The federal credit union adding the underserved community must document that the community meets the definition for serving underserved areas in the Federal Credit Union Act. The charter type of a federal credit union adding such a community will not change and therefore the credit union will not be able to receive the benefits afforded to low-income designated credit unions, such as expanded use of non member deposits and access to the Community Development Revolving Loan Program for Credit Unions.

A federal credit union that desires to include an underserved community in its field of membership must first develop a business plan specifying how it will serve the community. The business plan, at a minimum, must identify the credit and depository needs of the community and detail how the credit union plans to serve those needs. The credit union will be expected to regularly review the business plan, to determine if the community is being adequately served. The regional director may require periodic service status reports from a credit union about the underserved area to ensure that the needs of the underserved area are being met as well as requiring such reports before NCUA allows a federal credit union to add an additional underserved area.

[FR Doc. 02–9971 Filed 4–23–02; 8:45 am]

BILLING CODE 7535–01–U

SOCIAL SECURITY ADMINISTRATION

20 CFR Part 404

[Regulations No. 4 and 16]

RIN 0960–AE99

Technical Revisions to Medical Criteria for Determinations of Disability

AGENCY: Social Security Administration (SSA).

ACTION: Final rules.

SUMMARY: These final rules make a number of technical revisions to the Listing of Impairments (the listings). We use the listings when you claim benefits based on disability under titles II and XVI of the Social Security Act (the Act). We are making these revisions to reflect advances in medical knowledge, treatment and terminology, to clarify certain criteria in the listings, to remove listings that we rarely use, and to add new listings consistent with current medical practice. We are making these individual technical revisions in order to improve our medical listings and make them easier to understand and use.

DATES: These final regulations are effective May 24, 2002.

FOR FURTHER INFORMATION CONTACT: Carolyn Kiefer, Social Insurance Specialist, Office of Disability, Social Security Administration, 3–B–9 Operations Building, 6401 Security Boulevard, Baltimore, Maryland 21235–6401, (410) 965–9104 or TTY 1–800–966–5609 for information about these rules. For information on eligibility, filing for benefits, or coverage of earnings, call our national toll-free number, 1–800–772–1213 or TTY (410) 966–5609, or visit our Internet web site, Social Security Online, at *http://www.sss.gov.*

SUPPLEMENTARY INFORMATION: We are revising and making final the rules we proposed in the Notice of Proposed Rulemaking (NPRM) published in the **Federal Register** on February 11, 2000 (65 FR 6932).

Background

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

- Workers insured under the Act;
- Children of insured workers; and
- Widows, widowers, and surviving divorced spouses (see 20 CFR 404.336) of insured workers.

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

Under both title II and title XVI programs, disability must be the result of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of at least 12 months.

Our definitions of disability are shown in the following table:

If you file a claim under * * *	And you are * * *	Disability means you have a medically determinable impairment(s) that meets the statutory duration requirement and results in * * *
Title II	An adult or a child	The inability to do any substantial gainful activity (SGA).
Title XVI	An adult	The inability to do any SGA.
Title XVI	A child	Marked and severe functional limitations.

We use a sequential evaluation process, set out in §§ 404.1520 and 416.920 of our regulations, when we evaluate a claim for disability benefits if you are an adult. We use a separate sequential evaluation process described in § 416.924 of our regulations if you are a child claiming SSI payments based on disability. At step three of both sequential evaluation processes, we determine whether you have an impairment(s) that meets or medically equals the listings. If you are a child applying for SSI payments based on disability, we also determine if your impairment(s) functionally equals the listings.

The listings describe, for each of the major body systems, impairments that we consider severe enough to prevent you from doing any gainful activity. In the case of a child applying for SSI payments based on disability, the listings describe impairments that we consider severe enough to result in marked and severe functional limitations.

The listings are divided into Part A and Part B. We apply the medical criteria in Part A when we assess your claim if you are an adult (i.e., a person age 18 or over). If you are a child, we first use the criteria in Part B. If the criteria in Part B do not apply, and the specific disease process(es) has a similar effect on adults and children, we then use the criteria in Part A (see §§ 404.1525, 404.1526, 416.925, and 416.926).

The changes we are making in these final rules are not intended to be a comprehensive update and revision of the listings. We continue to review each of the body system listings to determine appropriate substantive revisions and updates. If we determine that more substantive revisions are necessary, we will publish notices of proposed rulemaking in the **Federal Register** describing those proposed revisions and requesting public comments.

Explanation of Revisions

We are revising language throughout the listings to incorporate imaging techniques other than x-rays alone. This revised language was incorporated in the following listing sections: 2.00B2; 5.03; 5.04; 5.05; 6.02(C)(1); 7.16; and 9.03. This is being done by adding language allowing for ''appropriate medically acceptable imaging'' to be used when imaging evidence is called for as part of the medical documentation. Since x-rays are incorporated in the phrase ''appropriate medically acceptable imaging,'' we have removed the specific mention of ''x-rays'' when we refer to appropriate medically acceptable imaging throughout the listings addressed in this rulemaking.

We made a revision to our proposed rulemaking language in the prefaces of the listings for the body systems affected by this change. We added language to explain that appropriate medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. To further clarify what we mean by ''appropriate,'' we added a sentence to these prefaces that states ''Appropriate means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.''

