopic lenses because they significantly reduce the visual field. If you have an absent response to VER testing in an eye, we can determine that your best-corrected visual acuity is 20/200 or less in that eye. However, if you have a positive response to VER testing in an eye, we will not use that result to determine your best-corrected visual acuity in that eye. Additionally, we will not use the results of pinhole testing or automated refraction acuity to determine your best-corrected visual acuity.

(ii) We will use the best-corrected visual acuity for distance in your better eye when we determine whether your loss of visual acuity satisfies the criteria in 102.02A. The best-corrected visual acuity for distance is usually measured by determining what you can see from 20 feet. If your visual acuity is measured for a distance other than 20 feet, we will convert it to a 20-foot measurement. For example, if your visual acuity is measured at 10 feet and is reported as 10/40, we will convert this to 20/80.

(iii) If you cannot participate in visual acuity testing, we will determine that your best-corrected visual acuity is 20/200 or less in your better eye if your visual disorder meets the criteria in 102.02B. To meet 102.02B1, your impairment must result in the absence of fixation and visual-following behavior and abnormal anatomical findings indicating a visual acuity of 20/200 or less in your better eye. Such abnormal anatomical findings include, but are not limited to, the presence of Stage III or worse retinopathy of prematurity despite surgery, hypoplasia of the optic nerve, albinism with macular aplasia, and bilateral optic atrophy. To meet 102.02B2, your impairment must result in the absence of fixation and visual-following behavior and abnormal neuroimaging documenting damage to the cerebral cortex which would be expected to prevent the development of a visual acuity better than 20/200 in your better eye. Such abnormal neuroimaging includes, but is not limited to, neuroimaging showing bilateral encephalomyelitis or bilateral encephalomalacia.

6. *How do we measure visual fields?*

a. *Testing for visual fields.*

(i) We generally need visual field testing when you have a visual disorder that could result in visual field loss, such as glaucoma, retinitis pigmentosa, or optic neuropathy, or when you display behaviors that suggest a visual field loss.

(ii) When we need to measure the extent of your visual field loss, we will use visual field measurements obtained with an automated static threshold perimetry test performed on a perimeter, like the Humphrey Field Analyzer, that satisfies all of the following requirements:

A. The perimeter must use optical projection to generate the test stimuli.

B. The perimeter must have an internal normative database for automatically comparing your performance with that of the general population.

C. The perimeter must have a statistical analysis package that is able to calculate visual field indices, particularly mean deviation.

D. The perimeter must demonstrate the ability to correctly detect visual field loss and correctly identify normal visual fields.

E. The perimeter must demonstrate good test-retest reliability.

F. The perimeter must have undergone clinical validation studies by three or more independent laboratories with results published in peer-reviewed ophthalmic journals.

(iii) The test must use a white size III Goldmann stimulus and a 31.5 apostilb (10 cd/m^2) white background. The stimuli locations must be no more than 6 degrees apart horizontally or vertically. Measurements must be reported on standard charts and include a description of the size and intensity of the test stimulus.

(iv) To determine statutory blindness based on visual field loss (102.03A), we need a test that measures the central 24 to 30 degrees of the visual field; that is, the area measuring 24 to 30 degrees from the point of fixation. Acceptable tests include the Humphrey 30–2 or 24–2 tests.

(v) The criterion in 102.03B is based on the use of a test performed on a Humphrey Field Analyzer that measures the central 30 degrees of the visual field. We can also use comparable results from other acceptable perimeters; for example, a mean defect of 22 on an acceptable Octopus test, to determine that the criterion in 102.03B is met. We cannot use tests that do not measure the central 30 degrees of the visual field, such as the Humphrey 24–2 test, to determine if your impairment meets or medically equals 102.03B.

(vi) We measure the extent of visual field loss by determining the portion of the visual field in which you can see a white III4e stimulus. The ''III'' refers to the standard Goldmann test stimulus size III, and the

''4e''efers to the standard Goldmann intensity filters used to determine the intensity of the stimulus.

