of the safety, power quality, or reliability on the borrower's electric power system or other electric power systems interconnected to the borrower's electric power system. The Agency encourages borrowers to consider model policy templates developed by knowledgeable and expert institutions, such as, but not limited to, the National Association of Regulatory Utility Commissioners, the Federal Energy Regulatory Commission and the National Rural Electric Cooperative Association. The Agency encourages all related electric borrowers to cooperate in the development of a common Distributed Resource policy.

§ 1730.62 Definitions.

''Distributed Resources'' as used in this subpart means sources of electric power that are not directly connected to a bulk power transmission system, having an installed capacity of not more than 10 MVA, connected to the borrower's electric power system through a point of common coupling. Distributed resources include both generators and energy storage technologies.

''Responsible Party'' as used in this subpart means the owner, operator or any other person or entity that is accountable to the borrower under the borrower's interconnection policy for Distributed Resources.

§ 1730.63 IDR policy criteria.

(a) General.

(1) The borrower's IDR policy and procedures shall be readily available to the public and include, but not limited to, a standard application, application process, application fees, and agreement.

(2) All costs to be recovered from the applicant regarding the application process or the actual interconnection are to be clearly explained to the applicant and authorized by the applicant prior to the borrower incurring these costs. The borrower may require separate nonrefundable deposits sufficient to insure serious intent by the applicant prior to proceeding either with the application or actual interconnection process.

(3) IDR policies must be approved by the borrower's Board of Directors.

(4) The borrower may establish a new rate classification for customers with Distributed Resources.

(5) IDR policies must provide for reconsideration and updates every three years or more frequently as circumstances warrant.

(b) Technical requirements.

(1) IDR policies must be consistent with prudent electric utility practice.

(2) IDR policies must incorporate the standard 1547 as promulgated and amended by the Institute of Electrical and Electronic Engineers (IEEE). The title of IEEE Standard 1547 is ''IEEE Standard for Interconnecting Distributed Resources with Electric Power Systems''. You may obtain a copy of IEEE Standard 1547 from: IEEE, 3 Park Avenue, New York, NY 10016–5997.

(3) IDR policies must provide for appropriate electric power system disconnect facilities, as determined by the borrower, which shall include a lockable disconnect, a visible open, and fusing, that are readily accessible to and operable by authorized personnel at all times.

(4) IDR policies must provide for borrower access to the Distributed Resources facility during normal business hours and all emergency situations.

(c) Responsible party obligations. IDR policies must provide for appropriate Responsible Parties to assume the following risks and responsibilities:

(1) A Responsible Party must agree to maintain appropriate liability insurance as outlined in the borrower's interconnection policy.

(2) A Responsible Party must be responsible for the Distributed Resources compliance with all national, State, local government requirements and electric utility standards for the safety of the public and personnel responsible for utility electric power system operations, maintenance and repair.

(3) A Responsible Party must be responsible for the safe and effective operation and maintenance of the facility.

(4) Only Responsible Parties may apply for interconnection and the Responsible Party must demonstrate the financial and managerial capability to develop, construct and operate the distributed resources.

§ 1730.64 Power purchase agreements.

Nothing in this subpart requires the borrower to enter into purchase power arrangements with the owner of the Distributed Resources.

§ 1730.65 Effective dates.

(a) Each electric program borrower with an approved electric program loan as of [DATE OF PUBLICATION OF THE FINAL RULE] shall have an IDR policy board approved and in effect no later than [DATE 2 YEARS FROM DATE OF PUBLICATION OF THE FINAL RULE].

(b) An electric program borrower that submits an application to the Agency for financial assistance on or after [DATE 2 YEARS FROM DATE OF PUBLICATION OF THE FINAL RULE] shall include with its application package a letter of certification executed by the General Manager that the borrower meets the requirements of this subpart.

§ 1730.66 Administrative waiver.

The Administrator may waive in all or part, for good cause, the requirements and procedures of this subpart.

§§ 1730.67–1730.99 [Reserved]

Dated: July 11, 2008.

James M. Andrew,

Administrator, Rural Utilities Service.

[FR Doc. E8–18800 Filed 8–12–08; 8:45 am]

BILLING CODE 3410–15–P

SOCIAL SECURITY ADMINISTRATION

20 CFR Part 404

[Docket No. SSA–2008–0016]

RIN 0960–AG20

Revised Medical Criteria for Evaluating Hearing Loss

AGENCY: Social Security Administration.

ACTION: Notice of proposed rulemaking.

SUMMARY: We propose to revise the criteria in the Listing of Impairments (the listings) that we use to evaluate claims involving hearing loss. 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 proposed revisions reflect current medical knowledge, treatment, and methods of evaluating hearing loss, as well as our adjudicative experience since the publication of the current rules.

DATES: To be sure that your comments are considered, we must receive them by October 14, 2008.

ADDRESSES: You may submit comments by any one of four methods—Internet, facsimile, regular mail, or hand-delivery. Commenters should not submit the same comments multiple times or by more than one method. Regardless of which of the following methods you choose, please state that your comments refer to Docket No. SSA–2008–0016 to ensure that we can associate your comments with the correct regulation:

1. Federal eRulemaking portal at *http://www.regulations.gov*. (This is the most expedient method for submitting your comments, and we strongly urge you to use it.) In the *Comment or Submission* section of the webpage, type ''SSA–2008–0016,'' select ''Go,'' and then click ''Send a Comment or

Submission.'' The Federal eRulemaking portal issues you a tracking number when you submit a comment.

2. Telefax to (410) 966–2830.

3. Letter to the Commissioner of Social Security, P.O. Box 17703, Baltimore, MD 21235–7703.

4. Deliver your comments to the Office of Regulations, Social Security Administration, 922 Altmeyer Building, 6401 Security Boulevard, Baltimore, MD 21235–6401, between 8 a.m. and 4:30 p.m. on regular business days.

All comments are posted on the Federal eRulemaking portal, although they may not appear for several days after receipt of the comment. You may also inspect the comments on regular business days by making arrangements with the contact person shown in this preamble.

Caution: All comments we receive from members of the public are available for public viewing in their entirety on the Federal eRulemaking portal at *http://www.regulations.gov*. Therefore, you should be careful to include in your comments only information that you wish to make publicly available on the Internet. We strongly urge you not to include any personal information, such as your Social Security number or medical information, in your comments.

FOR FURTHER INFORMATION CONTACT: Diane Braunstein, Director, Office of Compassionate Allowances and Listings Improvement, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020. 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*.

Why are we proposing to revise the listings for hearing loss?