We made a number of revisions to the listings for the Special Senses and Speech body systems, 2.00 and 102.00. We substituted the heading ''Disorders of Vision'' in 2.00A for ''Ophthalmology'' to make clear that these listings deal with visual disorders, rather than the branch of medicine dealing with the anatomy, physiology, and pathology of the eye. We also removed the word ''central'' when referring to visual acuity in the preface sections 2.00A1, 2.00A2, 2.00A5, 2.00A6, 102.00A, listings 2.02 and 102.02, and in Table No. 1, because the word is redundant. It is the loss of visual acuity in itself (be it central or peripheral) that results in the inability to distinguish detail, and thereby prevents reading and fine work. We further clarify this in a revision to section 2.00A2 which states that ''Loss of visual acuity may result in impaired distant vision or near vision, or both.'' We also clarified listing 2.04 by replacing the phrase ''central visual efficiency'' with the phrase ''visual acuity efficiency.'' We removed listing 2.05, *Complete homonymous hemianopsia,* as a separate listing since it merely directs evaluation to listing 2.04, which we are not substantively changing. Listing 2.04 will permit evaluation of this disorder.

We also removed the word ''organic'' in section 2.00B3 and in listing 2.09 because the cause of the loss of speech is not material to its evaluation under this body system. We also clarified listing 2.09 to make it clear that the inability to produce by any means speech that can be heard, understood, or sustained is sufficient to meet this listing; all three of these factors do not need to be present to meet the listing.

For the respiratory system listings for adults and children, 3.00 and 103.00, we changed some of the technical testing requirements to be simpler and to be consistent with standard laboratory practices. If the spirogram is generated by any means other than direct pen linkage to a mechanical displacement-type spirometer, we will no longer require separate calibration tracings to be performed at the time each pulmonary function test is performed. Rather, a single daily calibration of the testing device will suffice. For direct pen linkage spirometry equipment, the tracing is directly generated and inherently accurate so that no mechanically generated calibrations are required. We also revised listing section 3.00F so that we no longer require that the algorithm used to calculate the test for diffusing capacity of the lungs for carbon monoxide be provided as part of the documentation for this test. Rather, the source of the predicted equation should be provided. This information is sufficient to verify that the test was performed adequately.

We added a new listing for both adults and children to cover lung transplants, listings 3.11 and 103.05, respectively. These listings provide that we will consider an individual to be disabled for 12 months following the date of surgery. After that time, we will evaluate any residual impairment.

In order to correct a possible misinterpretation in our intent, we revised listing sections 4.00A and 104.00A. We now state that we will ''consider'' (rather than ''make'') a medical equivalence finding for an adult, and a medical or functional equivalence finding for a child seeking SSI payments, in situations where the individual has either a medically determinable impairment that is not listed, or has a combination of impairments, no one of which meets a listing. We have always intended that we consider whether the impairment or combination of impairments medically equals a listing (or, as appropriate, medically or functionally equals a listing). The use of the word ''make'' may have given the erroneous impression that we would automatically find medical equivalence in all cases where the impairment(s) was severe but did not meet the exact requirements of a listing.

For the digestive body systems listings for adults and children, 5.00 and 105.00, we added new listings to address liver transplantation, listings 5.09 and 105.09, respectively. Under these listings, we will consider the individual to be disabled for 12 months following the date of the liver transplant surgery. After that period, we will evaluate any residual impairment.

For the hemic and lymphatic body system listings, for adults and children, we added T-cell lymphoblastic lymphoma to listings 7.11 and 107.11, respectively. These listings currently address acute leukemia only. We also included a discussion of T-cell lymphoblastic lymphoma in the sections 7.00E and 107.00C of the preface to the listings. Because T-cell lymphoblastic lymphoma follows the same course and requires the same treatment as acute leukemia, we believe it will simplify adjudication by naming this particular lymphoma in the listings. We also added stem cell transplantation as a new medical technique comparable to bone marrow transplantation in listing 7.17.

In the skin body system listing, we corrected a spelling error in listing 8.06.

In the endocrine body system listing for adults, we removed paragraph A of listing 9.02. This listing, which addresses progressive exophthalmos as measured by exophthalmometry, is a rare complication in light of today's medical treatments for thyroid disease.

In the neurological body system listings for adults and children, 11.00 and 111.00, we made a number of changes to reflect current medical terminology (convulsive and nonconvulsive epilepsy), and to modify the documentation requirement for an electroencephalogram (EEG). With the exception of nonconvulsive epilepsy in children, we will no longer require that an EEG be part of the documentation needed to support the presence of epilepsy. An EEG is a definitive diagnostic tool in cases of nonconvulsive epilepsy in children, but it is rare for an EEG to confirm epilepsy in its other forms for either adults or children. In listings 11.02 and 11.03, we changed the terminology to reflect convulsive and nonconvulsive epilepsy, and we made comparable changes to the childhood epilepsy listings. We also changed references to ''anticonvulsive''

treatment to ''antiepileptic'' treatment and ''antiepileptic'' drugs. These changes are consistent with current medical usage.

We changed listing 111.02B3 to refer to a ''Significant mental disorder'' for consistency with other listing terminology, for example, that of listings 111.07B3 and 4, and to clarify that we require a defined mental impairment in order to fulfill this listing criteria for convulsive epilepsy.

We eliminated current listing 11.15 for tabes dorsalis because this disease is rarely seen today, given the availability of effective medical screening and treatment for syphilis. With this deletion, we also amended listing 11.17 by removing the reference to listing 11.15B currently in listing 11.17A. The current reference to listing 11.04B contained in listing 11.17 adequately addresses the disorganization of motor function that is needed to evaluate the effects of these degenerative diseases on an individual's gait.

In the neoplastic diseases body system listings for adults, 13.00, we amended listing 13.08 to add the criterion, ''Anaplastic (undifferentiated) carcinoma of the thyroid,'' and designated it as listing 13.08A. This is a distinct type of thyroid carcinoma with a poor prognosis, and it is of the same level of severity as the current thyroid listing. By identifying this type of carcinoma specifically, we believe we will simplify adjudication for these types of cases.