(vii) In automated static threshold perimetry, the intensity of the stimulus varies. The intensity of the stimulus is expressed in decibels (dB). We need to determine the dB level that corresponds to a 4e intensity for the particular perimeter being used. We will then use the dB printout to determine which points would be seen at a 4e intensity level. For example, in Humphrey Field Analyzers, a 10 dB stimulus is equivalent to a 4e stimulus. A dB level that is higher than 10 represents a dimmer stimulus, while a dB level that is lower than 10 represents a brighter stimulus. Therefore, for tests performed on Humphrey Field Analyzers, any point seen at 10 dB or higher is a point that would be seen with a 4e stimulus.

(viii) We can also use visual field measurements obtained using kinetic perimetry, such as the Humphrey ''SSA Test Kinetic'' or Goldmann perimetry, instead of automated static threshold perimetry. The kinetic test must use a white III4e stimulus projected on a white 31.5 apostilb (10 cd/m^2) background. In automated kinetic tests, such as the Humphrey ''SSA Test Kinetic,'' testing along a meridian stops when you see the stimulus. Because of this, automated kinetic testing does not detect limitations in the central visual field. If your visual disorder has progressed to the point at which it is likely to result in a significant limitation in the central visual field, such as a scotoma (see 102.00A8c), we will not use automated kinetic perimetry to evaluate your visual field loss. Instead, we will assess your visual field loss using automated static threshold perimetry or manual kinetic perimetry.

(ix) We will not use the results of visual field screening tests, such as confrontation tests, tangent screen tests, or automated static screening tests, to determine that your impairment meets or medically equals a listing, or functionally equals the listings. However, we can consider normal results from visual field screening tests to determine whether your visual disorder is severe when these test results are consistent with the other evidence in your case record. (See § 416.924(c).) We will not consider normal test results to be consistent with the other evidence if either of the following applies:

A. The clinical findings indicate that your visual disorder has progressed to the point that it is likely to cause visual field loss; or

B. You have a history of an operative procedure for retinal detachment.

b. *Use of corrective lenses.* You must not wear eyeglasses during the visual field examination because they limit your field of vision. Contact lenses or perimetric lenses may be used to correct visual acuity during the visual field examination in order to obtain the most accurate visual field measurements. For this single purpose, you do not need to demonstrate that you have the ability to use the contact or perimetric lenses on a sustained basis.

7. *How do we calculate visual efficiency?*

a. *Visual acuity efficiency.* We use the percentage shown in Table 1 that corresponds to the best-corrected visual acuity for distance in your better eye.

b. *Visual field efficiency.* We use kinetic perimetry to calculate visual field efficiency by adding the number of degrees seen along the eight principal meridians in your better eye and dividing by 500. (See Table 2.)

c. *Visual efficiency.* We calculate the percent of visual efficiency by multiplying the visual acuity efficiency by the visual field efficiency and converting the decimal to a percentage. For example, if your visual acuity efficiency is 75 percent and your visual field efficiency is 64 percent, we will multiply 0.75×0.64 to determine that your visual efficiency is 0.48, or 48 percent.

8. *How do we evaluate specific visual problems?*

a. *Statutory blindness.* Most test charts that use Snellen methodology do not have lines that measure visual acuity between 20/100 and 20/200. Newer test charts, such as the Bailey-Lovie or the Early Treatment Diabetic Retinopathy Study (ETDRS), do have lines that measure visual acuity between 20/100 and 20/200. If your visual acuity is measured with one of these newer charts, and you cannot read any of the letters on the 20/100 line, we will determine that you have statutory blindness based on a visual acuity of 20/200 or less. For example, if your best-corrected visual acuity for distance in the better eye was determined to be 20/160 using an ETDRS chart, we will find that you have statutory blindness. Regardless of the type of test chart used, you do not have statutory blindness if you can read at least one letter on the 20/100 line. For example, if your best-corrected visual acuity for distance in the better eye was determined to be 20/125+1 using an ETDRS chart, we will find that you do not have statutory blindness as you are able to read one letter on the 20/100 line.

b. *Blepharospasm.* This movement disorder is characterized by repetitive, bilateral, involuntary closure of the eyelids. If you have this disorder, you may have measurable visual acuities and visual fields that do not satisfy the criteria of 102.02 or 102.03. Blepharospasm generally responds to therapy. However, if therapy is not effective, we will consider how the involuntary closure of your eyelids affects your ability to maintain visual functioning over time.

c. *Scotoma.* A scotoma is a non-seeing area in the visual field surrounded by a seeing area. When we measure the visual field, we subtract the length of any scotoma, other than the normal blind spot, from the overall length of any diameter on which it falls.