We are proposing to revise the listings for hearing loss to update the medical criteria in the listings, to provide more information about how we evaluate hearing loss, and to reflect our adjudicative experience. The listings for hearing loss are in the special senses and speech body system. That body system also includes listings for visual disorders, disturbances of labyrinthine-vestibular function, and loss of speech. In this Notice of Proposed Rulemaking (NPRM), we are proposing changes only to the listings for hearing loss. We published final rules revising the listings for visual disorders in the **Federal Register** on November 20, 2006 (71 FR 67037). We intend to publish separately proposed rules that would update the criteria for disturbances of labyrinthine-vestibular function and loss of speech.

Prior to the publication of the final rules for evaluating visual disorders mentioned above, 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 in the **Federal Register** on March 16, 1977 (42 FR 14705). The current special senses and speech listings will no longer be effective on February 20, 2015, unless we extend them, or revise and issue them again.

How did we develop these proposed rules?

We developed these proposed rules based on our adjudicative experience and advances in medical knowledge, treatment, and methods of evaluating hearing loss. These proposed rules also reflect comments we asked the public to provide to help us develop the proposals.

We published an advance notice of proposed rulemaking (ANPRM) in the **Federal Register** on April 13, 2005 (70 FR 19353). The purpose of the ANPRM was to inform the public that we were planning to update and revise the rules we use to evaluate hearing impairments and disturbance of labyrinthine-vestibular function and to invite interested individuals and organizations to send us comments and suggestions for updating and revising the listings for these disorders. In the ANPRM, we provided a 60-day period for comments and suggestions; that period ended on June 13, 2005. We received 13 letters and e-mails from medical experts, advocates, and State agencies that adjudicate claims for us, commenting on our criteria for hearing loss. Although we are not summarizing or responding to the comments in this notice, we read and considered them carefully. We are proposing changes to our rules for evaluating hearing loss based on some of the suggestions we received.

We also hosted a policy conference on ''Hearing Impairments and Disturbance of Labyrinthine-Vestibular Function'' at Gallaudet University in Washington, DC, on November 7 and 8, 2005. At this conference, we heard comments and suggestions for updating and revising the rules we use to evaluate these disorders from individuals who have hearing loss or vestibular disorders, their family members, physicians who treat them, other professionals who work with them, and advocates who represent them. The transcript of this conference is available on our Web site at *http://policy.ssa.gov/erm/rules.nsf/5da82b031a6677dc85256b41006b7f8d/9314dd803ad5579885256fe200496264!OpenDocument*.

Several of the changes to the criteria for evaluating hearing loss that we propose in these rules are based on information we obtained from individuals at this conference.

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

2.00 Special Senses and Speech

We propose to reorganize and expand the second through fifth paragraphs of current 2.00B1, ''Hearing impairment,'' to provide additional guidance. We propose to remove the guidance in the first paragraph of current 2.00B1, which states that hearing ability should be evaluated in terms of the person's ability to hear and distinguish speech. Because our current and proposed listings provide for using tones to evaluate hearing loss, this language may be misleading. We also propose to remove the guidance in the last paragraph of current 2.00B1, which provides that cases of alleged ''deaf mutism'' should be documented by a hearing evaluation. This guidance refers only to the evaluation of deaf mutism as a hearing impairment; however, we can also evaluate cases of alleged mutism under listing 2.09, for loss of speech. In that case, we would not need a hearing test. We are not proposing special requirements for evaluating hearing loss if you have deaf mutism; we would require the same documentation as for other hearing disorders.

We also propose to redesignate current 2.00B2, ''Vertigo associated with disturbances of labyrinthine-vestibular function, including Meniere's disease,'' as proposed 2.00C, and to redesignate current 2.00B3, ''Loss of speech,'' as proposed 2.00D. We are proposing separate sections for these disorders to recognize that they are not always associated with hearing loss. Although we are not proposing any substantive changes to these sections at this time, we are proposing to make minor editorial changes so that the format of these sections will be consistent with other sections of the introductory text in these proposed rules. Because of these changes, we also propose to redesignate

current 2.00C, ''How do we evaluate impairments that do not meet one of the special senses and speech listings?'' as proposed 2.00E.

The following is a detailed explanation of proposed 2.00B.

Proposed 2.00B—How do we evaluate hearing loss?

Proposed 2.00B1—What evidence do we need to evaluate hearing loss?

This proposed section revises the fourth and fifth paragraphs of current 2.00B1as follows:

• The fourth paragraph of current 2.00B1 provides that an otolaryngologic examination should precede audiometric testing. We propose to remove the requirement for an otolaryngologic examination and instead require a complete otologic examination. We would make this change because an otolaryngologic examination contains elements, such as an evaluation of the head, face, and neck, that are not needed to assess hearing loss. As we describe in proposed 2.00B1b, a complete otologic examination must include the medical history, a description of how the hearing loss affects the individual, a description of the appearance of the external ear (pinna and the external ear canal), an evaluation of the tympanic membrane, and an assessment of any middle ear abnormalities.

• We also propose to revise the guidance in the current rules that the otolaryngologic examination should precede the audiometric testing and instead provide that the audiometric testing should be performed within 2 months of the complete otologic examination. Having the otologic examination precede the audiometric testing can help identify conditions that could interfere with the audiometric testing. However, having the otologic examination follow the audiometric testing will allow the physician to consider the results of that testing in reaching his or her conclusions about the individual's hearing loss. We believe that either sequence is acceptable for determining whether the individual has a medically determinable impairment that has resulted in hearing loss. However, we would appreciate having specific comments on this change, replacing an otolaryngologic examination with an otologic examination.

• Lastly, we propose to revise the current requirement in the fifth paragraph of 2.00B1 that an otolaryngologic examination be performed in conjunction with any audiometric testing used to assess the severity of the hearing loss. As indicated above, we propose to require a complete otologic examination instead of an otolaryngologic examination. Additionally, we propose that the complete otologic examination be required only to establish that a medically determinable impairment exists. After the impairment is established, we propose to allow the severity of the hearing loss to be determined based on audiometric testing without another complete otologic examination.

Proposed 2.00B2—What audiometric testing do we need when you do not have a cochlear implant?

This proposed section expands and clarifies the guidance in the second, third, and fifth paragraphs of current 2.00B1 as follows:

• We would replace the term ''speech discrimination'' with ''word recognition testing'' to reflect current medical terminology. In addition, we would add a parenthetical statement to explain that this testing may also be referred to as word discrimination or speech discrimination testing.

• We would clarify that we require that pure tone air conduction and bone conduction testing must be conducted in accordance with the most recently published American National Standards Institute (ANSI) standards for air conduction and bone conduction stimuli. Our current rules provide that audiometric testing be conducted in accordance with the 1969 and 1972 ANSI standards or subsequent comparable revisions.