For clarity, we refer to the changes we are making here as the ''final'' rules and to the rules that will be changed by these final rules as the ''current'' rules. However, these final rules do not go into effect until 30 days after the date of this publication. Therefore, the ''current'' rules will still be in effect until that date.

Public Comments

On February 11, 2000, we published a notice of proposed rulemaking (NPRM) in the **Federal Register** (65 FR 6929) proposing to make a number of technical revisions to our listings. We gave interested persons 60 days within which to submit written comments on the proposed rules; the comment period closed on April 11, 2000. We received 90 comments from the public. Most of the comments came from disabled individuals. Other comments came from State agencies that make disability determinations for us, advocacy organizations, and professional organizations whose members have interests and responsibilities that require them to have some expertise in the evaluation of disability claims.

Several commenters simply expressed agreement with the proposed changes, believed that they would be beneficial, and stated that the language was improved so that it was easier to understand. Along this line, some of these commenters specifically supported our proposal to update the language in our listings concerning imaging techniques to include other appropriate medically acceptable imaging techniques in addition to x-rays. These commenters believed this was an improvement that would be beneficial for both claimants and adjudicators.

A few commenters, however, stated that the proposed revisions to the listings were difficult to read and understand. These commenters recommended that the listings be written to be understandable to lay people, rather than to doctors. Since the listings summarize required medical signs, laboratory findings, and symptoms, we often find it necessary to retain appropriate medical terms and language in the listings. To the extent possible, we write our regulations in plain language. We intend to incorporate as much plain language as possible as we review and revise each individual body system listing, and we wrote these proposed revisions as simply as possible within the context of the listing being revised.

The following are summaries of comments that directly related to the proposed rules, or related to areas that were discussed in the proposed rules, along with our responses. Because some of the comments were lengthy, we have condensed, summarized and paraphrased them. We have tried, however, to summarize the commenters' views accurately, and to respond to all of the significant issues raised by the commenters that were within the scope of these rules. Many of the comments, however, pertained to matters that were not within the scope of these proposed rules. We referred those comments to the appropriate components of the Social Security Administration and do not address them in this preamble.

Musculoskeletal Body System

Comment: Two commenters requested that we make additional changes to the listings on the evaluation of osteomyelitis (listings 1.08 and 101.08). One commenter recommended that we include the spinal manifestations of the disorder in the listings. The other commenter suggested that we clarify the reference to a ''major joint of an upper or lower extremity'' in listing 1.08, since osteomyelitis involves bones, not joints. The first commenter also expressed concern that chronic osteomyelitis was not listed because she knew of situations in which treatment did not eliminate the infection.

Response: We have not adopted these comments. We have not included any technical revisions to the musculoskeletal body system listings in these final rules. On November 19, 2001, we published final rules in the **Federal Register** revising the medical criteria we use for evaluating musculoskeletal impairments in adults and children. In those final rules, we noted that we removed listings 1.08 and 101.08, osteomyelitis or septic arthitis, because fundamental advances in antibiotic therapy has meant that, when they do occur, these conditions are not usually expected to last for one year. Therefore, we will evaluate claims involving these impairments on a case-by-case basis to determine whether they medically equal (or, as appropriate, functionally equal) the listings (66 FR 58010).

Comment: One commenter suggested that we make an additional change to listing 1.11, fracture of the femur, tibia, tarsal bone, or pelvis, to include the non-union of the distal fibula.

Response: This listing, which is now listing 1.06 as a result of the final rules that we published on November 19, 2001, addresses the major bones of the lower extremities that are usually involved in weight bearing. While we did not specifically include reference to situations involving non-union of the distal fibula, a case of this type that fulfilled the overall severity requirements of listing 1.06 could be found to medically equal this listing.

Special Senses and Speech

Comment: One commenter recommended that we make changes to listing 2.09 in addition to the ones we proposed. This commenter first suggested that we clarify the term ''sustained'' in listing 2.09. This commenter also expressed concern that, if the term ''organic'' was deleted from listing 2.09, the rules should also clarify whether all known means to produce speech must have been tried and failed. Finally, the commenter recommended that we include language from the preamble to the NPRM in the final rules, either in listing 2.09 or in the introductory section of the listing, section 2.00B3. The commenter stated that we should include in the regulatory text the statement that, ''We believe that any one of these factors is sufficient to establish that an individual has a listing-level impairment.''

Response: We have not adopted these comments. Revised listing 2.09 makes

clear that the inability to produce speech linked to any of the three factors (can be heard, can be understood, or can be sustained) will satisfy the requirements of the listing. We do not believe that adding the sentence from the preamble to the proposed rules, as the commenter suggested, clarifies the rule any further. The other issues raised by this commenter will require more extensive revisions to the special senses and speech listings than were intended under this rulemaking proceeding. We will consider more detailed clarifications as part of our review of the special senses and speech body system listings.

Comment: Some commenters expressed concern about the changes we proposed to listing section 2.00, on the evaluation of vision disorders. One commenter recommended that section 2.00A1 not be revised to remove the word ''central'' when referring to vision and visual acuity because the terms ''central vision'' and ''visual acuity'' are not medically synonymous. The commenter noted that it is possible to have a small island of usable vision in the center of a dense central field loss. This could result in measurable but unusable central visual acuity. This could potentially occur in cases involving impairments such as macular degeneration, diabetic retinopathy, end-stage glaucoma, end-stage retinitis pigmentosa, and ischemic vision loss. The commenter also stated that the term ''peripheral fields'' was unclear. The second commenter, an ophthalmologist, expressed similar concerns. He commented that we were not using accurate terminology when we proposed to use the terms ''visual acuity'' and ''peripheral fields.''

