ACTION: Notice of enforcement of regulation.

SUMMARY: The Coast Guard will enforce the San Diego Bayfair special local regulations on Friday, September 12, 2014 through Sunday, September 14, 2014. This recurring marine event occurs on the navigable waters of Mission Bay in San Diego, California. This action is necessary to provide for the safety of the high speed boat race participants, crew, spectators, safety vessels, and general users of the waterway. During the enforcement period, persons and vessels are prohibited from entering into, transiting through, or anchoring within this regulated area unless authorized by the Captain of the Port, or his designated representative.

DATES: This rule is effective from 7:00 a.m. to 6:00 p.m. on Friday, September 12, 2014 through Sunday, September 14, 2014.

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice, call or email Petty Officer Giacomo Terrizzi, Waterways Management, U.S. Coast Guard Sector San Diego, CA; telephone (619) 278–7261, email *Giacomo.Terrizzi@uscg.mil.*

SUPPLEMENTARY INFORMATION: The Coast Guard will enforce the special local regulations in Mission Bay for the San Diego Bayfair as listed in 33 CFR 100.1101, Table 1, Item 12 from 7:00 a.m. to 6:00 p.m.

Under the provisions of 33 CFR 100.1101, persons and vessels are prohibited from entering into, transiting through, or anchoring within the regulated area encompassing all navigable waters of Mission Bay to include Fiesta Island, the east side of Vacation Isle, and Crown Point Shores, unless authorized by the Captain of the Port, or his designated representative. Persons or vessels desiring to enter into or pass through the regulated area may request permission from the Captain of the Port or a designated representative. If permission is granted, all persons and vessels shall comply with the instructions of the Captain of the Port or designated representative. Spectator vessels may safely transit outside the regulated area, but may not anchor, block, loiter, or impede the transit of participants or official patrol vessels. The Coast Guard may be assisted by other Federal, State, or local law enforcement agencies in patrol and notification of this regulation.

This notice is issued under authority of 5 U.S.C. 552(a) and 33 CFR 100.1101. In addition to this notice in the **Federal Register**, the Coast Guard will provide the maritime community with advance notification of this enforcement period via the Local Notice to Mariners, Broadcast Notice to Mariners, and local advertising by the event sponsor. If the Captain of the Port Sector San Diego or his designated representative determines that the regulated area need not be enforced for the full duration stated on this notice, he or she may use a Broadcast Notice to Mariners or other communications coordinated with the event sponsor to grant general permission to enter the regulated area.

Dated: July 20, 2014

S.M. Mahoney,

Captain, U.S. Coast Guard, Captain of the Port San Diego.

[FR Doc. 2014–18365 Filed 8–1–14; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100

[Docket No. USCG–2012–1036]

Special Local Regulations; Recurring Marine Events in Captain of the Port Long Island Sound Zone

AGENCY: Coast Guard, DHS.

ACTION: Notice of enforcement of regulation.

SUMMARY: The Coast Guard will enforce one special local regulation for a regatta in the Sector Long Island Sound area of responsibility on October 5, 2014. This action is necessary to provide for the safety of life on navigable waterways during the event. During the enforcement period, no person or vessel may enter the regulated area without permission of the Captain of the Port (COTP) Sector Long Island Sound or designated representative.

DATES: The regulations for the marine event listed in the Table to 33 CFR 100.100(1.4) will be enforced on October 5, 2014 from 5:30 a.m. through 5:30 p.m.

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice, call or email Petty Officer Ian Fallon, Waterways Management Division, U.S. Coast Guard Sector Long Island Sound; telephone 203–468–4565, email *Ian.M.Fallon@uscg.mil.*

SUPPLEMENTARY INFORMATION: The Coast Guard will enforce the special local regulation listed in 33 CFR 100.100(1.4) on the specified date and times as indicated below. The final rule establishing this special local regulation was published in the **Federal Register** on May 24, 2013 (78 FR 31402).

1.4 Riverfront Regatta, Hartford, CT.	• Event type: Regatta. • Date: October 5, 2014. • Time: 5:30 a.m. to 5:30 p.m. • Location: All water of the Connecticut River, Hartford, CT, between the Putnum Bridge 41°42.87′ N 072°38.43′ W and the Riverside Boat House 41°46.42′ N 072°39.83′ W (NAD 83).

Under the provisions of 33 CFR 100.100, the regatta listed above is established as a special local regulation. During the enforcement period, persons and vessels are prohibited from entering into, transiting through, mooring, or anchoring within the regulated area unless they receive permission from the COTP or designated representative.

This notice is issued under authority of 33 CFR 100 and 5 U.S.C. 552(a). In addition to this notice in the **Federal Register**, the Coast Guard will provide the maritime community with advance notification of this enforcement period via the Local Notice to Mariners or marine information broadcasts. If the COTP determines that the regulated area need not be enforced for the full duration stated in this notice, a Broadcast Notice to Mariners may be used to grant general permission to enter the regulated area.

Dated: July 14, 2014,

E.J. Cubanski, III,

Captain, U.S. Coast Guard, Captain of the Port Sector Long Island Sound.

[FR Doc. 2014–18360 Filed 8–1–14; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Parts 3 and 4

RIN 2900–AO96

Schedule for Rating Disabilities—Mental Disorders and Definition of Psychosis for Certain VA Purposes

AGENCY: Department of Veterans Affairs.

ACTION: Interim final rule.

SUMMARY: The Department of Veterans Affairs (VA) is amending the portion of its Schedule for Rating Disabilities (VASRD) dealing with mental disorders and its adjudication regulations that define the term ''psychosis.'' The

VASRD refers to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM–IV), and VA's adjudication regulations refer to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM–IV–TR). DSM–IV and DSM–IV–TR were recently updated by issuance of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5). This rulemaking will remove outdated DSM references by deleting references to DSM–IV and DSM–IV–TR and replacing them with references to DSM–5. Additionally, this rulemaking will update the nomenclature used to refer to certain mental disorders to conform to DSM–5.

DATES: *Effective Date:* This interim final rule is effective August 4, 2014. The incorporation by reference of certain publications listed in the rule is approved by the Director of the Federal Register as of August 4, 2014.

Comment Date: Comments must be received on or before October 3, 2014.