• We would clarify that each ear must be tested separately and that hearing aids must not be worn during the testing. Our reasons for proposing to remove the current requirement that hearing be tested with aids in place are discussed in our explanation of proposed listing 2.10 below. We also propose to require that the testing be conducted in a soundproof booth. Our current rules require that hearing measurements be performed in an environment which meets the 1977 ANSI standard for maximal permissible background sound.

• We would require that an otoscopic examination be performed immediately before the audiometric testing to ensure that there are no conditions present that would prevent valid testing. In proposed 2.00B2b, we explain that an otoscopic examination provides a description of the appearance of the external ear canal and an evaluation of the tympanic membrane.

• We would describe the frequencies at which pure tone air conduction and bone conduction are usually measured.

• We would incorporate the guidance in current listing 2.08A that explains that we average the pure tone hearing thresholds for air conduction and bone conduction at 500, 1000, and 2000 Hertz (Hz) to determine whether the listing criteria are met.

• We would explain that the speech reception threshold (SRT) is generally within 10 decibels (dB) of the average pure tone air conduction hearing thresholds at 500, 1000, and 2000 Hz. If it is not, the reason for the discrepancy should be documented.

• We would expand the guidance on word recognition testing and clarify that the words should be presented at a level of amplification that will measure your maximum discrimination ability, which is usually 35 to 40 dB above your SRT. We would also provide that the amplification level used in the testing must be medically appropriate and that you must be able to tolerate it.

Proposed 2.00B3—What audiometric testing do we need when you have a cochlear implant?

In this new section, we propose to explain that we will consider you to be disabled until 1 year after implantation of a cochlear implant. We propose to add this criterion to recognize the length of the rehabilitation and training period needed to use a cochlear implant effectively.

After that period, we propose to evaluate your hearing loss by measuring your word recognition ability on the Hearing in Noise Test (HINT). We propose to use the HINT because the American Academy of Neurology indicated in their comments in response to our ANPRM that the HINT is the ''accepted standard used to assess hearing outcome after cochlear implantation.'' We would also explain our requirements for how that testing should be conducted. Our proposed requirements are based on recommendations we received at our policy conference.

Proposed 2.00B4—How do we evaluate your word recognition ability if you are not fluent in English?

Word recognition testing should be conducted using an appropriate word list. If you are not fluent in English, the testing should be conducted using an appropriate word list for the language in which you are most fluent. However, appropriate word lists are not available in all languages. Additionally, the individual conducting the test should also be fluent in the language used for

the test. If the test needs to be conducted in a language other than English, there may not be individuals available who are qualified to perform the testing in that language. Therefore, we propose to add this section to provide guidance on how we would evaluate your word recognition ability if you are not fluent in English.

In this new section, we would provide that, if you are not fluent in English, it may not be possible to measure your word recognition ability. We would also explain that, if we cannot measure your word recognition ability because you are not fluent in English, your hearing loss cannot meet listing 2.10B or 2.11B. In this situation, we would consider the facts of your case to determine whether you have difficulty understanding words in the language in which you are most fluent, and if so, whether that degree of difficulty medically equals listing 2.10B or 2.11B. For example, we will consider how you interact with family members, interpreters, and other individuals who speak the language in which you are most fluent.

We welcome and are very interested in receiving comments about other methods that you think we can use to evaluate word recognition ability for individuals who are not fluent in English and who have listing-level hearing disorders.

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

2.01 Category of Impairments, Special Senses and Speech

Under our current listings, we do not consider the effects of treatment with cochlear implantation on an individual's hearing loss. Due to advances in the technology used in cochlear implants, we believe it is now appropriate to consider the effects of cochlear implantation on an individual's hearing loss. Therefore, we propose to add a separate listing to evaluate hearing loss treated with cochlear implantation. Because we are proposing to add a listing, we also propose to renumber the listings for ease of reference. We would revise current listing 2.08, ''Hearing impairments,'' renumber it as listing 2.10, ''Hearing loss not treated with cochlear implantation,'' and add listing 2.11, ''Hearing loss treated with cochlear implantation.''

Proposed Listing 2.10—Hearing Loss Not Treated With Cochlear Implantation

In this proposed listing, we would revise current listing 2.08, ''Hearing impairments,'' and specify that these criteria apply to individuals who do not have cochlear implants.

Current listing 2.08 provides that a hearing loss is of listing-level severity when ''hearing [is] not restorable by a hearing aid'' and satisfies either of the criteria in the listing. Our longstanding interpretation of the phrase ''hearing not restorable by a hearing aid'' is that the hearing loss is so severe that a hearing aid would not improve it to a level at which it no longer satisfies the listing criteria. To determine this, we need testing with a hearing aid.

We propose to remove the requirement for testing with hearing aids for the following reasons:

- At our policy conference, we were advised that aided hearing testing is not usually performed in clinical practice.
- Audiometric testing with a hearing aid does not demonstrate whether the individual will be able to use the aid effectively.
- When we published the current listings, generic hearing aids were available for testing purposes. However, advances in technology have resulted in hearing aids that are programmed to address each individual's specific hearing loss. Due to this degree of specificity, generic aids are no longer widely available.

Although we propose to no longer require aided testing, we are not proposing to change the level of hearing loss needed to demonstrate a listing-level impairment. Based on our adjudicative experience and the comments we received in response to our ANPRM and at our policy conference, we have determined that individuals with this level of hearing loss do not usually obtain significant improvement in their ability to hear and communicate from hearing aids. Therefore, we believe that without a cochlear implant, a hearing loss at the level specified in the current listing is indicative of listing-level severity even if the individual were to use hearing aids.

Current listing 2.08A requires ''[a]verage hearing threshold sensitivity for air conduction of 90 decibels or greater, and for bone conduction to corresponding maximal levels, in the better ear, determined by the simple average of hearing threshold levels at 500, 1000, and 2000 hz.'' We would clarify the criterion in current listing 2.08A for ''bone conduction to corresponding maximal levels'' by specifying that this means that the average bone conduction hearing threshold must be 60 dB or greater in the better ear.

Current listing 2.08B requires ''[s]peech discrimination scores of 40 percent or less in the better ear.'' As we mentioned above, ''speech discrimination'' is now referred to as ''word recognition testing.'' When we published the current rules, word recognition testing was usually conducted using a standardized list of phonetically balanced monosyllabic words. Other types of word recognition testing, such as sentence testing, are now available. Therefore, we propose to specify the type of word recognition testing to be used.

Proposed Listing 2.11—Hearing Loss Treated With Cochlear Implantation

We propose to add criteria to evaluate individuals who have cochlear implants. Cochlear implants are devices that attempt to replace the function of damaged inner ear hair cells. The implant may destroy any remaining hearing in the implanted ear.