Response: We have not adopted these comments. While we understand the commenters' concerns, our use of the terms we proposed in this section of the preface is consistent with common definitions which satisfy our needs for purposes of disability adjudication. We agree that vision physiologists might prefer to use more sophisticated terminology in accordance with their professional needs to discern complex distinctions. However, for purposes of disability adjudication, our use of the terms ''visual acuity'' and ''peripheral fields'' are familiar and defined concepts. We believe, based on our program experience, that they adequately satisfy our needs in evaluating disability claims of individuals with visual impairments. However, we will consider these comments when we review and revise the special senses and speech body system listings.

Comment: One commenter recommended that we continue to use the term ''Ophthalmology'' instead of our proposed revision, ''Disorders of Vision,'' for the heading of listing section 2.00A. Similarly, another commenter thought we should use the term ''Visual Impairment'' rather than ''Disorders of Vision.'' This commenter stated that this was consistent with terminology used by schools and most rehabilitation facilities.

Response: We have not adopted these comments. As we noted above, we believe our use of more common terminology is suitable for our purposes. We also believe that changing our heading of listing section 2.00A to ''Disorders of Vision'' is appropriate to convey our identification of the material in this section of the listings.

Comment: One commenter stated that we should revise our measurement assessment tools for the peripheral field and for central visual function, and eliminate the use of the Goldmann perimeter and the Snellen visual acuity tests. Another commenter agreed that we should revise our rules on the use of the Goldmann perimeter in light of our emphasis on changes in the listings to reflect advances in medical knowledge.

Response: We have not adopted these comments. These comments raise issues that are outside the scope of this rulemaking proceeding. We will consider the concerns the commenters expressed as we consider more substantive revisions to the special senses and speech body system listings.

Digestive System

Comment: One commenter suggested that we include other diagnostic techniques, such as a CAT scan or ultrasound, as acceptable confirmation of liver disease, in addition to a liver biopsy, under listing 5.05F.

Response: We have not adopted this comment because it is beyond the scope of this rulemaking proceeding. We will, however, consider the comment as part of our comprehensive review of the digestive system listings.

Neurological

Comment: One commenter recommended that we revise the preface to the listing to reflect the deletion of listing 11.15, for tabes dorsalis.

Response: We have not adopted this comment. Listing 11.15 is not discussed in the preface to the current neurological listings, and we see no need to add a discussion regarding its deletion. Tabes dorsalis is rarely seen in modern medicine. If we had to evaluate this condition, it would be appropriate to consider whether the condition medically equaled other neurological listings. For example, sensory deficits associated with tabes dorsalis could be evaluated under listing 11.04A, or visual limitations associated with this condition could be evaluated using listing 11.09B.

Comment: One commenter, from an advocacy organization on behalf of individuals with epilepsy, commended the proposed change of wording to use ''antiepileptic'' in place of ''anticonvulsant.'' Another commenter, however, stated that the change would limit the listing, because convulsive disorders other than epilepsy would no longer fall under this listing section. The first commenter also supported the elimination of the requirement for an electroencephalogram (EEG) in all diagnoses of epilepsy. However, this commenter also expressed concern that we did not change some other outdated terminology contained in the epilepsy listings, and recommended that we make additional changes to the listings.

Response: We agree with the commenter about the need to make additional revisions to the listings for epilepsy in order to further update them. We are in the process of reviewing and revising the neurological body system listings and expect to issue proposed rules as part of that revision. We expect that any future revisions will address the commenter's concerns. Because the changes the commmenter suggested are more detailed and substantive, we do not believe that these suggested changes are within the scope of this rulemaking proceeding. In regard to the concern that these proposed changes would limit the usefulness of the seizure listings, the primary disorder being addressed here is in fact epilepsy. Other convulsive disorders or similarly disruptive disorders can still be evaluated under these epilepsy listings by using medical equivalence, as has been done in the past with such disorders as narcolepsy and pseudoseizures.

Comment: One commenter stated that we should use the terms ''partial'' seizures and ''generalized'' seizures in the listings, rather than ''convulsive epilepsy'' (listing 11.02) and ''nonconvulsive epilepsy'' (listing 11.03).

Response: As noted above, we are currently reviewing the entire neurological body system to identify further appropriate revisions. As part of this process, we anticipate some restructuring of listings using broader impairment categories, as well as additional changes in the listings dealing with epilepsy and terminology related to epilepsy. We will consider the

commenter's recommendations during the review of the entire neurological body system listings.

Comment: One commenter expressed concern that we were removing myasthenia gravis from the listings as a listed impairment.

Response: We did not propose removing this impairment as a listed impairment in our regulations. Myasthenia gravis is evaluated under listing 11.12.

Comment: One commenter questioned when we would recognize post-polio syndrome as a disabling impairment, since the neuromuscular effects result in additional functional loss and are usually permanent and slowly progressive.

Response: The late effects of polio, also referred to as post-polio syndrome or sequelae, are recognized as a potentially disabling impairment and are evaluated under our current listing 11.11, Anterior poliomyelitis. Under listing 11.11, we evaluate your overall motor function. If the impairment is not found to meet or equal a listed impairment, we consider the impact of the impairment and any related symptoms in determining your residual functional capacity and we proceed to evaluate your impairment under our sequential evaluation procedures in accordance with § 404.1545.

Mental

Comment: One commenter recommended that we use the definition of mental retardation (MR) found in the Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) (DSM–IV), published by the American Psychiatric Association, as the definition of MR in listing 12.05 and 112.05.

Response: We did not adopt the comment. The definition of MR we use in our listings is consistent with, if not identical to, the definitions of MR used by the leading professional organizations. The four major professional organizations in the United States that deal with MR have each established their own definition of MR. While all the definitions require significant deficits in intellectual functioning, as evidenced by IQ scores of approximately 70 or below, age of onset and the method of measuring the required deficits in adaptive functioning differ among the organizations.