Applicability Date: The provisions of this interim final rule shall apply to all applications for benefits that are received by VA or that are pending before the agency of original jurisdiction on or after the effective date of this interim final rule. The Secretary does not intend for the provisions of this interim final rule to apply to claims that have been certified for appeal to the Board of Veterans' Appeals or are pending before the Board of Veterans' Appeals, the United States Court of Appeals for Veterans Claims, or the United States Court of Appeals for the Federal Circuit.

ADDRESSES: Written comments may be submitted through *www.Regulations.gov;* by mail or hand-delivery to Director, Regulation Policy and Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420; or by fax to (202) 273–9026. Comments should indicate that they are submitted in response to ''RIN 2900–AO96—Schedule for Rating Disabilities—Mental Disorders and Definition of Psychosis for Certain VA Purposes.'' Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1068, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461–4902 for an appointment. (This is not a toll-free number.) In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at *www.Regulations.gov*.

FOR FURTHER INFORMATION CONTACT: Ioulia Vvedenskaya, Medical Officer, VASRD Regulations Staff (211C), Compensation Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, (202) 461–9700. (This is not a toll-free telephone number.)

SUPPLEMENTARY INFORMATION: The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association and provides a common language and standard criteria for the classification of mental disorders. DSM–IV, the version that is referenced in VA's current regulations, was initially published in 1994, with minor changes published in 2000 as the DSM–IV–TR. DSM–5, which replaces DSM–IV and DSM–IV–TR, was published in May 2013.

The DSM is referenced in VA's adjudication regulations and VASRD to ensure that claims for disability benefits for mental disorders are adjudicated in a consistent and objective manner. Additionally, reference to the DSM is included so that VA adjudicators apply the same principles and criteria that are used by both VA and non-VA health care providers. 61 FR 52695, Oct. 8, 1996.

In order to keep VA regulations, including the VASRD, current for immediate use in accordance with DSM–5, 38 CFR 3.384, 4.125, 4.126, 4.127, and 4.130 must be updated. This update will require VA rating personnel to use the diagnostic nomenclature contained in DSM–5 when adjudicating claims for mental disorders. This update to incorporate the current DSM will not affect evaluations assigned to mental disorders as it does not change the disability evaluation criteria in the VASRD.

Section 3.384: DSM Reference and DSM–5 Nomenclature Change

Currently, § 3.384 reads, ''For purposes of this part, the term 'psychosis' means any of the following disorders listed in Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, of the American Psychiatric Association (DSM–IV–TR).'' Reference to DSM–IV–TR is outdated in light of the publication of the most recent fifth edition of the DSM and is, by this rulemaking, replaced with reference to DSM–5. Additionally, the reference to Shared Psychotic Disorder as a distinct diagnosis in § 3.384(h) is removed as the DSM–5 now classifies it as a part of Delusional Disorder. Also included in current § 3.384 are the following listed disorders: Psychotic Disorder Due to General Medical Condition; Psychotic Disorder Not Otherwise Specified; and Substance-Induced Psychotic Disorder. To reflect the current nomenclature of the DSM–5, VA is updating the names of these disorders to Psychotic Disorder Due to Another Medical Condition, Other Specified Schizophrenia Spectrum and Other Psychotic Disorder, and Substance/Medication-Induced Psychotic Disorder, respectively.

Section 4.125: DSM Reference and DSM–5 Nomenclature Change

Section 4.125(a) currently reads, ''If the diagnosis of a mental disorder does not conform to DSM–IV or is not supported by the findings on the examination report, the rating agency shall return the report to the examiner to substantiate the diagnosis.'' Now that DSM–5 has been published, continued VASRD reference to DSM–IV will lead to inaccurate Compensation and Pension diagnoses and inefficient processing of related benefits claims. Additionally, mandating use of an outdated version of the DSM would not be consistent with VA's goal of using the most up-to-date medical information to describe veterans' rated disorders. Therefore, VA is removing the reference to DSM–IV and replacing it with reference to DSM–5.

Section 4.126: DSM–5 Nomenclature Change

Currently, § 4.126(c) reads, ''Delirium, dementia, and amnestic and other cognitive disorders shall be evaluated under the general rating formula for mental disorders; neurologic deficits or other impairments stemming from the same etiology (e.g., a head injury) shall be evaluated separately and combined with the evaluation for delirium, dementia, or amnestic or other cognitive disorder (see § 4.25).'' DSM–5 renames the ''Delirium, Dementia, and Amnestic and Other Cognitive Disorders'' category as ''Neurocognitive Disorders.'' Therefore, VA is deleting the reference to ''Delirium, dementia, and amnestic and other cognitive disorders'' as a disease category in § 4.126(c) and replacing it with ''Neurocognitive Disorders'' to be consistent with the terminology in DSM–5.

Section 4.127: DSM–5 Nomenclature Change

Currently, § 4.127 is titled ''Mental retardation and personality disorders.'' It reads, ''Mental retardation and personality disorders are not diseases or injuries for compensation purposes, and, except as provided in § 3.310(a) of this chapter, disability resulting from them may not be service-connected.

However, disability resulting from a mental disorder that is superimposed upon mental retardation or a personality disorder may be service-connected.'' The term ''mental retardation'' was used in DSM–IV. However, the term ''intellectual disability (intellectual developmental disorder)'' has replaced ''mental retardation'' in common use over the past two decades among medical, educational, and other professionals and conforms with nomenclature in the DSM–5. Therefore, VA is deleting the reference to ''Mental retardation'' and replacing it with ''Intellectual disability (intellectual developmental disorder)'' in § 4.127 and its title.

Section 4.130: DSM Reference and DSM–5 Nomenclature Change

Currently, § 4.130 reads, ''The nomenclature employed in this portion of the rating schedule is based upon the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, of the American Psychiatric Association (DSM–IV).'' As explained above, continued reference to the DSM–IV will lead to inaccurate Compensation and Pension diagnoses and inefficient processing of related benefits claims. Additionally, mandating the use of an outdated version of the DSM would not be consistent with VA's goal of using the most up-to-date medical information to describe veterans' rated disorders. Therefore, VA is deleting the reference to DSM–IV in § 4.130 and replacing it with a reference to DSM–5.

