

additional details regarding the conference.

### I. Background

2. In Order No. 561, the Commission established an indexing methodology that allows oil pipelines to change rates based upon an annual index as opposed to making cost-of-service filings.<sup>5</sup> In Order No. 561, the Commission committed to review the index level every five years to ensure that the index level chosen by the Commission adequately reflects changes to industry costs.<sup>6</sup>

3. In Order No. 561 and each successive index review, the Commission calculated the index level based upon a methodology developed by Dr. Alfred E. Kahn.<sup>7</sup> The Kahn Methodology measures changes in operating costs and capital costs on a per barrel-mile basis using FERC Form No. 6 (Form No. 6) data from the prior five-year period (for example, between 2009 and 2014 in this proceeding).<sup>8</sup> The Kahn Methodology uses net carrier property per barrel-mile as a proxy for capital cost data. The Kahn Methodology assigns a weight to the Form No. 6 operating expenses relative to the net carrier property using an "operating ratio."<sup>9</sup> The weighted operating expense and the weighted net carrier property are then added together to establish the cumulative cost change for each pipeline.<sup>10</sup>

4. Once these cumulative cost changes have been calculated for each pipeline with sufficient Form No. 6 data, the Kahn Methodology culls a data set consisting of pipelines with cumulative per-barrel-mile cost changes in the middle 50 percent of all pipelines. This trimming removes statistical outliers or spurious data points that could bias the sample in either direction. For the middle 50 percent data set, the Kahn

Methodology considers three different measures of central tendency. One measure is the median of each data set. Another measure, the weighted mean, calculates an average barrel-mile cost change in which each pipeline's cost change is weighted by its barrel-miles. A third measure, the un-weighted average, calculates the simple average of the percentage cost change per barrel-mile for each pipeline. A composite is calculated by taking the simple average of the median, the weighted mean, and the un-weighted mean. This composite is compared to the value of the PPI-FG index data over the same period. The index level is then set at PPI-FG plus (or minus) this differential.

### II. Commission Proposal

5. The Commission proposes to use an index level between PPI-FG+2.0 percent and PPI-FG+2.4 percent as the index level for the five-year period commencing July 1, 2016. This proposal is based upon the Kahn Methodology as applied to Form No. 6 data from the 2009 through 2014 period. The Commission's calculations are included in Attachment A to this order.

### III. Conference and Comment Procedures

6. The Commission invites interested persons to submit comments regarding this proposal and any alternative methodologies for calculating the index level for the five-year period commencing July 1, 2016.

7. Initial Comments are due August 24, 2015 and Reply Comments are due September 21, 2015. Comments must refer to Docket No. RM15-20-000, and must include the name of the commenter, and if applicable, the organization represented and their address. On July 30, 2015, the Commission plans to hold a conference to discuss the issues raised by this notice. A subsequent notice will provide additional details regarding the conference.

8. The Commission encourages comments to be filed electronically via the eFiling link on the Commission's Web site at <http://www.ferc.gov>. The Commission accepts most standard word processing formats. Documents created electronically using word processing software should be filed in native applications or print-to-PDF format and not in a scanned format. All supporting workpapers must be submitted with formulas and in a spreadsheet format acceptable under the Commission's eFiling rules. Commenters filing electronically do not need to make a paper filing.

9. Commenters that are not able to file comments electronically must send an original of their comments to: Federal Energy Regulatory Commission, Secretary of the Commission, 888 First Street NE., Washington, DC 20426.

10. All comments will be placed in the Commission's public files and may be viewed, printed, or downloaded remotely as described in the Document Availability section below. Commenters are not required to serve copies of their comments on other commenters.

### IV. Document Availability

11. In addition to publishing the full text of this document in the **Federal Register**, the Commission provides all interested persons an opportunity to view and/or print the contents of this document via the Internet through the Commission's Home Page (<http://www.ferc.gov>) and in the Commission's Public Reference Room during normal business hours (8:30 a.m. to 5:00 p.m. Eastern time) at 888 First Street NE., Room 2A, Washington DC 20426.

12. From the Commission's Home Page on the Internet, this information is available in the Commission's document management system, eLibrary. The full text of this document is available on eLibrary in PDF and Microsoft Word format for viewing, printing, and/or downloading. To access this document in eLibrary, type the docket number (excluding the last three digits) in the docket number field.

13. User assistance is available for eLibrary and the Commission's Web site during normal business hours. For assistance, please contact the Commission's Online Support at 1-866-208-3676 (toll free) or 202-502-6652 (email at [FERCOnlineSupport@ferc.gov](mailto:FERCOnlineSupport@ferc.gov)) or the Public Reference Room at 202-502-8371, TTY 202-502-8659 (email at [public.referenceroom@ferc.gov](mailto:public.referenceroom@ferc.gov)).

By direction of the Commission.

Dated: June 30, 2015.

**Nathaniel J. Davis, Sr.,**  
Deputy Secretary.

[FR Doc. 2015-16628 Filed 7-7-15; 8:45 am]

**BILLING CODE 6717-01-P**

## DEPARTMENT OF VETERANS AFFAIRS

### 38 CFR Part 4

#### RIN 2900-AO44

### Schedule for Rating Disabilities—The Endocrine System

**AGENCY:** Department of Veterans Affairs.

**ACTION:** Proposed rule.

<sup>5</sup> Order No. 561, FERC Stats. & Regs. ¶ 30,985 at 30,947.

<sup>6</sup> *Id.*

<sup>7</sup> The Commission's use of the Kahn Methodology has been affirmed by the United States Court of Appeals for the District of Columbia Circuit. *Assoc. of Oil Pipelines v. FERC*, 83 F.3d 1424 (D.C. Cir. 1996) and *Flying J Inc., et al., v. FERC*, 363 F.3d 495 (D.C. Cir. 2004).

<sup>8</sup> Specifically, this data is drawn from the Form No. 6: Carrier Property, page 110; Accrued Depreciation, page 111; Operating Revenues and Operating Expenses, page 114; Crude and Products Barrel-Miles, page 600. To the extent this information is incomplete, alternate data reported in the Form No. 6 has been substituted.