For example, the definition of MR used in the DSM–IV is predominantly based on (but not identical to) the revised definition of MR promulgated by the American Association on Mental Retardation (AAMR) in 1993. The DSM–IV states: ''The essential feature of mental retardation is significantly subaverage general intellectual functioning (further defined as an IQ standard score of approximately 70 or below), that is accompanied by significant limitations in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. The onset must occur before age 18 years.''

Following publication of this new definition of MR by the AAMR, the American Psychological Association published its own ''Manual of Diagnosis and Professional Practice in Mental Retardation, 1996.'' It states: ''Mental retardation refers to (a) significant limitations in general intellectual functioning; (b) significant limitations in adaptive functioning, which exist concurrently; and (c) onset of intellectual and adaptive limitations before the age of 22 years.'' In its definition, (a) is defined as ''* * * an IQ or comparable normed score that is two or more standard deviations below the population mean for the measure;'' and for (b), ''* * * the criterion of significance is a summary index score that is two or more standard deviations below the mean * * *.''

The definition of MR used by SSA in the listings is not restricted to diagnostic uses alone, nor does it seek to endorse the methodology of one professional organization over another. While capturing the essence of the definitions used by the professional organizations, it also is used to determine eligibility for disability benefits. SSA's definition establishes the necessary elements, while allowing use of any of the measurement methods recognized and endorsed by the professional organizations.

Neoplastic Diseases—Malignant

Comment: One commenter requested that we add ''undifferentiated'' carcinoma of the thyroid to the listing 13.08. The commenter noted that this would be the same as the proposed anaplastic carcinoma of the thyroid, but the inclusion of both terms would better clarify the rules.

Response: We have adopted this comment and have made the change in listing 13.08.

General

Comment: A professional organization representing disability adjudicators at the state level generally agreed with the proposed revisions. However, the comments expressed concern about the proposed deletion of listing 2.05 for complete homonymous hemianopsia and listing 11.15 for tabes dorsalis, and the removal of the reference in listing 9.02 to ''progressive exophthalmos as measured by exophthalmometry.'' The commenter agreed that these conditions were rarely seen, but remained concerned that their removal may lead to these conditions being overlooked. The commenter recommended that any revisions to these listings be done as we revise individual body system listings.

Response: We have not adopted these comments. We believe it is appropriate to delete listings 2.05 and 11.15 and to remove the reference to progressive exophthalmos in listing 9.02 as part of these final rules. All of these conditions are extremely rare and are amenable to treatment, given modern medical practices. The listings are intended to identify commonly occurring and frequently seen impairments that are considered severe enough to preclude any gainful activity in adults (or that result in ''marked and severe functional limitations'' in children). We do not believe there is any benefit in waiting to delete these listings until we revise the specific body system listings.

Comment: A number of commenters requested that other specific impairments be included in the listings. The commenters suggested that we add a number of impairments that are not now included in the listings, such as Lyme disease, trigeminal neuralgia, chronic fatigue syndrome (CFS), fibromyalgia, systemic mastocytosis, migraines, vestibular disorders, reflex sympathetic dystrophy syndrome, narcolepsy, arachnoiditis, porphyria, and hepatitis A, B, and C. The commenters believe that these impairments are medically severe and result in substantial functional loss due to the illnesses themselves as well as the associated symptoms and side effects from various treatments. They requested that specific listing criteria be included in our listings so that individuals with these disorders could be found disabled as appropriate and would not be overlooked solely due to the fact that their specific impairments were not named in the listings.

Response: We did not adopt these comments, which are outside the scope of this rulemaking proceeding. In proposing these revisions, we intended primarily to address existing listings and to update or clarify the medical terminology used in some listings. We explained in the NPRM that more substantive changes to the listings would be addressed when we reviewed the listing criteria for each individual body system (65 FR 6929). We will consider including new criteria for

specific impairments, such as those mentioned above, as we review the appropriate respective body systems.

However, we emphasize that if you have an impairment(s) that is not included in the listings, you may still be found disabled at the third step of the sequential evaluation processes for adults and children if your impairment(s) medically equals a listing. This longstanding policy is explained in §§ 404.1526 and 416.926 of our regulations. If you are a child under age 18, we may also find that an impairment or combination of impairments functionally equals the listings, as explained in § 416.926a of our regulations. In addition, if you are an adult, we can find you disabled at a later step in the sequential evaluation process, as explained in §§ 404.1545–404.1568 and 416.945–416.968 of our regulations. With respect to the specific impairments noted by the commenters, a Social Security Ruling (SSR), SSR 99–2p (64 FR 23380), provides detailed guidance on how we evaluate claims involving CFS.

Comment: Several commenters suggested that we make specific changes to listings that we did not propose changing in the proposed rules.

Response: We did not adopt these comments, which are also outside the scope of this rulemaking proceeding. However, we will consider the commenters' proposed changes as we revise individual body system listings.

Comment: A few commenters were concerned that individuals would lose their benefits based on the proposed technical changes to the listings.

Response: No individual's disability benefits will be ceased solely on the basis of these technical revisions to the listings. We conduct periodic reviews of individuals receiving benefits to determine whether they are still disabled. These reviews are known as continuing disability reviews (CDRs). However, when we conduct CDRs, we do not find that your disability has ended based on a change in a listing. In most cases, we must show that your impairment(s) has medically improved and that this improvement is ''related to the ability to work.'' If your impairment(s) has not medically improved, we will generally find that you are still disabled. Even if the impairment(s) has medically improved, our regulations provide that the improvement is not ''related to the ability to work'' if the impairment(s) continues to meet or equal the ''same listing section used to make our most recent favorable decision.'' This is true even if we have deleted or revised the listing section that we used to make the most recent favorable decision. See §§ 404.1594(c)(3)(i) and 416.994(b)(2)(iv)(A) of our regulations. A similar provision for CDRs for children eligible for SSI based on disability appears in § 416.994a(b)(2) of our regulations.