Cochlear implants are not hearing aids. Hearing aids amplify sound, while cochlear implants provide direct electrical stimulation of the auditory nerve. Therefore, even individuals with profound hearing loss may receive enough benefit from a cochlear implant to be able to engage in gainful activity. However, we recognize that if you are treated with cochlear implantation, you will need a period of rehabilitation and training to use the implant effectively. Therefore, if you have a cochlear implant, we propose to consider you to be under a disability for one year from the date of implantation.

After the 1-year period, we propose to determine whether your hearing loss meets the listing by assessing your word recognition ability using the HINT. We propose to use the HINT to assess your word recognition ability because, as mentioned in our discussion of proposed section 2.00B3, the American Academy of Neurology indicated in their comments in response to our ANPRM that the HINT is the ''accepted standard used to assess hearing outcome after cochlear implantation.''

The HINT is a sentence test. Individuals generally have higher word recognition scores when tested with a sentence test as opposed to a monosyllabic word test because sentences provide context for the words in them. Therefore, we propose to find that your hearing loss meets the listing if your word recognition score on the HINT is 60 percent or less.

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

102.00 Special Senses and Speech

We have repeated much of the introductory text of proposed 2.00B in the introductory text to proposed 102.00B. This is because the same basic rules for evaluating hearing loss in adults also apply to evaluating hearing loss in children age 5 and older. Because we have already described these provisions under the explanation of proposed 2.00B, the following discussion of proposed 102.00B describes only those provisions that apply to children under age 5, are unique to the childhood rules, or require further explanation specific to evaluating disability in children.

We propose to remove the first paragraph of current 102.00B, ''Hearing impairments in children.'' This paragraph explains that the criteria for hearing impairments in children take into account that a lesser impairment in hearing which occurs at an early age may result in a severe speech or language disorder. While this paragraph does explain why we use a lower threshold for children, it is not needed in the introductory text as it does not provide any guidance about how to evaluate hearing loss under these listings.

We also propose to remove the second paragraph of current 102.00B. This paragraph provides guidance on how to consider improvement in hearing due to use of a hearing aid. As we discussed in our explanation of proposed listing 2.10 above, we are proposing to remove the requirement for aided hearing testing. Therefore, this guidance is no longer needed.

Proposed 102.00B2—What audiometric testing do we need when you do not have a cochlear implant?

This proposed section expands and clarifies the guidance in the third and fourth paragraphs of current 102.00B as follows:

- We would clarify that we generally need behavioral or physiologic testing (other than screening testing) that is appropriate for your age at the time of testing.
- We would clarify that we require that audiometric testing be conducted in accordance with the most recently published American National Standards Institute (ANSI) standards for air conduction and, if appropriate, bone conduction stimuli. Our current rules provide that audiometric testing be conducted in accordance with the 1969 and 1972 ANSI standards or subsequent comparable revisions.
- We would provide that hearing aids not be used during audiometric testing.
- We would require that an otoscopic examination be performed immediately before the audiometric testing to ensure that there are no conditions present that would prevent valid testing.
- We would provide that we will not purchase physiologic testing. We are proposing this rule because such testing may require sedation.
- We would describe the hearing testing that is appropriate for children in the age ranges of birth to the attainment of age 6 months, age 6 months to the attainment of age 2, age 2 to the attainment of age 5, and age 5 to the attainment of age 18. The proposed guidance for hearing testing for children age 5 to the attainment of age 18 is similar to the proposed guidance for hearing testing in adults, except for the frequencies needed to determine the hearing threshold.
- We would revise the frequency levels used to determine the pure tone air conduction or bone conduction threshold from 500, 1000, 2000, and 3000 Hz to 500, 1000, 2000, and 4000 Hz. We received several comments in response to our ANPRM recommending that we make this change in how we determine the hearing threshold. Additionally, our adjudicative experience has shown that testing is often not done at 3000 Hz. We considered using the same hearing thresholds as in adults, but propose to continue to use 4000 Hz because of the importance of hearing at higher frequencies to a child's ability to learn speech.
- We would describe screening tests, such as otoacoustic emissions (OAE), and explain how we use them. We propose to provide this guidance because hearing screening tests are commonly given to children in newborn nurseries and schools. We do not propose to add this guidance to the introductory text for adults because hearing screening tests are not commonly given to adults.

Proposed 102.00B3—What audiometric testing do we need when you have a cochlear implant?

This new section is similar to proposed 2.00B3 except that we provide that a child who has a cochlear implant will be disabled until age 5 or until 1 year after implantation, whichever is later. We propose to consider children with cochlear implants to be disabled until age 5 because of the extensive rehabilitation and training needed for young children with cochlear implants to acquire speech and language skills.

We would also explain that after that period, we will evaluate your hearing loss by measuring your word recognition ability on the HINT or the Hearing in Noise Test for Children (HINT–C).

Proposed 102.00B5—What do we mean by a marked limitation in speech or language as used in 102.10B2?

In this new section, we explain when we will consider you to have a marked limitation in speech or language.

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

For the reasons mentioned in our discussion of 2.01 above, we propose to add a separate listing to evaluate hearing loss treated with cochlear implantation. Because we are proposing to add a listing, we also propose to renumber the listings for ease of reference. We would revise current listing 102.08, ''Hearing impairments,'' renumber it as listing 102.10, ''Hearing loss not treated with cochlear implantation,'' and add listing 102.11, ''Hearing loss treated with cochlear implantation.''

Proposed 102.10—Hearing Loss Not Treated With Cochlear Implantation

This proposed listing would revise current listing 102.08, ''Hearing impairments,'' and specify that it applies to children who do not have cochlear implants.

The current childhood listing requires that we assess your ability to hear with a hearing aid unless we determine that you are not able to use the aid effectively. For the reasons we stated in the discussion of proposed listing 2.10 above, we propose to no longer require aided hearing testing to determine if your hearing loss meets the listing.

Proposed listing 102.10A would replace current listing 102.08A. This proposed listing contains the criterion for evaluating hearing loss in children under age 5 who do not have a cochlear implant. We propose to replace the current criterion for an aided average hearing threshold of 40 dB in the better ear with a criterion for an unaided average air conduction hearing threshold of 50 dB or greater in the better ear. We propose to use a threshold of 50 dB because we believe that, even with the use of a hearing aid, a child under age 5 who has a 50 dB hearing loss will also have a marked limitation in speech or language.

Proposed listing 102.10B would replace current listing 102.08B. This proposed listing contains the criteria for evaluating hearing loss in children from age 5 to the attainment of age 18. For the reasons we explained earlier, we propose to no longer require aided hearing testing.