Section 4.130: Deletion of Organizational Categories

Currently, § 4.130 lists 38 diagnostic codes that are divided under eight organizational headers: Schizophrenia and Other Psychotic Disorders; Delirium, Dementia, and Amnestic and Other Cognitive Disorders; Anxiety Disorders; Dissociative Disorders; Somatoform Disorders; Mood Disorders; Chronic Adjustment Disorder; and Eating Disorders. These headers are based on the chapters in the DSM–IV and reflect classification of mental disorders in DSM–IV. The headers are not part of the actual rating criteria that pertain to how a mental disability is evaluated under the VASRD.

VA is changing § 4.130 terminology to conform to DSM–5. Accordingly, VA is deleting the organizational headers within the VASRD. This change adheres to the classification of mental disorders in DSM–5 and allows for accurate classification of mental disorders under the VASRD. For example, in the DSM–5, the Anxiety Disorders chapter no longer includes obsessive-compulsive disorder, which is in a new chapter ''Obsessive-Compulsive and Related Disorders,'' or posttraumatic stress disorder (PTSD), which is in the new chapter ''Trauma- and Stressor-Related Disorders.'' This change is technical and does not amend the criteria currently used to evaluate mental disorders under the VASRD.

In addition to deletion of these organizational categories, VA is adding a note to § 4.130. This note instructs rating specialists to evaluate mental disorders according to the general rating formula for mental disorders and to evaluate eating disorders according to the rating formula for eating disorders. This note is necessary due to the DSM–5 deletion of organizational categories. There is no change made to VA's criteria or method for evaluating mental and eating disorders. The note will read as follows: ''Note: Ratings under diagnostic codes 9201 to 9440 will be evaluated using the General Rating Formula for Mental Disorders. Ratings under diagnostic codes 9520 and 9521 will be evaluated using the General Rating Formula for Eating Disorders.''

Section 4.130: Diagnostic Codes and DSM–5 Nomenclature

Of the 38 diagnostic codes in § 4.130, 25 require updating to reflect the current terminology contained in the DSM–5. The changes do not affect the evaluation of these mental disorders. For reference purposes, the following table lists all affected diagnostic codes under amended § 4.130 and includes the nomenclature under DSM–IV and the new nomenclature under DSM–5:

Diagnostic code	DSM–IV	DSM–5
9201	Schizophrenia, disorganized type	Schizophrenia.
9202	Schizophrenia, catatonic type	Schizophrenia (DC 9201).
9203	Schizophrenia, paranoid type	Schizophrenia (DC 9201).
9204	Schizophrenia, undifferentiated type	Schizophrenia (DC 9201).
9205	Schizophrenia, residual type; other and unspecified types	Schizophrenia (DC 9201).
9210	Psychotic disorder, not otherwise specified (atypical psychosis)	Other specified and unspecified schizophrenia spectrum and other psychotic disorders.
9301	Dementia due to infection (HIV infection, syphilis, or other systemic or intracranial infections).	Major or mild neurocognitive disorder due to HIV or other infections.
9304	Dementia due to head trauma	Major or mild neurocognitive disorder due to traumatic brain injury.
9305	Vascular dementia	Major or mild vascular neurocognitive disorder.
9310	Dementia of unknown etiology	Unspecified neurocognitive disorder.
9312	Dementia of the Alzheimer's type	Major or mild neurocognitive disorder due to Alzheimer's disease.
9326	Dementia due to other neurologic or general medical conditions (endocrine disorders, metabolic disorders, Pick's disease, brain tumors, etc.) or that are substance-induced (drugs, alcohol, poisons).	Major or mild neurocognitive disorder due to another medical condition or substance/medication-induced major or mild neurocognitive disorder.
9327	Organic mental disorder, other (including personality change due to a general medical condition).	Unspecified neurocognitive disorder (DC 9310).
9403	Specific (simple) phobia; social phobia	Specific phobia; social anxiety disorder (social phobia).
9410	Other and unspecified neurosis	Other specified anxiety disorder (DC 9410); Unspecified anxiety disorder (DC 9413).
9413	Anxiety disorder, not otherwise specified	Unspecified anxiety disorder.
9416	Dissociative amnesia; dissociative fugue; dissociative identity disorder (multiple personality disorder).	Dissociative amnesia; dissociative identity disorder.
9417	Depersonalization disorder	Depersonalization/Derealization disorder.
9421	Somatization disorder	Somatic symptom disorder.
9422	Pain disorder	Other specified somatic symptom and related disorder.
9423	Undifferentiated somatoform disorder	Unspecified somatic symptom and related disorder.

Diagnostic code	DSM–IV	DSM–5
9424	Conversion disorder	Conversion disorder (functional neurological symptom disorder).
9425	Hypochondriasis	Illness anxiety disorder.
9433	Dysthymic disorder	Persistent depressive disorder (dysthymia).
9435	Mood disorder, not otherwise specified	Unspecified depressive disorder.

The changes in the table will also be reflected in identical amendments to Appendix A—Table of Amendments and Effective Dates Since 1946, Appendix B—Numerical Index of Disabilities, and Appendix C—Alphabetical Index of Disabilities, all contained in 38 CFR Part 4. In addition, diagnostic code 9412 in Appendix B—Numerical Index of Disabilities has been corrected to read ''Panic disorder and/or agoraphobia.'' This change is a correction as the previous listing in Appendix B omitted ''and/or agoraphobia'' from the listed diagnosis.

Incorporation by Reference

The Director of the Federal Register approves the incorporation by reference of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5) (2013) for the purposes of 38 CFR 4.125(a) in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain a copy from the American Psychiatric Association, 1000 Wilson Boulevard, Arlington, VA 22209–3901. You may inspect a copy at the Office of Regulation Policy and Management, Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420 or the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Although §§ 3.384 and 4.130 also mention DSM–5, incorporation by reference is not required because those sections merely refer to the DSM–5 as a source and not as a requirement. In contrast, § 4.125 requires claims adjudicators to use the DSM–5.

Administrative Procedure Act

In accordance with 5 U.S.C. 553(b)(B) and (d)(3), the Secretary of Veterans Affairs finds that there is good cause to dispense with the opportunity for prior notice and comment and good cause to publish this rule with an immediate effective date. The Secretary finds that it is impracticable, unnecessary, and contrary to the public interest to delay this regulation for the purpose of soliciting prior public comment.