* * * * *

C. *How do we evaluate impairments that do not meet one of the special senses and speech listings?*

1. These listings are only examples of common special senses and speech disorders that we consider severe enough to result in marked and severe functional limitations. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. If you have a medically determinable impairment(s) that does not meet a listing, we will determine whether the impairment(s) medically equals a listing or functionally equals the listings. (See §§ 416.926 and 416.926a.) We use the rules in § 416.994a when we decide whether you continue to be disabled.

102.01 Category of Impairments, Special Senses and Speech

102.02 Loss of visual acuity.

A. Remaining vision in the better eye after best correction is 20/200 or less;

OR

B. An inability to participate in testing using Snellen methodology or other comparable visual acuity testing and clinical findings that fixation and visual-following behavior are absent in the better eye, and:

1. Abnormal anatomical findings indicating a visual acuity of 20/200 or less in the better eye; or

2. Abnormal neuroimaging documenting damage to the cerebral cortex which would be expected to prevent the development of a visual acuity better than 20/200 in the better eye; or

3. Abnormal electroretinogram documenting the presence of Leber's congenital amaurosis or achromatopsia; or

4. An absent response to VER testing in the better eye.

102.03 *Contraction of the visual field in the better eye,* with:

A. The widest diameter subtending an angle around the point of fixation no greater than 20 degrees;

OR

B. A mean deviation of –22 or worse, determined by automated static threshold perimetry as described in 102.00A6a(v);

OR

C. A visual field efficiency of 20 percent or less as determined by kinetic perimetry (see 102.00A7b).

102.04 *Loss of visual efficiency.* Visual efficiency of the better eye of 20 percent or less after best correction (see 102.00A7c).

* * * * *

TABLE 1.—PERCENTAGE OF VISUAL ACUITY EFFICIENCY CORRESPONDING TO THE BEST-CORRECTED VISUAL ACUITY MEASUREMENT FOR DISTANCE IN THE BETTER EYE