Proposed listing 102.10B1 would correspond to current listing 102.08B1. Current listing 102.08B1 generally requires an aided average air conduction hearing threshold of 70 dB or greater in the better ear. We would expect hearing loss at that level to have a sensorineural component. (A sensorineural hearing loss is caused by permanent damage to the inner ear or to the nerve pathways from the inner ear to the brain.) We propose to replace the criterion in current listing 102.08B1 with an unaided average air conduction hearing threshold of 70 dB or greater in the better ear. In order to ensure that hearing loss at this level has a sensorineural component, we also propose to add a criterion in proposed listing 102.10B1 for an average bone conduction hearing threshold of 40 dB or greater in the better ear. We would continue to use a 70 dB average air conduction hearing threshold because we believe a hearing loss with a sensorineural component at this level will significantly affect a child's ability to engage in learning. Also, we do not use the same hearing threshold levels for children from age 5 to the attainment of age 18 as we use for adults because of the importance of hearing to a child's ability to communicate and learn.

Proposed listing 102.10B2 would correspond to current listing 102.08B2. We propose to make the same editorial changes as we did in proposed listing 2.10B.

Proposed listing 102.10B3 would correspond to current listing 102.08B3. As we discussed in our explanation of proposed listing 102.10A above, we propose to use an unaided hearing threshold of 50 dB in the better ear. Because children typically acquire basic speech and language skills by age 5, we believe that it is not appropriate to presume that a child over age 5 who has a 50 dB hearing loss will also have a marked limitation in speech or language. Therefore, for children over age 5, we also propose to require an assessment of speech and language skills.

Proposed 102.11—Hearing Loss Treated With Cochlear Implantation

This proposed listing is similar to proposed listing 2.11 except that we propose to consider you to be under a disability until age 5, or for 1 year after implantation, whichever is later. We also propose to use either the HINT or the HINT–C to assess your word recognition ability.

What programs would these proposed regulations affect?

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

Who can get disability benefits?

Under title II of the Act, we provide for the payment of disability benefits 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 if you are disabled and have limited income and resources.

How do we define disability?

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 can be 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 and that results in . . .
title II	an adult or a child	the inability to do any substantial gainful activity (SGA).
title XVI	an individual age 18 or older	the inability to do any SGA.
title XVI	an individual under age 18	marked and severe functional limitations.

How do we decide whether you are disabled?

If you are applying for benefits under title II of the Act, or if you are an adult applying for 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 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 (RFC) 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 RFC, 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 SSI. If you are already receiving benefits, we also use a different sequential evaluation process when we decide whether your disability continues. See §§ 404.1594, 416.924, 416.994, and 416.994a of our regulations. However, all of these

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 never 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. Part B contains criteria that apply only to individuals who are under age 18. If the criteria in part B do not apply, we may use the criteria in part A when those criteria give appropriate consideration to the effects of the impairment(s) in children. (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 or decide that you no longer qualify for benefits because your impairment(s) does not meet or medically equal a listing. If 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.'' Likewise, we will not decide that your disability has ended only because your impairment(s) no longer meets or medically equals 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 qualified for disability benefits or SSI payments based on our determination or decision that your impairment(s) met or medically equaled a listing. 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 your impairment(s) no longer meets or medically equals 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 when we decide that you have experienced medical improvement in your condition(s). See § 416.994a(b)(2).

When will we start to use these rules?

We will not use these rules until we evaluate the public comments we receive on them, determine whether they should be issued as final rules, and issue final rules in the **Federal Register**. If we publish final rules, we will explain in the preamble how we will apply them, and summarize and respond to the public comments. Until the effective date of any final rules, we will continue to use our current rules.

How long would these proposed rules be effective?

If we publish these proposed rules as final rules, they will remain in effect for 8 years after the date they became effective, unless we extend them, or revise and issue them again.

Clarity of these proposed rules

Executive Order 12866, as amended, requires each agency to write all rules in plain language. In addition to your substantive comments on these proposed rules, we invite your comments on how to make them easier to understand.

For example:

- Have we organized the material to suit your needs?
- Are the requirements in the rules clearly stated?
- Do the rules contain technical language or jargon that is not clear?
- Would a different format (grouping and order of sections, use of headings, paragraphing) make the rules easier to understand?
- Would more (but shorter) sections be better?
- Could we improve clarity by adding tables, lists, or diagrams?
- What else could we do to make the rules easier to understand?

Regulatory Procedures

Executive Order 12866

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

Regulatory Flexibility Act

We certify that these proposed rules would 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

In these regulations, we are proposing to: (1) Revise the listings for hearing loss to update the medical criteria in the listings; (2) provide more information about how we evaluate hearing loss; and (3) reflect our adjudicative experience. The listings for hearing loss are in the special senses and speech body system. That body system also includes listings for visual disorders, disturbances of labyrinthine-vestibular function and loss of speech. In this NPRM, we are proposing changes only to the listings for hearing loss. As part of the listings, we identify specific documentation requirements used in evaluating impairments within a body system, including medical and other evidence. The documentation and evidentiary requirements are public reporting burdens that must be cleared by OMB under the Paperwork Reduction Act. However, the public reporting burdens are accounted for in the Information Collection Requests for the various forms that the public uses to submit the information to SSA. Consequently, we are reporting no burden for this regulation aside from a 1-hour placeholder burden shown in the chart below, for the sections listed.

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE

Title/section & collection description	Annual number of respondents	Frequency of response	Average burden per response (minutes)	Estimated annual burden (hours)
Hearing Loss (2.00B and 102.00B)				1

An Information Collection Request has been submitted to OMB for clearance. We are soliciting comments on the burden estimate; the need for the information; its practical utility; ways to enhance its quality, utility and clarity; and ways to minimize the burden on respondents, including the use of automated collection techniques or other forms of information technology. Requests for the Information Collection Request package and/or comments should be directed to SSA and OMB at the following addresses/phone numbers:

Office of Management and Budget, *Attn:* Desk Officer for SSA, *Fax Number:* 202–395–6974, *E-mail address: OIRA_Submission@omb.eop.gov*.

Social Security Administration, *Attn:* Reports Clearance Officer, 1333 Annex Building, 6401 Security Blvd., Baltimore, MD 21235, *Fax:* 410–965–6400, *E-mail address: OPLM.RCO@ssa.gov.*

Comments on the paperwork burdens associated with this rule can be received for up to 60 days after publication of this notice and will be most useful if received within 30 days of publication. This does not affect the deadline for the public to comment to SSA on the proposed regulations. These information collection requirements will not become effective until approved by OMB. When OMB has approved these information collection requirements, SSA will publish a notice in the **Federal Register**.