It is impracticable to provide opportunity for prior notice and comment for this rulemaking because a delay in implementation will require the Veterans Health Administration (VHA) to continue to diagnose mental disorders under two versions of the DSM until this regulation is effective, one for clinical purposes (under DSM–5) and one for compensation purposes (under DSM–IV). In order to maintain the highest and most modern level of care for veterans, and as required by the American Psychiatric Association, VHA clinicians must use the DSM–5-based clinical guidelines to appropriately diagnose and treat veterans with mental disorders. This use of the DSM–5 not only provides veterans with the most up-to-date care for mental disorders, but also ensures that non-VA health care providers who employ the DSM–5 are able to understand, interpret, and continue the care documented in VA treatment records.

Similarly, the Veterans Benefits Administration's (VBA) failure to employ DSM–5 will place VASRD diagnostic terminology and classifications of mental disorders at odds with the DSM–5-based diagnostic criteria and terminology now standard in the psychiatric community. Continued reliance on the DSM–IV would also potentially place VBA at odds with its own regulations, which require ''accurate and fully descriptive medical examinations'' in order to apply the VASRD. 38 CFR 4.1. Failure to adopt the most current medical standards for the diagnosis of mental disorders, as contained in the DSM–5, would thus result in an inability to apply the VASRD, as DSM–IV-based examinations are now outdated and therefore inaccurate.

It is therefore imperative that VBA adopt the DSM–5 as the diagnostic standard for disability compensation purposes. As described above, prior notice and comment period for this rulemaking will result in negative consequences for both the VHA treatment and VBA evaluation of mental health disorders. Specifically, without this immediate change, VHA medical professionals would be required to diagnose and record their clinical findings using two standards. Under commonly accepted American Psychiatric Association and medical guidelines, the DSM–5, the current authoritative standard, must be used for the purposes of clinical diagnosis and treatment of mental disorders. However, under the existing requirement to diagnose mental disorders under DSM–IV when performing Compensation and Pension examinations, these same VHA clinicians would be required to record their clinical findings using the obsolete and now-irrelevant DSM–IV. This would put VHA physicians at odds with their professional responsibilities as members of the medical community and providers of veterans' care. Moreover, asking VHA to continue providing medical evidence based on DSM–IV ignores the numerous advances in mental health science reflected in the DSM–5.

VA notes that it is unnecessary to provide opportunity for prior notice and comment for this rulemaking because it is inevitable that VBA will adopt the DSM–5 for diagnostic purposes. With its foundations based upon the most current medical science as determined by experts in the field of mental health, the new and current DSM–5 terminology and classification of mental disorders must be applied to the adjudication process without undue delay. In this context, VA recognizes that applying the new and current DSM–5-based updates to the VASRD immediately upon publication of this rule will enable the Secretary of Veterans Affairs to make available to all veterans who are diagnosed with mental health disorders, including those who suffer from PTSD, timely access to benefits based on current and accurate clinical diagnostic criteria already adopted by the psychiatric community. Taking this step will avoid disruption in providing accurate disability benefits to veterans for mental health disorders in a timely manner.

Upon publication of the DSM–5, the American Psychiatric Association and the Centers for Medicare and Medicaid Services instructed health care providers to begin using the DSM–5 immediately. VHA clinicians followed thereafter and began utilizing the DSM–5 in treatment of mental disorders on November 1, 2013. However, the American Psychiatric Association also noted that there will be a period of time during which insurers and other agencies, to include VA, will need to

update forms and data systems associated with the transition from DSM–IV to DSM–5. For the purposes of VA disability benefits, the forms and data systems that must be updated include, but are not limited to, Disability Benefits Questionnaires, the Veterans Benefits Management System, and VA's own Compensation and Pension adjudication regulations. In addition, the National Academy of Sciences' Institute of Medicine (IOM) has recommended that VA adopt systematic reviews of clinical guidelines. The goal of these systematic reviews is to enhance the quality and reliability of health-care guidance for veterans. VA has reviewed DSM–5 and has found that its implementation for diagnostic purposes is appropriate.

Furthermore, it is inevitable that VBA will eventually rely on the DSM–5-based terminology and classification of mental disorders to describe diagnosed mental disorders. Use of the DSM–5 as a standard for the diagnosis of mental disorders is not a decision that rests with VA, VHA, or VBA. VHA clinicians, as well as all mental health providers, have a professional duty as licensed medical practitioners to use the most current medical guidelines, in this case the DSM–5. In addition, IOM has encouraged VBA to review the VASRD to ensure that it relies on current medical science. With successive editions over the past 60 years, DSM has become the standard reference for clinical practice in the mental health field. Its fifth edition, DSM–5, presents the most current classification of mental disorders with associated criteria designed to facilitate more reliable diagnosis of these disorders. VBA must eventually rely on the DSM–5 in order for VHA physicians to comply with their professional obligations and to ensure adherence to guidance from the IOM.

The change to the references from DSM–IV to DSM–5 in VBA's adjudication regulations does not present a change in how mental disorders are evaluated under the VASRD, nor are any disorders removed from the VASRD. The only foreseeable substantive public comments would be limited to the contents of the DSM–5 itself, something over which VBA has no control or input. VBA has reviewed the contents of the DSM–5 to ensure that, while some disabilities have been renamed, re-categorized, or consolidated into another diagnosis, all mental disorders currently listed in the VASRD are accounted for. The changes made to diagnostic nomenclature, however, are beyond the scope and expertise of VBA, and any comments suggesting changes to how disabilities are diagnosed could not be answered by VBA. In cases of periodic updates of clinical guidelines and medical terminology used by the medical community, such as DSM–5, VBA has no authority to comment, challenge, or change the content, terminology, or nomenclature based on public comment. VBA's use of the DSM–5 is limited to conforming to the most current medical standards and practices in diagnosing mental disabilities. While an interim final rulemaking forgoes prior notice and comment, VBA will still accept and consider all significant comments received in response to the publication of this rulemaking and can make changes through future rulemakings if necessary.