<sup>9</sup> The "operating ratio" = ((Operating Expense at Year 1/Operating Revenue at Year 1) + (Operating Expense at Year 5/Operating Revenue at Year 5))/2. If the operating ratio is greater than one, then it is assigned the value of 1 in the Kahn Methodology calculations.

<sup>10</sup> Cumulative Cost Change = (1-operating ratio) \* net plant + operating ratio \* operating expenses.

**SUMMARY:** The Department of Veterans Affairs (VA) proposes to revise the portion of the VA Schedule for Rating Disabilities (Rating Schedule) that addresses the endocrine system. The intended effects of these changes are to update medical terminology, add medical conditions not currently in the Rating Schedule, revise the criteria to reflect medical advances since the last revision in 1996, and clarify the criteria.

**DATES:** Comments must be received by VA on or before September 8, 2015.

**ADDRESSES:** Written comments may be submitted through [www.Regulations.gov](http://www.Regulations.gov); by mail or hand-delivery to the Director, Regulations 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-AO44-Schedule for Rating Disabilities—The Endocrine System.” 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](http://www.Regulations.gov)

**FOR FURTHER INFORMATION CONTACT:** Nick Olmos-Lau, M.D., FAAN, Medical Officer, Compensation Service, Veterans Benefits Administration, Department of Veterans Affairs, (211C) 810 Vermont Avenue NW., Washington, DC 20420, (202) 461-9700. (This is not a toll-free number.)

**SUPPLEMENTARY INFORMATION:** As part of the ongoing revision of the VA Schedule for Rating Disabilities (“Rating Schedule”), VA is proposing changes to 38 CFR 4.119, Schedule of ratings-endocrine system. This section was last updated in 1996. The endocrine system is made up of multiple hormone-producing glands. Hormones are chemical messengers that control the function of many body processes. While the actual dysfunction occurs at the site of the gland, the signs and symptoms manifest in the body systems on which the specific hormones act. For diagnosis and acute management of endocrine diseases, medical professionals focus on addressing the problem within the endocrine system. However, the residual effects of an endocrine disease may manifest within multiple body systems. Therefore, in general, VA

proposes specific criteria for the initial rating of endocrine diseases within § 4.119 to account for the unique functional impairments associated with attempts to bring the condition under control. Once the condition is effectively managed or has reached maximal medical outcome, VA proposes to evaluate for the residual effects of disease within the appropriate (adversely impacted) body system. For rating clarity, the most commonly impacted systems would be referenced within the specific diagnostic code (DC). By the revisions discussed herein, VA aims to update medical terminology, add medical conditions not currently in the Rating Schedule, revise the criteria to reflect medical advances, and clarify the criteria.

In preparing this proposed revision, VA conducted a mini-summit in Washington, DC, on December 2, 2009. VA also researched current medical information and consulted with Veterans Health Administration (VHA) subject matter experts.

#### **DC 7900: Hyperthyroidism, Including, But Not Limited to, Graves’ Disease**

VA proposes to update the title of DC 7900. Currently, this DC is titled “Hyperthyroidism.” The most common cause of hyperthyroidism is Graves’ disease, an autoimmune disease that affects multiple organ systems, including the eyes and skin. “Hyperthyroidism (overactive thyroid),” Mayo Clinic, <http://www.mayoclinic.com/health/hyperthyroidism/DS00344/DSECTION=causes>. Given the prevalence of hyperthyroidism due to Graves’ Disease, VA proposes to explicitly recognize Graves’ disease under this DC by changing the title of DC 7900 from “Hyperthyroidism” to “Hyperthyroidism, including, but not limited to, Graves’ disease.” This is not a substantive change, but simply an effort to increase rating efficiency. To account for less common causes of hyperthyroidism not addressed by other DCs, VA does not propose to limit this DC so that it is only applicable to Graves’ disease.

Hyperthyroidism refers to the excess synthesis or secretion of thyroid hormone. Regardless of the specific cause, the symptoms directly caused by excess thyroid hormone are the same. Therefore, VA proposes to evaluate the disability associated with excess thyroid hormone using a single set of rating criteria that reflects an earlier diagnosis and current treatment options. Medical advances have facilitated earlier diagnosis and treatment of hyperthyroidism. Treatment is directed

at symptom relief and includes antithyroid medications, radioactive iodine therapy, and thyroidectomy (surgical removal of the thyroid gland). Earlier treatment has decreased the duration and severity of both acute and chronic symptoms of hyperthyroidism, as well as its disabling residual effects. Therefore, the existing evaluations of 100 and 60 percent for this condition are no longer appropriate and VA proposes to no longer assign them.

In the majority of cases, by the time patients present with the symptoms currently reflected in the criteria for a 30 percent evaluation (tachycardia, tremor, and increased blood pressure or pulse pressure), treatment is initiated. With treatment, these symptoms generally resolve completely within three to six months. Therefore, VA proposes to evaluate hyperthyroidism at 30 percent for six months after initial diagnosis. Because symptoms generally resolve completely while the 30 percent evaluation is applicable, VA also proposes to no longer assign a 10 percent evaluation. To account for symptoms that do not resolve completely within six months, VA proposes adding a directive instructing VA personnel to “rate residuals of disease or complications of medical treatment . . . within the appropriate body system.”

Since cardiovascular abnormalities are common in hyperthyroidism, and some persist despite treatment with antithyroid medications, VA proposes an alternative to the current approach which rates certain cardiovascular manifestations within DC 7900 but refers VA personnel to DC 7008 (hyperthyroid heart disease) if heart disease is the predominant disability (see current Note (1)). Hyperthyroidism is associated with a variety of cardiovascular problems including tachycardia, systolic hypertension, cardiac arrhythmias particularly atrial fibrillation, supraventricular tachycardia, congestive heart failure or angina among others. See Faizel Osman et al., “Cardiovascular manifestations of hyperthyroidism before and after antithyroid therapy,” 49 (1) J. Am. College of Cardiology, 71–81 (2007). In order to address more specifically cardiovascular issues related to hyperthyroidism, VA proposes to modify the existing Note (1) to state that if cardiovascular or cardiac problems related to hyperthyroidism are present separately evaluate under DC 7008.