As we noted in the effective date section of this preamble, these final rules will be effective on May 24, 2002. Our current rules will continue to apply until the effective date of these final rules. When these final rules become effective, we will apply them to new applications filed on or after the effective date of the rules. We will also apply them to the entire period at issue for claims that are pending at any stage of our administrative review process, including claims that are pending administrative review after remand from a Federal court.

With respect to claims in which we have made a final decision, and that are pending judicial review in Federal court, we expect that the court's review of the Commissioner's final decision would be made in accordance with the rules in effect at the time of the final decision. If the court determines that the Commissioner's final decision is not supported by substantial evidence, or contains an error of law, we would expect that the court would reverse the final decision, and remand the case for further administrative proceedings pursuant to the fourth sentence of section 205(g) of the Act, except in those few instances where the court determines that it is appropriate to reverse the final decision and award benefits, without remanding the case for further administrative proceedings. In those cases decided by a court after the effective date of the rules, where the court reverses the Commissioner's final decision and remands the case for further administrative proceedings, on remand, we will apply the provisions of these final rules to the entire period at issue in the claim.

Comment: One commenter felt that these proposed revisions were structured to take disability benefits away from individuals who were stabilized by medications. This individual felt that medications had masked the severity of his liver disease and this had adversely affected his ability to receive a transplant.

Response: These proposed revisions are not in any way intended to change the way we evaluate the impairment(s) of individuals who benefit from prescribed medication(s). In evaluating any medical impairment, we must consider the impact of any treatments and medications that you are taking, both from the standpoint of how they benefit you as well as any adverse side effects you may experience. We evaluate your impairment in light of the medications or treatments that you have been provided by your medical sources. We do not judge the appropriateness of such medications or treatments.

Other Changes

We proposed several changes to the listings that we are not making in these final rules. The NPRM contained a drafting error in reference to section 11.02 addressing epilepsy. We proposed to revise the heading to be more consistent with current medical technology, but we had not intended to change the frequency criterion for the number of seizures required to meet this listing. The proposed rules incorrectly stated the frequency as ''occurring more frequently than once weekly.'' (65 FR 6935). We did not intend to change the existing frequency criterion, which continues to read, ''occurring more frequently than once a month.'' We have revised the final rules consistent with our original intent.

Second, the NPRM proposed revising § 416.926a(d) to remove subparagraphs (8) and (9) of this section and revise the numbering accordingly. On June 14, 2000, we published a notice of intent to issue regulations and request for comments that asked experts in growth impairments in children, and other interested members of the public, for comments on how we should revise the childhood growth impairment listings (65 FR 37321). We will consider whether and how we should revise these examples of growth impairments, which we consider to functionally equal the listings, in the context of that rulemaking proceeding. As a result, we are not making any changes to § 416.926a in these final rules. Former § 416.926a(d)(8) and (9) were redesignated as § 416.926a(m)(7) and (m)(8), respectively, in the final childhood disability rules that we published on September 11, 2000 (65 FR 54747). Those final rules were effective on January 2, 2001.

Third, we have not included the technical revisions involving the adult mental disorders body system listings (section 12.00) in these final rules. On August 21, 2000, we published final rules revising the medical criteria we use for evaluating mental disorders and traumatic brain injury in adults (65 FR 50746). In those final rules, we made several revisions to listing 12.05, including a revision to the capsule definition to the listing. Consequently, there is no need to include any additional changes to that listing in these final rules.

Fourth, we did not include the technical revisions involving the musculoskeletal body system listings (section 1.00 and 101.00) for adults and children in these final rules. On November 19, 2001, we published final rules revising the medical criteria we use for evaluating musculoskeletal disorders in adults and children (66 FR 58010). In those final rules, we made the revisions we had proposed in this rulemaking proceeding.

However, the language we used in the final rules revising the musculoskeletal listings to describe what we mean by appropriate medically acceptable imaging techniques should also be included in the preface of other body systems that refer to imaging techniques. Accordingly, we added this language to the prefaces of those body systems that we address in this rulemaking proceeding as part of these final rules. We will also add it as needed to other body system listings as we revise them in the future. The addition of this language allows us to delete the specific references to ''x-rays'' in listing sections 2.00B2 and 113.00A, and to delete the phrase ''x-ray imaging'' previously included in listings 5.03, 5.04, 5.05, and 105.05.

Aside from those changes noted above, we are not making any other changes to the proposed revisions.

Regulatory Procedures

Executive Order 12866

The Office of Management and Budget (OMB) has reviewed these final rules in accordance with Executive Order (E.O.) 12866, as amended by E.O. 13258. We have also determined that these rules meet the plain language requirements of E.O. 12866.

Regulatory Flexibility Act

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

Paperwork Reduction Act

These final rules contain reporting requirements at: 2.00B; 3.00F; 11.02; 11.03; 14.00B; 14.08M; 100.00B; 102.00A; 104.00E; 105.00B; 111.00A; and 113.00B; 114.00B; and 114.08N. The public reporting burden is accounted for in the Information Collection Requests for the various forms that the public uses to submit the information to SSA. Consequently, a 1-hour placeholder burden is being assigned to the specific reporting requirement(s) contained in these rules. We are seeking clearance of the burdens referenced in these rules because these rules were not considered during the clearance of the forms. An Information Collection Request has been submitted to OMB. While these rules will be effective 30 days from publication, these burdens will not be effective until cleared by OMB. We are soliciting comments on the burden estimate; the need for the information; its practical utility; ways to enhance its quality, utility and clarity; and on ways to minimize the burden on respondents, including the use of automated collection techniques or other forms of information technology. We will publish a notice in the **Federal Register** upon OMB approval of the information collection requirements. Comments should be submitted to the OMB desk officer for SSA within 30 days of publication of this final rule at the following address: Office of Management and Budget, Attn: Desk Officer for SSA, New Executive Office Building, Room 10235, 725 17th St., NW, Washington, DC 20503.