As the understandings of mental disorders and their treatments have evolved, clinical professionals have developed strong, objective, and consistent scientific validators of individual disorders. As a result, the DSM–5 has moved to a non-axial documentation of diagnoses, based on dimensional concepts in the diagnosis of mental disorders. The DSM–IV incorporated a Global Assessment of Functioning (GAF) scale, which was used to measure the individual's overall level of functioning on a scale of 1 to 100. The American Psychiatric Association has determined that the GAF score has limited usefulness in the assessment of the level of disability. Noted problems include lack of conceptual clarity and doubtful value of GAF psychometrics in clinical practice. Currently, VA's mental health examinations performed under DSM–IV include the GAF score in evaluating PTSD and all other disorders, but the score is only marginally applicable to PTSD and other disorders because of its emphasis on the symptoms of mood disorder and schizophrenia and its limited range of symptom content.

During VA's review of the DSM–5, questions were raised as to the impact of DSM–5 changes in PTSD diagnostic criteria and, therefore, the number of veterans eligible to receive disability compensation for this mental disorder. Specifically, there was concern that a change in the diagnostic criteria for PTSD in the DSM–5 would result in fewer diagnoses, given that the DSM–5 includes more explicit definitions for stressors. The new diagnostic criteria for PTSD no longer include the subjective reaction to the traumatic event (Criterion A2), such as experiencing fear, helplessness, or horror, but the revised stressor criterion (Criterion A) includes a more explicit definition for stressors as exposure to actual or threatened death, serious injury or sexual violation. According to DSM–5, the exposure must result from at least one of the following scenarios, in which the individual: Directly experiences the traumatic event; witnesses the traumatic event in person; learns that the traumatic event occurred to a close family member or close friend (with actual or threatened death being either violent or accidental); or experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television, or movies unless work-related).

The DSM–5 also includes four diagnostic clusters for PTSD, instead of the three clusters under the DSM–IV. These clusters are described as re-experiencing, avoidance, negative alterations in cognition and mood, and arousal. The number of symptoms that must be identified to support a diagnosis depends on the cluster in which the symptoms fall. Most importantly, the DSM–5 only requires that a disturbance continue for more than one month and eliminates the distinction between acute and chronic PTSD; this will likely result in more veterans meeting the diagnostic criteria for PTSD.

Although DSM–5 does present minor changes in the manner in which PTSD is diagnosed—i.e., it includes more explicit definitions for stressors for purposes of clinical diagnosis, it is important to note that such changes do not impact VA's adjudication regulations, which provide evidentiary criteria for establishing the existence of an in-service stressor, in certain circumstances. For example, 38 CFR 3.304(f)(3) provides the relaxed evidentiary criteria for establishing a stressor based on fear of hostile military or terrorist activity under which an examiner determined that the stressor criteria for a diagnosis of PTSD under the DSM–5 have been satisfied. 75 FR 39843, July 13, 2010. VA also provides for full development of potential sources of stressor evidence in claims based on military sexual trauma under 38 CFR 3.304(f)(5). In addition, it is important to note that the DSM–5 now specifically lists sexual violation/assault as a traumatic event to satisfy the stressor criteria. Also, once a diagnosis is established, DSM–5 does not change how the existing VASRD evaluation criteria are applied to diagnosed mental disorders to determine an appropriate disability rating.

To the extent that VA and non-VA physicians will no longer use GAF scores in their examinations, such discontinuance will only alter the form in which physicians make and report

their findings regarding disability levels. There will be no effect on the rating criteria in the VASRD or the manner in which VA applies the VASRD criteria to the medical evidence of record. In order to provide a global measure of disability, DSM–5 recommends using the World Health Organization Disability Assessment Schedule, Version 2; this assessment can also be used over time to track changes in a patient's disabilities. DSM–5 benefits veterans by improving the quality and consistency of the mental disorder diagnoses, consequently improving the quality and consistency of disability evaluations. In order to maintain the most accurate level of clinical care for veterans with mental disabilities, VHA has already deployed the DSM–5 in a clinical setting. VBA must utilize the DSM–5 in its adjudication regulations as soon as possible to ensure that disability compensation is as accurate and up to date as the current standards used to diagnose and treat these mental disorders.

Finally, it is contrary to the public interest to provide opportunity for prior notice and comment for this rulemaking because a delay in VBA's transition to the DSM–5 will negatively impact the current claims backlog. For example, if mental health conditions continue to be adjudicated based on DSM–IV nomenclature while VHA treats mental conditions based on DSM–5 nomenclature, VHA records will not be relevant for the purposes of adjudicating claims for mental disabilities. This outcome will require additional development by VBA leading to increased processing times. Therefore, immediate implementation of the DSM–5 in VBA's regulations will ensure rating decisions reflect current diagnostic standards and promote consistency between VHA and VBA.

The regulations under 38 CFR Parts 3 and 4 require that all pertinent evidence of record be considered when evaluating a veteran's disability for compensation purposes. The mental health regulations of the VASRD currently require that all mental conditions be diagnosed in accordance with the standards set under DSM–IV. However, VHA currently uses the DSM–5 criteria for the purposes of diagnosis and treatment of mental disorders. As such, DSM–5 VA treatment records are not legally sufficient for VA disability evaluations under VASRD's current reference to DSM–IV. Ready availability of VHA treatment records expedites VBA adjudicators' accurate evaluation of mental health disorders, particularly when considering claims for increased benefits.

This discrepancy between the standards for diagnosis and treatment and disability evaluation of mental disorders will ultimately add to the current backlog of disability claims. Without the ability to adjudicate claims based on existing medical evidence, VA will have no choice but to require disability examinations for mental disorders utilizing the criteria set forth in DSM–IV to ensure compliance with current regulations. This will place an additional and unnecessary strain on VHA and VBA resources. This will result in claim processing delays and frustrate VA's efforts to achieve its stated agency priority goal of eliminating the claims backlog.

Historically, in response to the previous update from DSM–III to DSM–IV, VA employed a notice of proposed rulemaking prior to finalizing changes to 38 CFR 4.125. DSM–IV was published in May 1994 and VA's notice of proposed rulemaking to incorporate the newest version of the DSM was published in the **Federal Register** on October 26, 1995, with a 60-day comment period. 60 FR 54825. The final rule to reference DSM–IV in 38 CFR Part 4 was published on October 8, 1996, almost one calendar year following the proposed rule, and more than two years after publication of the updated DSM. 61 FR 52695. In addition to updating references to the most current DSM in 38 CFR 4.125, the rulemaking included changes to the VASRD evaluation criteria for mental disorders under 38 CFR 4.130, which had not been revised since 1964 when the rule was first published for public viewing. The previous rulemaking also proposed changes to four other portions of 38 CFR Part 4. Due to the significant nature of the changes made, a proposed rule was required to provide prior notice and solicit public comment on the nature and impact of the changes. It should also be noted that, at that time, the concept of an interim final rule did not exist.