In order to clarify a potentially confusing element in DC 7008 that directs hyperthyroid heart disease to be part of the overall evaluation of hyperthyroidism under DC 7900, VA

proposes to amend DC 7008 by directing that hyperthyroid heart disease be rated under the appropriate cardiovascular diagnostic code, depending on particular findings.

Currently, DC 7008 states that only when atrial fibrillation is present hyperthyroidism may be evaluated either under DC 7900 or under 7010 (supraventricular arrhythmia), whichever results in a higher evaluation. As described above, the potential cardiovascular conditions related to hyperthyroidism are numerous and complex, and the current approach limits the alternatives and precludes optimal assessment in instances other than for atrial fibrillation.

Currently, Note (2) of DC 7900 states: "If ophthalmopathy is the sole finding, evaluate as field vision, impairment of (DC 6080); diplopia (DC 6090); or impairment of central visual acuity (DC 6061–6079)." In the case of Graves' disease, which is evaluated under proposed DC 7900, eye abnormalities can occur independently and in the absence of hyperthyroidism. As such, it is not appropriate to limit evaluation of such manifestations under either DC 7900 or an appropriate DC within the eye body system. VA therefore proposes to revise current Note (2) to read: Separately evaluate eye involvement occurring as a manifestation of Graves' Disease as diplopia (DC 6090); impairment of central visual acuity (DCs 6061–6066); or under the most appropriate DCs in § 4.79.

#### **DC 7901: Thyroid Enlargement, Toxic**

VA proposes to update the title of DC 7901 from "Thyroid gland, toxic adenoma of" to "Thyroid enlargement, toxic." When discussing thyroid enlargement, "toxic" is the term used by the medical community to indicate overactive thyroid function, also known as hyperthyroidism. Currently, the rating criteria accompanying this DC are identical to that accompanying current DC 7900. Therefore, rather than repeating the criteria for hyperthyroidism, VA proposes Note (1) to direct raters to evaluate toxic thyroid enlargement under proposed DC 7900 (hyperthyroidism, including, but not limited to, Graves' disease).

An enlarged thyroid may cause a visible swelling at the base of the neck or thyroidectomy may result in disfigurement. To account for such disfigurement, VA proposes Note (2) directing VA personnel: If disfigurement of the neck is present due to thyroid disease or enlargement, separately evaluate under DC 7800 (burn scar(s) of the head, face, or neck; scar(s) of the

head, face, or neck due to other causes; or other disfigurement of the head, face, or neck).

#### **DC 7902: Thyroid Enlargement, nontoxic**

VA proposes to change the current title of DC 7902, "Thyroid gland, nontoxic adenoma of," to "Thyroid enlargement, nontoxic." In the context of thyroid function, "nontoxic" means that thyroid function is normal.

Because thyroid function is normal, the disabling effects of nontoxic thyroid enlargement are a result of disfigurement or pressure on adjacent organs. A person with this condition may experience one or both of these effects. However, under the current criteria an evaluation may only be assigned for the more disabling effect. Therefore, to better reflect the full impact of the condition, VA proposes to amend the existing criteria to account for both effects occurring simultaneously.

When the enlarged thyroid gland compresses adjacent organs, it may produce symptoms due to pressure on anterior neck structures, including the trachea (wheezing, cough), the esophagus (dysphagia), and the recurrent laryngeal nerve (hoarseness). The severity of disabilities related to pressure on adjacent organs is best evaluated under the DC(s) within the appropriate body system. Therefore, VA proposes to edit the current note under DC 7902, which would be proposed Note (1), to clarify VA's intention to evaluate the symptoms due to pressure on adjacent organs under the appropriate diagnostic code within the appropriate body system and to delete the current phrase "if doing so would result in a higher evaluation than using this [DC]." Currently, DC 7902 provides a 20 percent evaluation when there is disfigurement of the head or neck and a 0 percent evaluation when there is no such disfigurement. Disfigurement due to an enlarged thyroid gland is not defined in the existing criteria and, therefore, is subject to individual interpretation. Objective criteria for evaluating disfigurement of the neck already exist under DC 7800 (burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck). Because this set of criteria covers all types of disfigurement of the neck and provides a wider range of disability compensation, VA proposes deletion of the current criteria and addition of proposed Note (2) stating that disfigurement of the neck related to nontoxic thyroid enlargement should be evaluated under DC 7800.

The proposed notes read as follows: "Note (1): Evaluate symptoms due to pressure on adjacent organs (such as the trachea, larynx, or esophagus) under the appropriate diagnostic code(s) within the appropriate body system." "Note (2): If disfigurement of the neck is present due to thyroid disease or enlargement, separately evaluate under DC 7800 (burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck)."

#### **DC 7903: Hypothyroidism**

Hypothyroidism is currently evaluated at levels of 100, 60, 30, and 10 percent. Severe hypothyroidism is characterized by myxedema (coma or crisis), a life-threatening form of hypothyroidism found predominantly in undiagnosed or undertreated individuals that requires inpatient hospitalization for stabilization. Medical advances in the diagnosis and treatment of hypothyroidism have decreased the incidence of myxedema to the point that myxedema coma occurs in only 0.1 percent of all cases of hypothyroidism. Erik D Schraga, MD, "Hypothyroidism and Myxedema Coma in Emergency Medicine," Medscape Reference (Mar. 29, 2012), <http://emedicine.medscape.com/article/768053-overview>. Symptoms of myxedema are currently evaluated at 100 and 60 percent. However, given the severity of the condition, a 60 percent evaluation is insufficient. Therefore, VA proposes a 100 percent evaluation for all instances of hypothyroidism with myxedema. VA proposes to add a note to provide: "This evaluation shall continue for six months beyond the date that an examining physician has determined crisis stabilization. Thereafter, the residual effects of hypothyroidism shall be rated under the appropriate diagnostic code(s) within the appropriate body system(s) (e.g., eye, digestive, and mental disorders)."

Medical management of hypothyroidism, in the absence of myxedema, results in improvement of laboratory values within a few weeks. However, alleviation of other clinical symptoms may take up to six months to resolve. See Bijay Vaidya, "Management of Hypothyroidism," BMJ 337:a801 (2008). Therefore, VA proposes to evaluate hypothyroidism in the absence of myxedema at 30 percent for six months after initial diagnosis and would explain this in a note that would also provide that, thereafter, the residual effects of hypothyroidism shall be rated under the most appropriate diagnostic code(s) within the appropriate body

system(s) (e.g., eye, digestive, and mental disorders).