Snellen		Percent visual acuity efficiency
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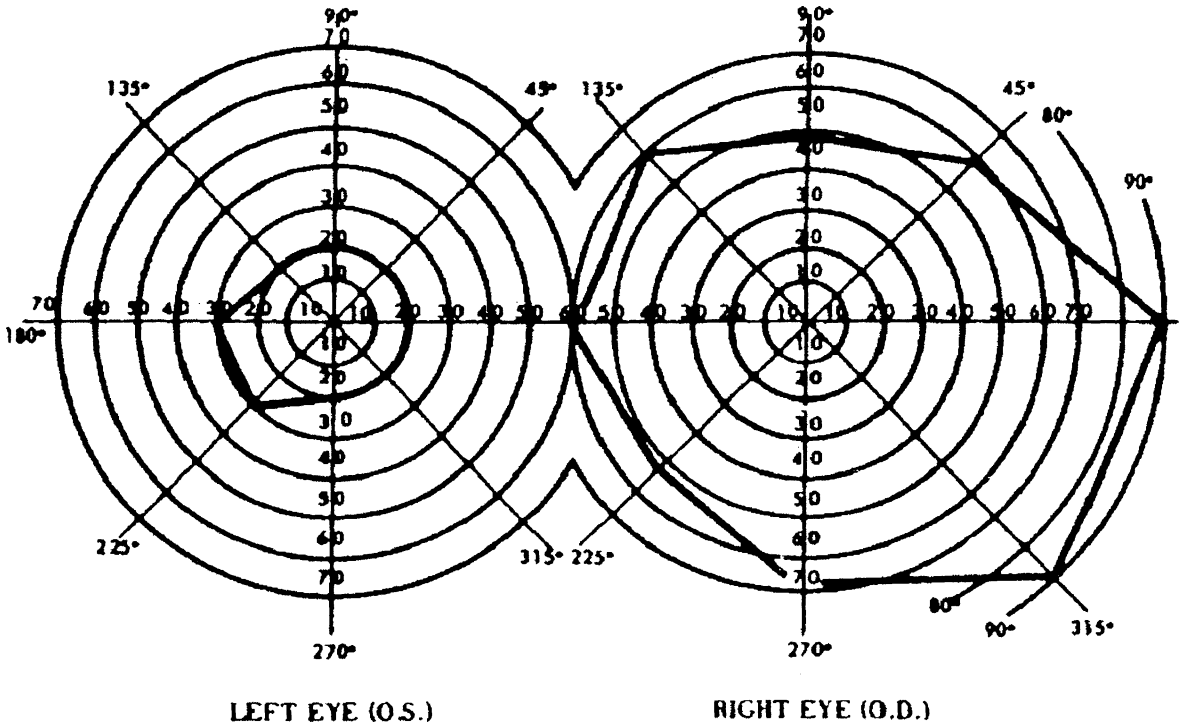
20/50	6/15	75
20/60	6/18	70
20/70	6/21	65
20/80	6/24	60
20/100	6/30	50

TABLE 2.—CHART OF VISUAL FIELDS



1. The diagram of the right eye illustrates the extent of a normal visual field as measured with a III4e stimulus. The sum of the eight principal meridians of this field is 500 degrees.

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[FR Doc. 06–9236 Filed 11–17–06; 8:45 am]

BILLING CODE 4191–02–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[CGD01–06–131]

RIN 1625–AA00

Safety Zone; Cocheco River Dredging Project, Cocheco River, NH

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone around a blasting project between the Upper and Lower Narrows of the Cocheco River near Dover, NH. This safety zone is necessary to provide for the safety of persons and vessels in the maritime community from the hazards associated with a blasting project. Entry into this zone by any vessel is prohibited unless specifically authorized by the Captain of the Port, Northern New England.

DATES: This rule is effective from 8 a.m. Eastern Standard Time (EST) on November 15, 2006 until 4 p.m. Eastern Standard Time (EST) on December 30, 2006.

ADDRESSES: Documents indicated in this preamble as being available in the docket are part of docket CGD01–06–131 and are available for inspection or copying at U.S. Coast Guard Sector Northern New England, 259 High Street, South Portland, ME 04106 between 8 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Lieutenant Junior Grade J. B. Bleacher, Prevention Department, Sector Northern New England at (207) 742–5421.

SUPPLEMENTARY INFORMATION:

Regulatory Information

We did not publish a notice of proposed rulemaking (NPRM) for this regulation. Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing an NPRM. The final details of the project were not determined until October 23, 2006 making it impossible to publish a NPRM or a final rule 30 days in advance of the desired effective dates. Further, postponing the blasting project is impractical as ice conditions in the river will increase the difficulty of completing this project on schedule. The Coast Guard finds that immediate action is needed to protect mariners against the potential hazards associated with these blasting operations. Under 5 U.S.C. 553(d)(3), the Coast Guard also finds, for the same reasons, that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**.

Background and Purpose

On November 1, 2006, Charter Environmental, Inc. began dredging operations on the Cocheco River between the Upper and Lower Narrows in order to both widen and deepen the river channel. Ledge areas in the river will be removed by drilling and blasting methods. Blasting operations are scheduled to begin November 15, 2006 and end on December 30, 2006. Charter Environmental, Inc. will notify the USCG at least 24 hours prior to any blasting operation and all blasting will be conducted only at high tide. Public notifications will be made during the effective period via marine safety information broadcasts. This regulation establishes a 100 yard safety zone around all blasting areas. Entry into this