In stark contrast, the current rule only updates nomenclature in the VASRD and other regulations to be consistent with DSM–5; evaluation criteria under § 4.130 remain unchanged. Given that the current rulemaking does not change evaluation criteria and given the need to ensure veterans receive timely and accurate disability compensation, VA is making these changes through an interim final rule. VA stresses that it will consider and address significant comments received within 60 days of the date this interim final rule is published in the **Federal Register**.

As previously noted, the American Psychiatric Association released the DSM–5 for clinical use in May 2013. At that time, clinicians from VHA and medical officers from VBA, as part of a workgroup, reviewed the DSM–5 for changes in diagnostic criteria, disability nomenclature, and any other pertinent shifts from the previous version. Based upon their review of the DSM–5, the changes from the DSM–IV were then reviewed by VBA personnel with a focus on the disability compensation claims process. VBA determined that the DSM–5 required that changes be made to the VASRD nomenclature and certain adjudication regulations. VBA undertook an extensive development process to ensure that all potential issues were considered and adequately addressed in the regulations. While this process took considerable time, it allowed VBA to anticipate and address potential problems with rulemaking prior to publication, ultimately saving time.

For the foregoing reasons, the Secretary of Veterans Affairs finds it is impracticable, unnecessary, and contrary to public interest to delay this rulemaking for the purpose of soliciting advance public comment or to have a delayed effective date. Accordingly, VA is issuing this rule as an interim final rule with an immediate effective date. We will consider and address significant comments that are received within 60 days of the date this interim final rule is published in the **Federal Register**.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a ''significant regulatory action,'' which requires review by the Office of Management and Budget (OMB), as ''any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or

communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order.''

The economic, interagency, budgetary, legal, and policy implications of this interim final rule have been examined, and it has been determined not to be a significant regulatory action under Executive Order 12866. VA's impact analysis can be found as a supporting document at *http://www.regulations.gov,* usually within 48 hours after the rulemaking document is published. Additionally, a copy of this rulemaking and its impact analysis are available on VA's Web site at *http://www1.va.gov/orpm/,* by following the link for ''VA Regulations Published.''

Regulatory Flexibility Act

The Secretary hereby certifies that this interim final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This interim final rule will not affect any small entities. Only certain VA beneficiaries could be directly affected. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Unfunded Mandates

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

Paperwork Reduction Act

This interim final rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

Catalog of Federal Domestic Assistance Numbers and Titles

The Catalog of Federal Domestic Assistance program numbers and titles for this rule are 64.009, Veterans Medical Care Benefits; 64.104, Pension for Non-Service-Connected Disability for Veterans; 64.109, Veterans Compensation for Service-Connected Disability; and 64.110, Veterans Dependency and Indemnity Compensation for Service-Connected Death.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Jose D. Riojas, Chief of Staff, Department of Veteran Affairs, approved this document on July 24, 2014, for publication.

List of Subjects

38 CFR Part 3

Administrative practice and procedure, Claims, Disability benefits, Health Care, Pensions, Radioactive materials, Veterans, Vietnam.

38 CFR Part 4

Disability benefits, Incorporation by reference, Pensions, Veterans.

Dated: July 29, 2014.

Robert C. McFetridge,

Director, Regulation Policy and Management, Office of the General Counsel, Department of Veterans Affairs.

For the reasons set forth in the preamble, the Department of Veterans Affairs amends 38 CFR parts 3 and 4 as follows:

PART 3—ADJUDICATION

Subpart A—Pension, Compensation, and Dependency and Indemnity Compensation

■ 1. The authority citation for part 3, subpart A continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

■ 2. Revise § 3.384 to read as follows:

§ 3.384 Psychosis.

For purposes of this part, the term ''psychosis'' means any of the following disorders listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5) (see § 4.125 for availability information):

(a) Brief Psychotic Disorder;

(b) Delusional Disorder;

(c) Psychotic Disorder Due to Another Medical Condition;

(d) Other Specified Schizophrenia Spectrum and Other Psychotic Disorder;

(e) Schizoaffective Disorder;

(f) Schizophrenia;

(g) Schizophreniform Disorder; and

(h) Substance/Medication-Induced Psychotic Disorder.

(Authority: 38 U.S.C. 501(a), 1101, 1112(a) and (b))

PART 4—SCHEDULE FOR RATING DISABILITIES

Subpart B—Disability Ratings

■ 3. The authority citation for part 4 continues to read as follows:

Authority: 38 U.S.C. 1155, unless otherwise noted.

■ 4. Revise § 4.125(a) to read as follows:

§ 4.125 Diagnosis of mental disorders.

(a) If the diagnosis of a mental disorder does not conform to DSM–5 or is not supported by the findings on the examination report, the rating agency shall return the report to the examiner to substantiate the diagnosis. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5), American Psychiatric Association (2013), is incorporated by reference into this section with the approval of the Director of the Federal Register under 5 U.S.C. 552(a) and 1 CFR part 51. To enforce any edition other than that specified in this section, the Department of Veterans Affairs must publish notice of change in the **Federal Register** and the material must be available to the public. All approved material is available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209–3901, 703–907–7300, *http://www.dsm5.org.* It is also available for inspection at the Office of Regulation Policy and Management, Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420. It is also available for inspection at the National Archives and Records Administration (NARA). For information on the availability of this information at NARA, call 202–741–6030 or go to *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_publications.html.*

* * * * *

■ 5. Revise § 4.126(c) to read as follows:

§ 4.126 Evaluation of disability from mental disorders.

* * * * *

(c) Neurocognitive disorders shall be evaluated under the general rating

formula for mental disorders; neurologic deficits or other impairments stemming from the same etiology (e.g., a head injury) shall be evaluated separately and combined with the evaluation for neurocognitive disorders (see § 4.25).

* * * * *

■ 6. Revise § 4.127 to read as follows:

§ 4.127 Intellectual disability (intellectual developmental disorder) and personality disorders.