VA also proposes to add a note to provide that eye involvement associated with hypothyroidism would also be evaluated under § 4.79. Specifically, the proposed note reads: "If eye involvement, such as exophthalmos, corneal ulcer, blurred vision, or diplopia, is also present due to thyroid disease, also separately evaluate under appropriate diagnostic code(s) in § 4.79, Schedule of Ratings—Eye (such as diplopia (DC 6090) or impairment of central visual acuity (DCs 6061–6066))."

#### DC 7904: Hyperparathyroidism

Hyperparathyroidism, DC 7904, is currently evaluated at levels of 100, 60, and 10 percent. Due to increased routine laboratory testing, hyperparathyroidism is usually diagnosed before patients develop severe disease and often before any signs or symptoms, such as kidney stones, gastrointestinal problems or weakness, are present. John I. Lew, "Surgical Management of Primary Hyperparathyroidism: State of the Art," 89 *Surgical Clinics of N. Am.* 1205–25 (2009); "Hyperparathyroidism," Mayo Clinic, <http://www.mayoclinic.com/health/hyperparathyroidism/DS00396>. Therefore, the existing criteria for evaluations at the 100 and 60 percent rating are no longer appropriate, and VA proposes revision of all the criteria consistent with medical advances.

Individuals diagnosed with hyperparathyroidism, but without symptoms (asymptomatic), require annual monitoring of their serum calcium levels and creatinine clearance (renal function). Bone density monitoring is also required every one to two years. These tests help medical professionals monitor the progression of the disease and to determine when surgery is necessary. Therefore, VA proposes to evaluate asymptomatic hyperparathyroidism at 0 percent.

Individuals with mild hyperparathyroidism may develop symptoms of hypercalcemia before surgery is determined to be necessary. Even after surgery, mild symptoms may persist. Therefore, VA proposes a 10 percent evaluation for the presence of symptoms, such as fatigue, anorexia, nausea, or constipation, despite surgery or in subjects deemed not to be candidates for surgery who require continuous medications for control.

Potential complications of hyperparathyroidism include gastric ulcers, kidney stones, decrease kidney function, and decreased bone mass associated with fragility fractures. Early intervention through laboratory monitoring generally prevents these

complications. An increase in serum calcium, decreases in creatinine clearance, and decreases in bone density are used as laboratory indicators for the worsening of disease and evaluation for surgical intervention. Therefore, VA proposes a 60 percent evaluation for hypercalcemia indicated by at least one of the following: Total Ca greater than 12mg/dL (3–3.5 mmol/L), Ionized Ca greater than 5.6 mg/dL (2–2.5 mmol/L), creatinine clearance less than 60 mL/min, bone mineral density T-score less than 2.5 (SD below mean) at any site or previous fragility fracture). Because these findings indicate that surgical or pharmacologic intervention is warranted and such intervention usually resolves symptoms, VA proposes that the 60 percent evaluation shall continue until such intervention occurs. If surgery is not indicated, the 60 percent evaluation would continue for 6 months after pharmacological treatment begins. After six months, rating would be based on residuals under the appropriate diagnostic code(s) within the appropriate body system based on examination.

Parathyroidectomy is the treatment of choice for symptomatic hyperparathyroidism. Therefore, VA proposes a 100 percent evaluation for six months after surgical intervention for hyperparathyroidism and thereafter, an evaluation based on the residuals of hyperparathyroidism or medical treatment under the appropriate diagnostic code(s) within the appropriate body system.

VA proposes to amend the current note under DC 7904 by numbering the note as proposed Note (4) and clarifying that the residuals of hyperparathyroidism are to be rated under the appropriate DC. The current note reads: "Following surgery or treatment, evaluate as digestive, skeletal, renal, or cardiovascular residuals or as endocrine dysfunction." The proposed Note (4) reads: "Following surgery or other treatment, evaluate chronic residuals, such as nephrolithiasis (kidney stones), decreased renal function, fractures, vision problems, and cardiovascular complications, under the appropriate diagnostic codes."

#### DC 7905: Hypoparathyroidism

Parathyroid hormone controls the balance of calcium in the body. When there is not enough of this hormone, the condition is known as hypoparathyroidism. The predominant symptoms of hypoparathyroidism is neuromuscular irritability, including, but not limited to, paresthesias (tingling and numbness involving fingertips, toes,

or perioral area), hyperirritability, fatigue, anxiety, mood swings and/or personality disturbances, seizures, hoarseness (due to laryngospasm), wheezing and dyspnea (due to bronchospasm), muscle cramps, and electrolyte imbalances (hypomagnesemia, hypokalemia, and alkalosis).

Currently, evaluations are assigned based on some of these symptoms. However, because many of the symptoms of parathyroid hormone deficiency are caused by an imbalance of calcium in the body (decreased extracellular ionized calcium levels and hypocalcemia), when hypoparathyroidism is treated with calcium and vitamin D supplementation, the symptoms are generally eliminated. Paul Fitzgerald, "Chapter 26. Endocrine Disorders" (2014), <http://accessmedicine.mhmedical.com/content.aspx?bookid=330&Sectionid=44291028>. Therefore, VA proposes new evaluation criteria that account for this treatment. Specifically, VA proposes a 100 percent evaluation for three months after initial diagnosis and, thereafter, to rate residual effects, such as nephrolithiasis (kidney stones), cataracts, decreased renal function, and congestive heart failure under the appropriate DCs.

#### New DC 7906: Thyroiditis

VA proposes to add a new DC for thyroiditis, which is inflammation of the thyroid gland. The condition most often results from an autoimmune disease (known as Hashimoto's thyroiditis), where the immune system attacks the thyroid gland.

However, regardless of the specific cause, thyroiditis may manifest as hyperthyroidism, hypothyroidism, or with no change in thyroid function. Because hyperthyroidism and hypothyroidism would be addressed in the Rating Schedule as proposed DCs 7900 and 7903, respectively, VA proposes a note to clarify that these manifestations be rated under those DCs.