List of References

During the development of these proposed rules, we reviewed the following information:

American Speech-Language-Hearing Association (ASHA). (2004). Guidelines for the audiologic assessment of children from birth to 5 years of age [Guidelines]. (Available at *http://www.asha.org/NR/rdonlyres/0BB7C840–27D2–4DC6–861B–1709ADD78BAF/0/v2GLAudAssessChild.pdf.)*

ASHA. (2004). Technical report: Cochlear implants. *ASHA Supplement 24.* (Available at *http://www.asha.org/NR/rdonlyres/215CC9B8–6831–494F–83ED–E02A6832A8A9/0/v2TRcochlearimplants.pdf.*)

Centers for Medicare & Medicaid Services. (2005). MLN Matters Number MM3796: Cochlear Implantation. (Available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3796.pdf.*)

Cunningham. M. and Cox, E.O. (2003). Hearing assessment in infants and children: Recommendations beyond neonatal screening. *Pediatrics*, 111(2), 436–440.

Dale, D.C. and Federman, D.D., eds. Neurology. *ACP Medicine.* (2004) Elliot M. Frohman, New York: WebMD Professional Publishing.

Gifford, R.H. and Shallop, J.K. (2007). Hearing preservation in patients with a cochlear implant. *The ASHA Leader*, 12(14), 15, 17, 34.

Gorga, M.P., et al. (2006). Using a combination of click- and tone burst-evoked auditory brain stem response measurements to estimate pure-tone thresholds. *Ear & Hearing*, 27(1), 60–74.

Joint Committee on Infant Hearing. (2000). Year 2000 position statement: Principles and guidelines for early hearing detection and intervention programs. *Pediatrics,* 106(4), 798–817.

Joint Committee on Infant Hearing. (2007). Year 2007 position statement: Principles and guidelines for early hearing detection and intervention programs. *Pediatrics,* 120(4), 898–921.

National Research Council (NRC): Committee on Disability Determination for Individuals with Hearing Impairments. (2005). *Hearing Loss: Determining Eligibility for Social Security Benefits.* Washington, DC: National Academy Press. (Available at *http://www.nap.edu/catalog.php?record_id=11099#toc.*)

Pittman, A.L., & Stelmachowicz, P.G. (2003). Hearing loss in children and adults: Audiometric configuration, asymmetry, and progression. *Ear & Hearing,* 24(3), 198–205.

U.S. Food and Drug Administration, Center for Devices and Radiological Health. (2007). Benefits and Risks of Cochlear Implants. (Available at: *http://www.fda.gov/cdrh/cochlear/RiskBenefit.html.*)

These references are included in the rulemaking record for these proposed rules and are available for inspection by interested individuals making arrangements with the contact person shown in this preamble.

(Catalog of Federal Domestic 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: May 12, 2008.

Michael J. Astrue,

Commissioner of Social Security.

Editorial Note: This document was received at the Office of the Federal Register on August 8, 2008.

For the reasons set out in the preamble, we propose to amend 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; sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

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

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

a. Revise item 3 of the introductory text before part A of appendix 1.

b. Revise section 2.00B of part A of appendix 1.

c. Redesignate section 2.00C of part A of appendix 1 as section 2.00E.

d. Add new sections 2.00C and 2.00D to part A of appendix 1.

e. Remove listing 2.08 of part A of appendix 1.

f. Add listings 2.10 and 2.11 to part A of appendix 1.

g. Revise section 102.00B of part B of appendix 1.

h. Remove listing 102.08 of part B of appendix 1.

i. Add listings 102.10 and 102.11 to 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): [Insert date 8 years from the effective date of the final rules].

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Part A

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2.00 Special Senses and Speech

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B. *How do we evaluate hearing loss?*

1. *What evidence do we need to evaluate hearing loss?*

a. To establish that you have a medically determinable impairment that causes your hearing loss, we require both a complete otologic examination and audiometric testing. The audiometric testing should be performed within 2 months of the complete otologic examination.

b. A complete otologic examination must include your medical history, your description of how your hearing loss affects you, a description of the appearance of the external ear (pinna and the external ear canal), an evaluation of the tympanic membrane, and an assessment of any middle ear abnormalities.

c. After your impairment has been established, we can use the results of subsequent audiometric testing to assess the severity of your hearing loss without another complete otologic examination.

d. Audiometric testing must be performed by, or under the supervision of, an otolaryngologist or by an audiologist qualified to perform such tests. We consider an audiologist to be qualified if the audiologist is currently and fully licensed or registered as a clinical audiologist by the state or U.S. territory in which he or she practices. If no licensure or registration is available, the audiologist must be currently certified by the American Board of Audiology or have a Certificate of Clinical Competence (CCC–A) from the American Speech-Language-Hearing Association (ASHA).

2. *What audiometric testing do we need when you do not have a cochlear implant?*

a. We generally need pure tone air conduction and bone conduction testing, speech reception threshold (SRT) testing, and word recognition testing. (Word recognition testing may be referred to as word discrimination or speech discrimination testing.) This testing must be conducted in a soundproof booth and each ear must be tested separately. Pure tone air conduction and bone conduction testing must be conducted in accordance with the most recently published standards of the American National Standards Institute (ANSI) for air conduction and bone conduction stimuli.

b. You must not wear hearing aids during the testing. Additionally, we require that an otoscopic examination be performed immediately before the audiometric testing. An otoscopic examination provides a description of the appearance of the external ear canal and an evaluation of the tympanic membrane. The otoscopic examination must also show that there are no conditions present that would prevent valid audiometric testing. Examples of such conditions are fluid in the ear, an ear infection, or an obstruction in the ear canal.

c. An audiological examination usually includes pure tone air conduction and bone conduction testing measured at 250, 500, 1000, 2000, and 4000 Hertz (Hz). To determine whether your hearing loss meets the air conduction criterion in 2.10A, we will average the air conduction hearing thresholds at 500, 1000, and 2000 Hz. To determine whether your hearing loss meets the bone conduction criterion in 2.10A, we will average the bone conduction hearing thresholds at 500, 1000, and 2000 Hz.

d. The SRT is the minimal decibel (dB) level required for you to recognize a standard list of words. The SRT is usually within 10 dB of the average pure tone air conduction hearing thresholds at 500, 1000, and 2000 Hz. If the SRT is not within 10 dB of the average pure tone air conduction threshold, the reason for the discrepancy should be documented.

e. Word recognition testing determines your ability to recognize a standardized list of phonetically balanced monosyllabic words in the absence of any visual cues. This testing must be performed in quiet. The words should be presented at a level of amplification that will measure your maximum ability to discriminate words, usually 35 to 40 dB above your SRT. However, the amplification level used in the testing must be medically appropriate and you must be able to tolerate it. The individual who performs the test should report your word recognition testing score at your highest comfortable level of amplification.