Intellectual disability (intellectual developmental disorder) and personality disorders are not diseases or injuries for compensation purposes, and, except as provided in § 3.310(a) of this chapter, disability resulting from them may not be service-connected. However, disability resulting from a mental disorder that is superimposed upon intellectual disability (intellectual developmental disorder) or a personality disorder may be service-connected.

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

■ 7. Revise § 4.130 to read as follows:

§ 4.130 Schedule of ratings—Mental disorders.

The nomenclature employed in this portion of the rating schedule is based upon the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5) (see § 4.125 for availability information). Rating agencies must be thoroughly familiar with this manual to properly implement the directives in § 4.125 through § 4.129 and to apply the general rating formula for mental disorders in § 4.130. The schedule for rating for mental disorders is set forth as follows:

9201 Schizophrenia
9202 [Removed]
9203 [Removed]
9204 [Removed]
9205 [Removed]
9208 Delusional disorder
9210 Other specified and unspecified schizophrenia spectrum and other psychotic disorders
9211 Schizoaffective disorder
9300 Delirium
9301 Major or mild neurocognitive disorder due to HIV or other infections
9304 Major or mild neurocognitive disorder due to traumatic brain injury
9305 Major or mild vascular neurocognitive disorder
9310 Unspecified neurocognitive disorder
9312 Major or mild neurocognitive disorder due to Alzheimer's disease
9326 Major or mild neurocognitive disorder due to another medical condition or substance/medication-induced major or mild neurocognitive disorder
9327 [Removed]
9400 Generalized anxiety disorder
9403 Specific phobia; social anxiety disorder (social phobia)
9404 Obsessive compulsive disorder
9410 Other specified anxiety disorder
9411 Posttraumatic stress disorder
9412 Panic disorder and/or agoraphobia
9413 Unspecified anxiety disorder
9416 Dissociative amnesia; dissociative identity disorder
9417 Depersonalization/Derealization disorder
9421 Somatic symptom disorder
9422 Other specified somatic symptom and related disorder
9423 Unspecified somatic symptom and related disorder
9424 Conversion disorder (functional neurological symptom disorder)
9425 Illness anxiety disorder
9431 Cyclothymic disorder
9432 Bipolar disorder
9433 Persistent depressive disorder (dysthymia)
9434 Major depressive disorder
9435 Unspecified depressive disorder
9440 Chronic adjustment disorder

GENERAL RATING FORMULA FOR MENTAL DISORDERS

	Rating
Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name.	100
Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships.	70
Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships.	50
Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events).	30
Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or symptoms controlled by continuous medication.	10
A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication.	0

9520 Anorexia nervosa

9521 Bulimia nervosa

RATING FORMULA FOR EATING DISORDERS

	Rating
Self-induced weight loss to less than 80 percent of expected minimum weight, with incapacitating episodes of at least six weeks total duration per year, and requiring hospitalization more than twice a year for parenteral nutrition or tube feeding.	100
Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of six or more weeks total duration per year.	60

RATING FORMULA FOR EATING DISORDERS—Continued

	Rating
Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of more than two but less than six weeks total duration per year.	30
Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder and incapacitating episodes of up to two weeks total duration per year.	10
Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder but without incapacitating episodes.	0

Note 1: An incapacitating episode is a period during which bed rest and treatment by a physician are required.
Note 2: Ratings under diagnostic codes 9201 to 9440 will be evaluated using the General Rating Formula for Mental Disorders. Ratings under diagnostic codes 9520 and 9521 will be evaluated using the General Rating Formula for Eating Disorders.

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

■ 8. Amend Appendix A to part 4 by revising the entries for Sec. 4.130 to read as follows:

Appendix A to Part 4—Table of Amendments and Effective Dates Since 1946

Sec.	Diagnostic code No.	
*	*	* * * * * * *
4.130		Re-designated from § 4.132 November 7, 1996.
	9200	Removed February 3, 1988.
	9201	Criterion February 3, 1988; Title August 4, 2014.
	9202	Criterion February 3, 1988; removed August 4, 2014.
	9203	Criterion February 3, 1988; removed August 4, 2014.
	9204	Criterion February 3, 1988; removed August 4, 2014.
	9205	Criterion February 3, 1988; criterion November 7, 1996; Removed August 4, 2014.
	9206	Criterion February 3, 1988; removed November 7, 1996.
	9207	Criterion February 3, 1988; removed November 7, 1996.
	9208	Criterion February 3, 1988; removed November 7, 1996.
	9209	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9210	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9211	Added November 7, 1996.
	9300	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996.
	9301	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9302	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9303	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9304	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9305	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9306	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9307	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9308	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9309	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9310	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9311	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9312	Added March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9313	Added March 10, 1976; removed February 3, 1988.
	9314	Added March 10, 1976; removed February 3, 1988.
	9315	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9316–9321	Added March 10, 1976; removed February 3, 1988.
	9322	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9323	Added March 10, 1976; removed February 3, 1988.
	9324	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9325	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9326	Added March 10, 1976; removed February 3, 1988; added November 7, 1996; Title August 4, 2014.
	9327	Added November 7, 1996; removed August 4, 2014.
	9400–9411	Evaluations February 3, 1988.
	9400	Criterion March 10, 1976; criterion February 3, 1988.
	9401	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9402	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9403	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996; Title August 4, 2014.
	9410	Added March 10, 1976; criterion February 3, 1988; Title August 4, 2014.
	9411	Added February 3, 1988.
	9412	Added November 7, 1996.
	9413	Added November 7, 1996; Title August 4, 2014.
	9416	Added November 7, 1996; Title August 4, 2014.
	9417	Added November 7, 1996; Title August 4, 2014.
	9421	Added November 7, 1996; Title August 4, 2014.
	9422	Added November 7, 1996; Title August 4, 2014.
	9423	Added November 7, 1996; Title August 4, 2014.