While thyroiditis may also be present in a person with normal thyroid function, because thyroiditis increases the likelihood of developing hyperthyroidism or hypothyroidism, the thyroid function of these individuals must be monitored. This factor is not currently accounted for in the Rating Schedule. Therefore, for these individuals, VA proposes that a 0 percent evaluation for asymptomatic thyroiditis be associated with this DC.

**DC 7907: Cushing's Syndrome**

Cushing's syndrome is the result of prolonged elevation in the amount of glucocorticoid in the body. The severity of the signs and symptoms is determined by the duration and level of glucocorticoid exposure.

Currently, evaluations for Cushing's syndrome are assigned based in part on enlargement of the adrenal gland (which produces these hormones) and the pituitary gland (which produces hormones that trigger the adrenal gland). However, glandular enlargement is not indicative of disease severity. Exogenous glucocorticoid exposure (the intake of glucocorticoids), the most common cause of Cushing's syndrome, does not involve enlargement of the pituitary or adrenal glands. Therefore, VA proposes to delete the requirement for the presence of enlargement of the pituitary or adrenal gland as one of the criteria required for 100 and 60 percent evaluations.

The muscle weakness associated with Cushing's syndrome is a result of proximal muscle wasting and weakness caused by excess glucocorticoid hormones. This muscle wasting results in the inability to rise from a squatting position without assistance, and, in more severe cases, the inability to climb stairs or get up from a deep chair.

Lynnette K. Nieman, MD, "Epidemiology and clinical manifestations of Cushing's syndrome" UpToDate (Oct. 22, 2013), <http://www.uptodate.com/contents/epidemiology-and-clinical-manifestations-of-cushings-syndrome>. To clarify the criteria for 100 and 60 percent evaluations, VA proposes to replace "loss of muscle strength" with the more specific criteria of "proximal upper and lower extremity muscle wasting that results in inability to rise from squatting position, climb stairs, rise from a deep chair without assistance, or raise arms." VA also proposes to remove "weakness" from the list of criteria for a 100 percent evaluation because it is already captured with language replacing "loss of muscle strength." With these proposed modifications, a 100 percent evaluation would be assigned for Cushing's syndrome if there is "active, progressive disease, including areas of osteoporosis, hypertension, and proximal upper and lower extremity muscle wasting that results in inability to rise from a squatting position, climb stairs, rise from a deep chair without assistance, or raise arms." Similarly, VA proposes a 60 percent evaluation for Cushing's syndrome if there is "[p]roximal upper or lower extremity

muscle wasting that results in inability to rise from a squatting position, climb stairs, rise from a deep chair without assistance, or raise arms." VA proposes no change to the current 30 percent evaluation criteria.

The treatment for Cushing's syndrome is determined by the glucocorticoid source. Endogenous hypercortisolism (overproduction of glucocorticoid hormones by the adrenal gland) is treated by surgical removal of the adrenal gland, medical adrenalectomy, surgical resection of a pituitary tumor, or radiation therapy of the pituitary gland. Exogenous hypercortisolism is treated via gradual reduction of the outside source, such as corticosteroid medications. Because early medical intervention has decreased the complications associated with Cushing's syndrome, VA proposes evaluations for Cushing's syndrome at the 100, 60, or 30 percent level for six months after initial diagnosis. Because treatment may not completely eliminated complications or may itself be associated with complications, after six months, VA proposes to rate residuals such as adrenal insufficiency, cardiovascular, psychiatric, skin, or skeletal complications under the appropriate diagnostic code(s) within the appropriate body system. Therefore, VA proposes to amend the note following DC 7907 to reflect the above proposed changes.

**DC 7908: Acromegaly**

Acromegaly, DC 7908, is a condition in which the pituitary gland produces excess growth hormone, usually due to a benign tumor. The excessive amount of hormone results in enlargement of various body tissues, including bone. Acromegaly is currently evaluated at levels of 100, 60, and 30 percent. VA proposes no changes in the evaluation criteria for the 100 and 60 percent levels. The current 30 percent evaluation criteria for acromegaly require that there be enlargement of acral parts or overgrowth of long bones, and an enlarged sella turcica (the depression at the base of the skull where the pituitary gland is located). VA proposes to remove "enlarged sella turcica" as one of the required criteria. Although acromegaly is generally due to a pituitary tumor (which commonly results in enlargement of the sella turcica), it occasionally arises from causes that do not produce an enlarged sella turcica. Further, enlargement of the sella turcica is not an indicator of the severity of the condition. Therefore, it is not appropriate to retain "enlarged sella turcica" as a required criterion, and VA proposes to remove it.

**DC 7909: Diabetes Insipidus**

Inadequate secretion of or a resistance to antidiuretic hormone (ADH) is the cause of diabetes insipidus (DI). ADH limits the amount of water that the kidneys allow to leave the body. A lack of or resistance to ADH causes excessive excretion of free water. This disease is characterized by polyuria (frequent urination), polydipsia (excessive thirst), and nocturia (frequent night time urination). Without treatment, dehydration and bladder enlargement commonly result. If treated, diabetes insipidus does not cause severe problems or a reduction in life expectancy. See Goldman's Cecil Medicine Chapter 232 (24th ed. 2011). The prognosis for this disease is excellent, because it is frequently transient and there are excellent medications with different means of administration to treat the condition on a chronic basis if this condition becomes permanent. Most individuals, even in emergency situations, can replace urine loss with increased fluid intake. Therefore, the reliance in the current criteria on the need for parenteral (IV) hydration is no longer appropriate, and VA proposes deletion of the current criteria.

In its place, in order to allow the condition to become stabilized and to determine if the condition is transient or becoming permanent, VA proposes a 30 percent evaluation for three months after the initial diagnosis. Once the condition is stabilized, the need for long term medication can be assessed. Many patients are able to control their condition with oral or trans-nasal medication, while others require parenteral treatment (when oral or trans-nasal medications are either not tolerable or effective). Therefore, VA proposes a reevaluation of diabetes insipidus after the three month period. If DI has subsided, VA would rate any residuals under the appropriate diagnostic code(s) within the appropriate body system. For those DI cases with persistent polyuria or requiring continuous hormonal therapy, VA proposes a 10 percent rating.