3. *What audiometric testing do we need when you have a cochlear implant?*

a. If you have a cochlear implant, we will consider you to be disabled until 1 year after implantation.

b. After that period, we need word recognition testing performed with the Hearing in Noise Test (HINT). This testing must be conducted in quiet in a sound field with your implant adjusted to your normal settings. The sentences should be presented at 60 dB HL (hearing level) and without any visual cues.

4. *How do we evaluate your word recognition ability if you are not fluent in English?*

If you are not fluent in English, it may not be possible to measure your word recognition ability. If your word recognition ability cannot be measured, your hearing loss cannot meet 2.10B or 2.11B. Instead, we will consider the facts of your case to determine whether you have difficulty understanding words in the language in which you are most fluent, and if so, whether that degree of difficulty medically equals 2.10B or 2.11B. For example, we will consider how you interact with family members, interpreters, and other individuals who speak the language in which you are most fluent.

C. *How do we evaluate vertigo associated with disturbances of labyrinthine-vestibular function, including Meniere's disease?*

1. These disturbances of balance are characterized by a hallucination of motion or a loss of position sense and a sensation of dizziness which may be constant or may occur in paroxysmal attacks. Nausea, vomiting, ataxia, and incapacitation are frequently observed, particularly during the acute attack. It is important to differentiate the report of rotary vertigo from that of ''dizziness,'' which is described as light-headedness, unsteadiness, confusion, or syncope.

2. Meniere's disease is characterized by paroxysmal attacks of vertigo, tinnitus, and fluctuating hearing loss. Remissions are unpredictable and irregular, but may be long-lasting; hence, the severity of the impairment is best determined after prolonged observation and serial reexaminations.

3. The diagnosis of a vestibular disorder requires a comprehensive neuro-otolaryngologic examination with a detailed description of the vertiginous episodes, including notation of frequency, severity, and duration of the attacks. Pure tone and speech audiometry with the appropriate special examinations, such as Bekesy audiometry, are necessary. Vestibular function is assessed by positional and caloric testing, preferably by electronystagmography. When polytomograms, contrast radiography, or other special tests have been performed, copies of the reports of these tests should be obtained in addition to appropriate medically acceptable imaging reports of the skull and temporal bone. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or

without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique is the proper one to support the evaluation and diagnosis of the impairment.

D. *Loss of speech.* In evaluating the loss of speech, the ability to produce speech by any means includes the use of mechanical or electronic devices that improve voice or articulation. Impairments of speech may also be evaluated under the body system for the underlying disorders, such as neurological disorders, 11.00ff.

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2.01 Category of Impairments, Special Senses and Speech

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2.10 *Hearing loss not treated with cochlear implantation.*

A. An average air conduction hearing threshold of 90 decibels or greater in the better ear and an average bone conduction hearing threshold of 60 decibels or greater in the better ear (see 2.00B2c); or

B. A word recognition score of 40 percent or less in the better ear determined using a standardized list of phonetically balanced monosyllabic words (see 2.00B2e).

2.11 *Hearing loss treated with cochlear implantation.*

A. Consider under a disability for 1 year after implantation; or

B. If more than 1 year after implantation, a word recognition score of 60 percent or less determined using the HINT (see 2.00B3b).

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Part B

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102.00 Special Senses and Speech

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B. *How do we evaluate hearing loss?*

1. *What evidence do we need to evaluate hearing loss?*

a. To establish that you have a medically determinable impairment that causes your hearing loss, we require both a complete otologic examination and audiometric testing. The audiometric testing should be performed within 2 months of the complete otologic examination.

b. A complete otologic examination must include your medical history, your description of how your hearing loss affects you, a description of the appearance of the external ear (pinna and the external ear canal), an evaluation of the tympanic membrane, and an assessment of any middle ear abnormalities.

c. After your impairment has been established, we can use the results of subsequent audiometric testing to assess the severity of your hearing loss without another complete otologic examination.

d. Audiometric testing must be performed by, or under the supervision of, an otolaryngologist or by an audiologist qualified to perform such tests. We consider an audiologist to be qualified if the audiologist is currently and fully licensed or registered as a clinical audiologist by the state or U.S. territory in which he or she practices. If no licensure or registration is available, the audiologist must be currently certified by the American Board of Audiology or have a Certificate of Clinical Competence (CCC–A) from the American Speech-Language-Hearing Association (ASHA).

2. *What audiometric testing do we need when you do not have a cochlear implant?*

a. *General.* We generally need behavioral or physiologic testing (other than screening testing, see 102.00B3g) that is appropriate for your age at the time of testing. We will make every reasonable effort to obtain the results of physiologic testing that has been done. However, if this testing has not been done, or, if we cannot obtain the results, we will not purchase it. In these situations, we will evaluate your hearing loss based on the other evidence in your case record.

b. *Testing requirements.* The testing must be conducted in accordance with the most recently published standards of the American National Standards Institute (ANSI) for air conduction stimuli, and if appropriate, bone conduction stimuli. You must not wear hearing aids during the testing. Additionally, we require that an otoscopic examination be performed immediately before the audiometric testing. An otoscopic examination provides a description of the appearance of the external ear canal and an evaluation of the tympanic membrane. The otoscopic examination must also show that there are no conditions present that would prevent valid audiometric testing. Examples of such conditions are fluid in the ear, an ear infection, or an obstruction in the ear canal.

c. *Children from birth to the attainment of age 6 months.*

i. We need physiologic testing, such as auditory brainstem response (ABR) testing, that measures the frequencies needed to recognize speech; that is, the range from 500 to 4000 Hertz (Hz). We also need an acoustic immittance assessment; that is, a tympanogram and acoustic reflex testing.

ii. To determine whether your hearing loss meets listing 102.10A, we will average the hearing thresholds at 500, 1000, 2000, and 4000 Hz.

d. *Children from age 6 months to the attainment of age 2.*

i. We need air conduction thresholds determined by a behavioral assessment, usually visual reinforcement audiometry (VRA), and an acoustic immittance assessment. We can use ABR testing results if the behavioral assessment cannot be completed or if the results of the behavioral assessment are inconclusive or unreliable.

ii. To determine whether your hearing loss meets listing 102.10A, we will average the hearing thresholds at 500, 1000, 2000, and 4000 Hz.

iii. For this age group, behavioral assessments are often performed in a sound field, and each ear is not tested separately. If each ear is not tested separately, we will consider the test results to represent the hearing in the better ear.

e. *Children from age 2 to the attainment of age 5.*

i. We need air conduction thresholds determined by a behavioral assessment, such as conditioned play audiometry (CPA), tangible or visually reinforced operant conditioning audiometry (TROCA, VROCA), or VRA, and an acoustic immittance assessment. We can use ABR testing results if the behavioral assessment cannot be completed or if the results of the behavioral assessment are inconclusive or unreliable.