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

List of Subjects in 20 CFR Part 404

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

Dated: February 12, 2002.

Jo Anne B. Barnhart,

Commissioner of Social Security.

For the reasons set forth in the preamble, part 404, subpart P of chapter III of title 20 of the Code of Federal Regulations is amended as follows:

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

Subpart P—Determining Disability and Blindness

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

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

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

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

A. In part A:

1. Section 2.00 is amended:

a. By revising the heading of paragraph A;

b. By revising paragraph A1, the first two sentences of paragraph A2, and paragraph A5;

c. By amending the first, fourth, fifth, and sixth sentences of paragraph A6 to remove the word ''central'';

d. By revising the last sentence in the second undesignated paragraph of paragraph B2 and by amending the second undesignated paragraph of paragraph B2 to add two new sentences at the end of the paragraph;

e. By revising paragraph B3;

2. Section 2.02 is amended by removing the word ''central'' in the heading.

3. Section 2.04 is revised.

4. Section 2.05 is removed and reserved.

5. Section 2.09 is revised.

6. Table No. 1 following section 2.09 is amended by revising the heading to read: ''PERCENTAGE OF VISUAL ACUITY EFFICIENCY CORRESPONDING TO VISUAL ACUITY NOTATIONS FOR DISTANCE IN THE PHAKIC AND APHAKIC EYE (BETTER EYE)''; by revising the heading of the right column on the first line of the table to read, ''PERCENT VISUAL ACUITY EFFICIENCY''; and by amending footnotes 2 and 3 to Table No. 1 by removing the word ''central.''

7. Section 3.00 is amended by revising the last sentence in the second undesignated paragraph of paragraph E, and by amending paragraph F1 by revising the fourth and fifth sentences of the fourth undesignated paragraph.

8. Section 3.11 is added.

9. Section 4.00, paragraph A, is amended by revising the second sentence of the third undesignated paragraph, and paragraph C3 is amended by revising the third sentence of the paragraph and adding two new sentences.

10. Section 5.00, paragraph C, is amended by revising the fourth sentence and by adding two new sentences.

11. Section 5.03 is revised.

12. Section 5.04 is amended by revising the heading and by revising paragraph C.

13. Section 5.05 is amended by revising the first sentence in paragraph A.

14. Section 5.09 is added after the tables.

15. Section 6.00 is amended by adding two new sentences to paragraph A.

16. Section 6.02 is amended by revising paragraph C1.

17. Section 7.00 is amended by adding two new sentences to paragraph B.

18. Section 7.00 is amended by revising the first sentence of the first paragraph of paragraph E.

19. Section 7.11 is amended by revising the heading.

20. Section 7.16 is amended by revising the heading and by revising paragraph A.

21. Section 7.17 is amended by revising the heading and by revising the first sentence.

22. Section 8.06 is amended by revising the heading.

23. Section 9.00, the first paragraph, is amended by adding two new sentences.

24. In section 9.02, the word ''With:'' following the heading and paragraph A are removed and the paragraph designation ''B'' is removed from paragraph B.

25. Section 9.03, paragraph A, is revised.

26. Section 11.00 is amended in paragraph A:

a. By revising the heading;

b. By revising the first sentence in paragraph 11.00A;

c. By removing the first undesignated paragraph; and

d. By revising the first, second and third sentences in the second undesignated paragraph.

27. Section 11.02 is amended by revising the heading.

28. Section 11.03 is amended by revising the heading.

29. Section 11.15 is removed and reserved.

30. Section 11.17 is amended by revising paragraph A.

31. Section 13.08 is revised.

32. Section 14.00 is amended by revising the first sentence of the first undesignated paragraph of paragraph B and by adding two new sentences following this sentence.

33. Section 14.08 is amended by revising paragraph M6.

B. In part B:

1. Section 100.00, paragraph B, is revised.

2. Section 102.00 is amended by revising the first and second sentences of paragraph A.

3. Section 102.02 is amended by revising the heading.

4. Section 103.00, paragraph B, is amended by revising the last sentence of the second undesignated paragraph.

5. Section 103.00, paragraph D, is amended by adding a new first undesignated paragraph.

6. Section 103.00, paragraph E, is amended by revising the second sentence.

7. Section 103.04, paragraph B3, is revised.

8. Section 103.05 is added after Table III.

9. Section 104.00, paragraph A, is amended by revising the last sentence of the fifth undesignated paragraph, and paragraph E is amended by revising the first sentence of the second undesignated paragraph and adding a new sentence to the second undesignated paragraph.

10. Section 105.00 is amended by revising the first sentence in paragraph B and adding two new sentences.

11. Section 105.05 is amended by revising paragraphs A and C.

12. Section 105.09 is added.

13. Section 107.00, paragraph C, is amended by revising the heading and by revising the first sentence.

14. Section 107.11 is amended by revising the heading.

15. Section 111.00 paragraph A is revised and paragraph B is amended by revising the heading, and by removing the second sentence.

16. Section 111.02 is amended by revising the headings of paragraphs A and B; by revising the first sentence of the introductory text of paragraphs A and B; and by revising paragraph B3.