**DC 7911: Addison's Disease (Adrenocortical Insufficiency)**

The medical community has shifted from the term "adrenal cortical hypofunction" to the term "adrenocortical insufficiency." Therefore, for clarity and consistency with current medical terminology, VA proposes to retitle this DC "Addison's disease (adrenocortical insufficiency)." VA does not propose changes to the

rating criteria and notes associated with this DC.

**DC 7912: Polyglandular Syndrome (Multiple Endocrine Neoplasia, Autoimmune Polyglandular Syndrome)**

“Pluriglandular syndrome” refers, not to a single condition, but to a group of conditions that impact multiple glands in the body. Therefore, a person is likely to be given a more specific diagnosis, rather than one with this general term. Therefore, VA proposes to include the most common forms of the condition in the title of the DC. Also, over time, the medical community has shifted from the term “pluriglandular” to “polyglandular” when referring to this condition. Therefore, to better reflect the terminology currently associated with the condition, VA proposes to update the title of DC 7912 to “Polyglandular syndrome (multiple endocrine neoplasia, autoimmune polyglandular syndrome).” The current guidance for evaluation is to evaluate according to major manifestations. VA proposes to revise the guidance to include some of the common manifestations of the syndrome. The proposed guidance reads: “Evaluate according to major manifestations to include, but not limited to, Type I diabetes mellitus, hyperthyroidism, hypothyroidism, hypoparathyroidism, or Addison’s disease.”

**DC 7913: Diabetes Mellitus**

Diabetes mellitus is a complex condition that impacts individuals in a variety of ways. At this time, VA proposes only one clarifying amendment to this DC. VA proposes to clarify that the rating criteria for a 20, 40, or 60 percent rating require “one or more daily injection” of insulin. This clarifying amendment is not a substantive change but rather a clarification of VA’s interpretation of this DC that an injection of insulin is required to achieve a 20, 40, 60, or 100 percent rating. To ensure that the full range of relevant factors is adequately addressed, VA is not proposing to amend the remaining rating criteria pertaining to this DC at this time. Rather, VA intends to establish a work group to specifically address this condition. Upon consideration of the work group’s findings, VA will determine whether amendments to the remaining existing criteria are necessary and such amendments, if any, will be addressed in a future proposal.

**DC 7914: Neoplasm, Malignant, Any Specified Part of the Endocrine System**

VA proposes no changes at this time.

**DC 7915: Neoplasm, Benign, Any Specified Part of the Endocrine System**

VA proposes to retain the existing direction to rate this condition based on residuals of endocrine dysfunction, but separate the rating direction from the title of DC 7915.

**DC 7916: Hyperpituitarism (Prolactin Secreting Pituitary Dysfunction)**

The existing note regarding the evaluation of this condition also applies to DCs 7917 and 7918 and is given after DC 7918. Therefore, it can be overlooked with regard to the other DCs. Therefore, VA proposes to include the same note regarding the evaluation of each condition directly under each DC and to amend the current note to reflect the proposed change. The conditions would all continue to be evaluated as malignant or benign neoplasm, as appropriate, so no substantive change is being made.

**DC 7917: Hyperaldosteronism (Benign or Malignant)**

See discussion of DC 7916.

**DC 7918: Pheochromocytoma (Benign or Malignant)**

See discussion of DC 7916.

**DC 7919: C-cell Hyperplasia of the Thyroid**

Currently, this condition is rated in the same way as a malignant neoplasm. However, this does not adequately address all potential manifestations of this condition. Therefore, VA proposes to replace the existing note with one that provides as follows: “If antineoplastic therapy is required, evaluate as a malignant neoplasm under DC 7914. If a prophylactic thyroidectomy is performed (based upon genetic testing) and antineoplastic therapy is not required, evaluate as hypothyroidism under DC 7903.” These changes are in keeping with current medical information about C-cell hyperplasia.

**Technical Amendments**

VA also proposes several technical amendments. We would add a citation reference to 38 U.S.C. 1155 at the end of § 4.119, and we would update Appendix A, B, and C of part 4 to reflect the above noted proposed amendments.

**Paperwork Reduction Act**

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

**Regulatory Flexibility Act**

The Secretary hereby certifies that this proposed rule would 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 proposed rule would directly affect only individuals and would not directly affect small entities. 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.

**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” requiring review by the Office of Management and Budget (OMB), unless OMB waives such review, 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 the Executive Order.”

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined, and it has been determined to be a significant regulatory action under Executive Order 12866 because it is likely to result in a rule that may raise novel policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order. VA’s impact