ii. To determine whether your hearing loss meets listing 102.10A, we will average the hearing thresholds at 500, 1000, 2000, and 4000 Hz.

iii. For this age group, behavioral assessments are often performed in a sound field and each ear is not tested separately. If each ear is not tested separately, we will consider the test results to represent the hearing in the better ear.

f. *Children from age 5 to the attainment of age 18.*

i. We generally need pure tone air conduction and bone conduction testing, speech reception threshold (SRT) testing, and word recognition testing. (Word recognition testing may be referred to as word discrimination or speech discrimination testing.) This testing must be conducted in a soundproof booth and each ear must be tested separately.

ii. An audiological examination usually includes pure tone air conduction and bone conduction testing measured at 250, 500, 1000, 2000, and 4000 Hz. To determine whether your hearing loss meets the air conduction criterion in 102.10B1 or 102.10B3, we will average the air conduction hearing thresholds at 500, 1000, 2000, and 4000

Hz. To determine whether your hearing loss meets the bone conduction criterion in 102.10B1, we will average the bone conduction hearing thresholds at 500, 1000, 2000, and 4000 Hz.

iii. The SRT is the minimal decibel (dB) level required for you to recognize a standard list of words. The SRT is usually within 10 dB of the average pure tone air conduction hearing thresholds at 500, 1000, and 2000 Hz. If the SRT is not within 10 dB of the average pure tone air conduction threshold, the reason for the discrepancy should be documented.

iv. Word recognition testing determines your ability to recognize a standardized list of phonetically balanced monosyllabic words in the absence of any visual cues. This testing must be performed in quiet. The words should be presented at a level of amplification that will measure your maximum ability to discriminate words, usually 35 to 40 dB above your SRT. However, the amplification level used in the testing must be medically appropriate and you must be able to tolerate it. The individual who performs the test should report your word recognition testing score at your highest comfortable level of amplification.

g. *Screening Testing.* ABR and other physiologic testing, such as otoacoustic emissions (OAE), can be used as hearing screening tests. When such testing is used as hearing screening tests, we will not use the results to determine that your hearing loss meets or medically equals a listing, or to assess functional limitations due to your hearing loss. We can, however, consider normal results from hearing screening tests to determine whether your hearing loss is severe when these test results are consistent with the other evidence in your case record. See § 416.924(c).

3. *What audiometric testing do we need when you have a cochlear implant?*

a. If you have a cochlear implant, we will consider you to be disabled until age 5, or for 1 year after implantation, whichever is later.

b. After that period, we need word recognition testing performed with the Hearing in Noise Test (HINT) or the Hearing in Noise Test for Children (HINT–C). This testing must be conducted in quiet in a sound field with your implant adjusted to your normal settings. The sentences should be presented at 60 dB HL (hearing level) and without any visual cues.

4. *How do we evaluate your word recognition ability if you are not fluent in English?* If you are not fluent in English, it may not be possible to measure your word recognition ability. If your word recognition ability cannot be measured, your hearing loss cannot meet 102.10B2 or 102.11B. Instead, we will consider the facts of your case to determine whether you have difficulty understanding words in the language in which you are most fluent, and if so, whether that degree of difficulty medically equals 102.10B2 or 102.11B. For example, we will consider how you interact with family members, interpreters, and other individuals who speak the language in which you are most fluent.

5. *What do we mean by a marked limitation in speech or language as used in 102.10B3?*

a. We will consider you to have a marked limitation in speech if:

i. According to the unfamiliar listener, entire phrases or sentences in your conversation are intelligible approximately 60 percent of the time or less on the first attempt; and

ii. Your sound production or phonological patterns (the ways in which you combine speech sounds) are atypical for your age.

b. We will consider you to have a marked limitation in language when your current and valid test score on an appropriate comprehensive, standardized test of overall language functioning is at least two standard deviations below the mean. In addition, the evidence of your daily communication functioning must be consistent with your test score. If you are not fluent in English, it may not be possible to test your language performance. If we cannot test your language performance, your hearing loss cannot meet 102.10B3. Instead, we will consider the facts of your case to determine whether your hearing loss medically equals 102.10B3.

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102.01 Category of Impairments, Special Senses and Speech

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102.10 *Hearing loss not treated with cochlear implantation.*

A. For children from birth to the attainment of age 5, an average air conduction hearing threshold of 50 decibels or greater in the better ear (see 102.00B2); or

B. For children from age 5 to the attainment of age 18:

1. An average air conduction hearing threshold of 70 decibels or greater in the better ear and an average bone conduction hearing threshold of 40 decibels or greater in the better ear (see 102.00B2f); or

2. A word recognition score of 40 percent or less in the better ear determined using a standardized list of phonetically balanced monosyllabic words (see 102.00B2f); or

3. An average air conduction hearing threshold of 50 decibels or greater in the better ear and a marked limitation in speech or language (see 102.00B2f and 102.00B5).

102.11 *Hearing loss treated with cochlear implantation.*

A. Consider under a disability until the attainment of age 5, or for 1 year after implantation, whichever is later; or

B. Upon the attainment of age 5 or 1 year after implantation, whichever is later, a word recognition score of 60 percent or less determined using the HINT or the HINT–C (see 102.00B3b).

* * * * *

[FR Doc. E8–18718 Filed 8–12–08; 8:45 am]

BILLING CODE 4191–02–P

LIBRARY OF CONGRESS

Copyright Office

37 CFR Part 201 and 255

[Docket No. RM 2000–7]

Compulsory License for Making and Distributing Phonorecords, Including Digital Phonorecord Deliveries

AGENCY: Copyright Office, Library of Congress.

ACTION: Extension of time to file comments and reply comments; Notice of Hearing.

SUMMARY: The Copyright Office is extending the time in which comments and reply comments may be filed in response to its Notice of Proposed Rulemaking proposing to amend its regulations to clarify the scope and application of the Section 115 compulsory license to make and distribute phonorecords of a musical work by means of digital phonorecord deliveries. 73 FR 40802. The Office is also announcing a hearing on the proposed rulemaking to take place on September 19, 2008.

DATES: Comments must be received in the Office of the General Counsel of the Copyright Office no later than Thursday, August 28, 2008 at 5:00 p.m. Reply Comments must be received no later than Monday, September 15, 2008 at 5:00 p.m. The hearing will take place on Friday, September 19, 2008, commencing at 10:00 a.m. in the Copyright Hearing Room at the Library of Congress, Room LM–408, 4th Floor, James Madison Building, 101 Independence Avenue, SE, Washington, DC. Requests to testify at the hearing must be received in writing no later