Sec.	Diagnostic code No.	
	9424	Added November 7, 1996; Title August 4, 2014.
	9425	Added November 7, 1996; Title August 4, 2014.
	9431	Added November 7, 1996.
	9432	Added November 7, 1996.
	9433	Added November 7, 1996; Title August 4, 2014.
	9434	Added November 7, 1996.
	9435	Added November 7, 1996; Title August 4, 2014.
	9440	Added November 7, 1996.
	9500	Criterion March 10, 1976; criterion February 3, 1988.
	9501	Criterion March 10, 1976; criterion February 3, 1988.
	9502	Criterion March 10, 1976; criterion February 3, 1988.
	9503	Removed March 10, 1976.
	9504	Criterion September 9, 1975; removed March 10, 1976.
	9505	Added March 10, 1976; criterion February 3, 1988.
	9506	Added March 10, 1976; criterion February 3, 1988.
	9507	Added March 10, 1976; criterion February 3, 1988.
	9508	Added March 10, 1976; criterion February 3, 1988.
	9509	Added March 10, 1976; criterion February 3, 1988.
	9510	Added March 10, 1976; criterion February 3, 1988.
	9511	Added March 10, 1976; criterion February 3, 1988.
	9520	Added November 7, 1996.
	9521	Added November 7, 1996.

* * * * *

■ 9. Amend Appendix B to part 4 by revising the entries for diagnostic codes 9201 through 9521 to read as follows:

Appendix B to Part 4—Numerical Index of Disabilities

Diagnostic code No.	
* * * * * * *	
Mental Disorders	
9201	Schizophrenia.
9208	Delusional disorder.
9210	Other specified and unspecified schizophrenia spectrum and other psychotic disorders.
9211	Schizoaffective Disorder.
9300	Delirium.
9301	Major or mild neurocognitive disorder due to HIV or other infections.
9304	Major or mild neurocognitive disorder due to traumatic brain injury.
9305	Major or mild vascular neurocognitive disorder.
9310	Unspecified neurocognitive disorder.
9312	Major or mild neurocognitive disorder due to Alzheimer's disease.
9326	Major or mild neurocognitive disorder due to another medical condition or substance/medication-induced major or mild neurocognitive disorder.
9400	Generalized anxiety disorder.
9403	Specific phobia; social anxiety disorder (social phobia).
9404	Obsessive compulsive disorder.
9410	Other specified anxiety disorder.
9411	Posttraumatic stress disorder.
9412	Panic disorder and/or agoraphobia.
9413	Unspecified anxiety disorder.
9416	Dissociative amnesia; dissociative identity disorder.
9417	Depersonalization/derealization disorder.
9421	Somatic symptom disorder.
9422	Other specified somatic symptom and related disorder.
9423	Unspecified somatic symptom and related disorder.
9424	Conversion disorder (functional neurological symptom disorder).
9425	Illness anxiety disorder.
9431	Cyclothymic disorder.
9432	Bipolar disorder.
9433	Persistent depressive disorder (dysthymia).
9434	Major depressive disorder.
9435	Unspecified depressive disorder.
9440	Chronic adjustment disorder.
9520	Anorexia nervosa.
9521	Bulimia nervosa.
* * * * * * *	

■ 10. In Appendix C to part 4, revise the entries for mental disorders to read as follows:

Appendix C to Part 4—Alphabetical Index of Disabilities

	Diagnostic code No.
* * * * * * *	
Mental disorders:	
Anorexia nervosa	9520
Bipolar disorder	9432
Bulimia nervosa	9521
Chronic adjustment disorder	9440
Conversion disorder (functional neurological symptom disorder).	9424
Cyclothymic disorder	9431
Delirium	9300
Delusional disorder	9208
Depersonalization/derealization disorder	9417
Dissociative amnesia; dissociative identity disorder	9416
Generalized anxiety disorder	9400
Illness anxiety disorder	9425
Major depressive disorder	9434
Major or mild neurocognitive disorder due to Alzheimer's disease	9312
Major or mild neurocognitive disorder due to another medical condition or substance/medication-induced major or mild neurocognitive disorder	9326
Major or mild neurocognitive disorder due to HIV or other infections	9301
Major or mild neurocognitive disorder due to traumatic brain injury	9304
Major or mild vascular neurocognitive disorder	9305
Obsessive compulsive disorder	9404
Other specified and unspecified schizophrenia spectrum and other psychotic disorders	9210
Other specified anxiety disorder	9410
Other specified somatic symptom and related disorder	9422
Panic disorder and/or agoraphobia	9412
Persistent depressive disorder (dysthymia)	9433
Posttraumatic stress disorder	9411
Schizoaffective disorder	9211
Schizophrenia	9201
Somatic symptom disorder	9421
Specific phobia; social anxiety disorder (social phobia)	9403
Unspecified somatic symptom and related disorder	9423
Unspecified anxiety disorder	9413
Unspecified depressive disorder	9435
Unspecified neurocognitive disorder	9310
* * * * * * *	

[FR Doc. 2014–18150 Filed 8–1–14; 8:45 am]
BILLING CODE 8320–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R10–OAR–2011–0609; FRL–9914–48–Region 10]

Approval and Promulgation of Implementation Plans; Alaska: Interstate Transport of Pollution

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The EPA is approving the State Implementation Plan (SIP) submittals from Alaska to address the interstate transport provisions of the Clean Air Act (CAA) for the 2006 fine particulate matter ($PM_{2.5}$), 2008 ozone, and 2008 lead (Pb) National Ambient Air Quality Standards (NAAQS). The CAA requires that each SIP contain adequate provisions prohibiting air emissions that will have certain adverse air quality effects in other states. The EPA has determined that Alaska's SIP submittals on March 29, 2011, and July 9, 2012, contain adequate provisions to ensure that air emissions in Alaska do not significantly contribute to nonattainment or interfere with maintenance of the 2006 $PM_{2.5}$, 2008 ozone, and 2008 Pb NAAQS in any other state.

DATES: This final rule is effective on September 3, 2014.

ADDRESSES: The EPA has established a docket for this action under Docket Identification No. EPA–R10–OAR–2011–0609. All documents in the docket are listed on the *http://www.regulations.gov* Web site. Although listed in the index, some information may not be publicly available, i.e., Confidential Business Information or other information the disclosure of which is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through *http://www.regulations.gov* or in hard copy at EPA Region 10, Office of Air, Waste, and Toxics, AWT–107, 1200 Sixth Avenue, Seattle, Washington 98101. The EPA requests that you contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to schedule your inspection. The Regional Office's official hours of business are Monday through Friday, 8:30 to 4:30, excluding Federal holidays.

FOR FURTHER INFORMATION CONTACT: Keith Rose at: (206) 553–1949,