	Rating
7904 Hyperparathyroidism	
For six months from date of discharge following surgery .....	100
Note (1): After six months, rate on residuals under the appropriate diagnostic code(s) within the appropriate body system(s) based on a VA examination.	
Hypercalcemia (indicated by at least one of the following: Total Ca greater than 12mg/dL (3–3.5 mmol/L), Ionized Ca greater than 5.6 mg/dL (2–2.5 mmol/L), creatinine clearance less than 60 mL/min, bone mineral density T-score less than 2.5 SD (below mean) at any site or previous fragility fracture)	60
Note (2): Where surgical intervention is indicated, this evaluation shall continue until the day of surgery, at which time the provisions pertaining to a 100 percent evaluation shall apply.	
Note (3): Where surgical intervention is not indicated, this evaluation shall continue for six months after pharmacologic treatment begins. After six months, rate on residuals under the appropriate diagnostic code(s) within the appropriate body system(s) based on a VA examination.	
Symptoms such as fatigue, anorexia, nausea, or constipation that occur despite surgery; or in individuals who are not candidates for surgery but require continuous medication for control .....	10
Asymptomatic .....	0
Note (4): Following surgery or other treatment, evaluate chronic residuals, such as nephrolithiasis (kidney stones), decreased renal function, fractures, vision problems, and cardiovascular complications, under the appropriate diagnostic codes.	
7905 Hypoparathyroidism:	
For three months after initial diagnosis .....	100
Thereafter, evaluate chronic residuals, such as nephrolithiasis (kidney stones), cataracts, decreased renal function, and congestive heart failure under the appropriate diagnostic codes.	
7906 Thyroiditis	
With normal thyroid function (euthyroid) .....	0
Note: Manifesting as hyperthyroidism, evaluate as hyperthyroidism, including, but not limited to, Graves' disease (DC 7900); manifesting as hypothyroidism, evaluate as hypothyroidism (DC 7903).	
7907 Cushing's syndrome:	
As active, progressive disease, including areas of osteoporosis, hypertension, and proximal upper and lower extremity muscle wasting that results in inability to rise from squatting position, climb stairs, rise from a deep chair without assistance, or raise arms .....	100
Proximal upper or lower extremity muscle wasting that results in inability to rise from squatting position, climb stairs, rise from a deep chair without assistance, or raise arms .....	60
With striae, obesity, moon face, glucose intolerance, and vascular fragility .....	30
Note: The evaluations specifically indicated under this diagnostic code shall continue for six months following initial diagnosis. After six months, rate on residuals under the appropriate diagnostic code(s) within the appropriate body system(s).	
7908 Acromegaly:	
Evidence of increased intracranial pressure (such as visual field defect), arthropathy, glucose intolerance, and either hypertension or cardiomegaly .....	100
Arthropathy, glucose intolerance, and hypertension .....	60
Enlargement of acral parts or overgrowth of long bones .....	30
7909 Diabetes insipidus:	
For three months after initial diagnosis .....	30
Note: Thereafter, if Diabetes insipidus has subsided, rate residuals under the appropriate diagnostic code(s) within the appropriate body system.	
With persistent polyuria or requiring continuous hormonal therapy .....	10
7911 Addison's disease (adrenalcortical insufficiency):	
Four or more crises during the past year .....	60
Three crises during the past year, or; five or more episodes during the past year .....	40
One or two crises during the past year, or; two to four episodes during the past year, or; weakness and fatigability, or; corticosteroid therapy required for control .....	20
Note (1): An Addisonian "crisis" consists of the rapid onset of peripheral vascular collapse (with acute hypotension and shock), with findings that may include: anorexia; nausea; vomiting; dehydration; profound weakness; pain in abdomen, legs, and back; fever; apathy, and depressed mentation with possible progression to coma, renal shutdown, and death.	
Note (2): An Addisonian "episode," for VA purposes, is a less acute and less severe event than an Addisonian crisis and may consist of anorexia, nausea, vomiting, diarrhea, dehydration, weakness, malaise, orthostatic hypotension, or hypoglycemia, but no peripheral vascular collapse.	
Note (3): Tuberculous Addison's disease will be evaluated as active or inactive tuberculosis. If inactive, these evaluations are not to be combined with the graduated ratings of 50 percent or 30 percent for non-pulmonary tuberculosis specified under § 4.88b. Assign the higher rating.	
7912 Polyglandular syndrome (multiple endocrine neoplasia, autoimmune polyglandular syndrome):	
Evaluate according to major manifestations to include, but not limited to, Type I diabetes mellitus, hyperthyroidism, hypothyroidism, hypoparathyroidism, or Addison's disease.	
7913 Diabetes mellitus	
Requiring more than one daily injection of insulin, restricted diet, and regulation of activities (avoidance of strenuous occupational and recreational activities) with episodes of ketoacidosis or hypoglycemic reactions requiring at least three hospitalizations per year or weekly visits to a diabetic care provider, plus either progressive loss of weight and strength or complications that would be compensable if separately evaluated .....	100
Requiring one or more daily injection of insulin, restricted diet, and regulation of activities with episodes of ketoacidosis or hypoglycemic reactions requiring one or two hospitalizations per year or twice a month visits to a diabetic care provider, plus complications that would not be compensable if separately evaluated .....	60
Requiring one or more daily injection of insulin, restricted diet, and regulation of activities .....	40
Requiring one or more daily injection of insulin and restricted diet, or; oral hypoglycemic agent and restricted diet .....	20
Manageable by restricted diet only .....	10



	Rating
<p>Note (1): Evaluate compensable complications of diabetes separately unless they are part of the criteria used to support a 100 percent evaluation. Noncompensable complications are considered part of the diabetic process under DC 7913.</p> <p>Note (2): When diabetes mellitus has been conclusively diagnosed, do not request a glucose tolerance test solely for rating purposes.</p> <p>7914 Neoplasm, malignant, any specified part of the endocrine system                      Note: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.</p> <p>7915 Neoplasm, benign, any specified part of the endocrine system:                      Rate as residuals of endocrine dysfunction.</p> <p>7916 Hyperpituitarism (prolactin secreting pituitary dysfunction):                      Note: Evaluate as malignant or benign neoplasm, as appropriate.</p> <p>7917 Hyperaldosteronism (benign or malignant):                      Note: Evaluate as malignant or benign neoplasm, as appropriate.</p> <p>7918 Pheochromocytoma (benign or malignant):                      Note: Evaluate as malignant or benign neoplasm as appropriate.</p> <p>7919 C-cell hyperplasia of the thyroid:                      If antineoplastic therapy is required, evaluate as a malignant neoplasm under DC 7914. If a prophylactic thyroidectomy is performed (based upon genetic testing) and antineoplastic therapy is not required, evaluate as hypothyroidism under DC 7903.</p>	100

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

■ 3. Amend appendix A to part 4 by revising the entries for Secs. §§ 4.104 and 4.119 to read as follows:

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

Sec.	Diagnostic code No.	
4.104	7000	Evaluation July 6, 1950; evaluation September 22, 1978; evaluation January 12, 1998.
	7008	Evaluation January 12, 1998; evaluation [effective date of final rule].
4.119	7900	Criterion August 13, 1981; evaluation June 9, 1996; title [effective date of final rule]; evaluation [effective date of final rule]; criterion [effective date of final rule]; note [effective date of final rule].
	7901	Criterion August 13, 1981; evaluation June 9, 1996; title [effective date of final rule]; evaluation [effective date of final rule]; criterion [effective date of final rule].
	7902	Evaluation August 13, 1981; criterion June 9, 1996; title [effective date of final rule]; evaluation [effective date of final rule]; criterion [effective date of final rule]; note [effective date of final rule].
	7903	Criterion August 13, 1981; evaluation June 9, 1996; evaluation [effective date of final rule]; criterion [effective date of final rule]; note [effective date of final rule].
	7904	Criterion August 13, 1981; evaluation June 9, 1996; evaluation [effective date of final rule]; criterion [effective date of final rule]; note [effective date of final rule].
	7905	Evaluation; August 13, 1981; evaluation June 9, 1996; evaluation [effective date of final rule]; criterion [effective date of final rule]; note [effective date of final rule]. Added [effective date of final rule].
	7906	Evaluation; August 13, 1981; evaluation June 9, 1996; criterion [effective date of final rule]; note [effective date of final rule].
	7907	Criterion August 13, 1981; criterion June 9, 1996; criterion [effective date of final rule].
	7908	Evaluation August 13, 1981; criterion June 9, 1996; evaluation June 9, 1996; criterion [effective date of final rule]; note [effective date of final rule].
	7909	Removed June 9, 1996.
	7910	Evaluation March 11, 1969; evaluation August 13, 1981; criterion June 9, 1996; title [effective date of final rule].
	7911	Title [effective date of final rule].
	7912	Criterion September 9, 1975; criterion August 13, 1981; criterion June 6, 1996; evaluation June 9, 1996; criterion [effective date of final rule].
	7913	Criterion March 10, 1976; criterion August 13, 1981; criterion June 9, 1996.
	7914	Criterion June 9, 1996.
	7915	Added June 9, 1996.
	7916	Added June 9, 1996.
	7917	Added June 9, 1996.
	7918	Added June 9, 1996; evaluation June 9, 1996; criterion [effective date of final rule].
	7919	* * *

■ 4. Amend Appendix B to Part 4 by revising the entries for diagnostic codes

7900, 7901, 7902, 7911, and adding diagnostic code 7906 to read as follows:

**Appendix B to Part 4—Numerical Index of Disabilities**

Diagnostic code No.						
	*	*	*	*	*	*
THE ENDOCRINE SYSTEM						
7900	.....	Hyperthyroidism, including, but not limited to, Graves' disease.				
7901	.....	Thyroid enlargement, toxic.				
7902	.....	Thyroid enlargement, nontoxic.				
	*	*	*	*	*	*
7906	.....	Thyroiditis.				
	*	*	*	*	*	*
7911	.....	Addison's disease (adrenocortical insufficiency).				
7912	.....	Polyglandular syndrome (multiple endocrine neoplasia, autoimmune polyglandular syndrome).				
	*	*	*	*	*	*

■ 4. Amend appendix C by:  
 ■ a. Adding entries for Graves' disease. Polyglandular syndrome and Thyroiditis in alphabetical order; and  
 ■ b. Revising the disability entry for Thyroid gland. The additions and revision read as follows:

**Appendix C to Part 4—Alphabetical Index of Disabilities**

	Diagnostic code No.
	*
Graves' disease .....	7900
	*
Polyglandular syndrome .....	7912
	*
Thyroid gland	
Nontoxic thyroid enlargement .....	7902
Toxic thyroid enlargement .....	7901
Thyroiditis .....	7906
	*

[FR Doc. 2015-16666 Filed 7-7-15; 8:45 am]  
 BILLING CODE 8320-01-P

**ENVIRONMENTAL PROTECTION AGENCY**

**40 CFR Part 52**

[EPA-R09-OAR-2015-0164; FRL-9927-77-Region 9]

**Revisions to the California State Implementation Plan, Feather River Air Quality Management District**

**AGENCY:** Environmental Protection Agency (EPA).

**ACTION:** Proposed rule.

**SUMMARY:** The Environmental Protection Agency (EPA) is proposing to approve revisions to the Feather River Air Quality Management District (FRAQMD) portion of the California State Implementation Plan (SIP). Included in this approval are the following three SIP demonstrations from FRAQMD: 2006 Reasonably Available Control Technology (RACT) Analysis for State Implementation Plan (SIP), November 2006; Reasonably Available Control Technology State Implementation Plan Revision Negative Declaration for Control Techniques Guidelines Issued 2006-2008, June 1, 2009; and Reasonably Available Control Technology Analysis and Negative Declarations, July 3, 2014. The first two demonstrations address the 1997 8-hour National Ambient Air Quality Standards (NAAQS) for ozone, and the third demonstration addresses the 2008 8-hour NAAQS for ozone. The submitted SIPs also contain negative declarations for volatile organic compound (VOC) source categories for the years 2006, 2009 and 2014. We are proposing to approve the submitted SIP revisions under the Clean Air Act as amended in 1990 (CAA or the Act). We are also proposing to approve a local rule that regulates gasoline dispensing facilities.

**DATES:** Any comments on this proposal must arrive by August 7, 2015.

**ADDRESSES:** Submit comments, identified by docket number EPA-R09-OAR-2015-0164, by one of the following methods:

1. *Federal eRulemaking Portal:* [www.regulations.gov](http://www.regulations.gov). Follow the on-line instructions.
2. *Email:* [steckel.andrew@epa.gov](mailto:steckel.andrew@epa.gov).

3. *Mail or deliver:* Andrew Steckel (Air-4), U.S. Environmental Protection Agency Region IX, 75 Hawthorne Street, San Francisco, CA 94105-3901.

*Instructions:* All comments will be included in the public docket without change and may be made available online at [www.regulations.gov](http://www.regulations.gov), including any personal information provided, unless the comment includes Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Information that you consider CBI or otherwise protected should be clearly identified as such and should not be submitted through [www.regulations.gov](http://www.regulations.gov) or email. [www.regulations.gov](http://www.regulations.gov) is an "anonymous access" system, and EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send email directly to EPA, your email address will be automatically captured and included as part of the public comment. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

*Docket:* Generally, documents in the docket for this action are available electronically at [www.regulations.gov](http://www.regulations.gov) and in hard copy at EPA Region IX, 75 Hawthorne Street, San Francisco, California 94105-3901. While all documents in the docket are listed at [www.regulations.gov](http://www.regulations.gov), some information may be publicly available only at the hard copy location (e.g., copyrighted material, large maps), and some may not be publicly available in either location