17. Section 111.03 is amended by revising the heading.

18. Section 113.00 is amended by revising the third sentence in paragraph B and by adding two new sentences to paragraph B.

19. Section 114.00 is amended by revising the first sentence of the second undesignated paragraph of paragraph B and by adding two new sentences following this sentence.

20. Section 114.08 is amended by revising paragraph N6.

The added and revised text is as follows:

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

* * * * *

2.00 Special Senses and Speech

A. Disorders of Vision

1. *Causes of impairment.* Diseases or injury of the eyes may produce loss of visual acuity or loss of the peripheral field. Loss of visual acuity results in inability to distinguish detail and prevents reading and fine work. Loss of the peripheral field restricts the ability of an individual to move about freely. The extent of impairment of sight should be determined by visual acuity and peripheral field testing.

2. *Visual acuity.* Loss of visual acuity may result in impaired distant vision or near vision, or both. However, for you to meet the level of severity described in 2.02 and 2.04, only the remaining visual acuity for distance of the better eye with best correction based on the Snellen test chart measurement may be used. * * *

* * * * *

5. *Visual efficiency.* Loss of visual efficiency may be caused by disease or injury resulting in reduction of visual acuity or visual field. The visual efficiency of one eye is the product of the percentage of visual acuity efficiency and the percentage of visual field efficiency. (See tables no. 1 and 2, following 2.09.)

* * * * *

B. * * *

2. * * *

* * * * *

* * * When polytomograms, contrast radiography, or other special tests have been performed, copies of the reports of these tests should be obtained in addition to appropriate medically acceptable imaging reports of the skull and temporal bone. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

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

* * * * *

2.04 *Loss of visual efficiency.* The visual efficiency of the better eye after best correction is 20 percent or less. (The percent of remaining visual efficiency is equal to the product of the percent of remaining visual acuity efficiency and the percent of remaining visual field efficiency.)

2.05 [Reserved.]

* * * * *

2.09 *Loss of speech* due to any cause, with inability to produce by any means speech that can be heard, understood, or sustained.

* * * * *

3.00 Respiratory System

* * * * *

E. *Documentation of pulmonary function testing.*

* * * * *

* * * If the spirogram was generated by any means other than direct pen linkage to a mechanical displacement-type spirometer, the testing device must have had a recorded calibration performed previously on the day of the spirometric measurement.

* * * * *

F. *Documentation of chronic impairment of gas exchange.*

1. * * *

* * * * *

* * * The percentage concentrations of inspired O_2 and inspired and expired CO and He for each of the maneuvers should be provided. Sufficient data must be provided, including documentation of the source of the predicted equation, to permit verification that the test was performed adequately, and that, if necessary, corrections for anemia or carboxyhemoglobin were made appropriately.

* * * * *

3.11 *Lung transplant.* Consider under a disability for 12 months following the date of surgery; thereafter, evaluate the residual impairment.

4.00 Cardiovascular System

A.* * *

* * * Therefore, in any case in which you have a medically determinable impairment that is not listed, or a combination of impairments no one of which meets a listing, we will consider a medical equivalence determination. * * *

* * * * *

C. * * *

3. * * * In selected cases, these tests may be purchased after a medical history and physical examination, report of appropriate medically acceptable imaging, ECGs, and other appropriate tests have been evaluated, preferably by a program physician with experience in the care of patients with cardiovascular disease. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment. * * *

* * * * *

5.00 Digestive System

* * * * *

C. * * * To be considered a severe impairment which will last for at least 12 months, a recurrent ulcer after definitive surgery must be demonstrated, despite therapy, by repeated appropriate medically acceptable imaging of the upper gastrointestinal tract or by gastroscopic examinations. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment. * * *

* * * * *

5.03 *Stricture, stenosis, or obstruction of the esophagus (demonstrated by endoscopy or other appropriate medically acceptable imaging)* with weight loss as described under listing 5.08.

5.04 *Peptic ulcer disease (demonstrated by endoscopy or other appropriate medically acceptable imaging).*

* * * * *

C. Recurrent obstruction demonstrated by endoscopy or other appropriate medically acceptable imaging; or,

* * * * *

5.05 *Chronic liver disease (e.g., portal, postnecrotic, or biliary cirrhosis; chronic active hepatitis; Wilson's disease).* With:

A. Esophageal varices (demonstrated by endoscopy or other appropriate medically acceptable imaging) with a documented history of massive hemorrhage attributable to these varices. * * *

* * * * *

5.09 *Liver transplant.* Consider under a disability for 12 months following the date of surgery; thereafter, evaluate the residual impairment(s).

6.00 Genito-Urinary System

A. * * * Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

* * * * *

6.02 * * *

* * * * *

C. * * *

1. Renal osteodystrophy manifested by severe bone pain and abnormalities shown by appropriate medically acceptable imaging (e.g., osteitis fibrosa, marked osteoporosis, pathologic fractures); or

* * * * *

7.00 Hemic and Lymphatic System

* * * * *

B. * * * Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

* * * * *

E. *Acute leukemia (including T-cell lymphoblastic lymphoma).* Initial diagnosis of acute leukemia or T-cell lymphoblastic lymphoma must be based upon definitive bone marrow pathologic evidence. * * *

* * * * *

7.11 *Acute leukemia (including T-cell lymphoblastic lymphoma).*

* * * * *

7.16 *Multiple myeloma (confirmed by appropriate serum or urine protein electrophoresis and bone marrow findings).* With:

A. Appropriate medically acceptable imaging evidence of bony involvement with intractable bone pain; or

* * * * *

7.17 *Aplastic anemias or hematologic malignancies (excluding acute leukemia and T-cell lymphoblastic lymphoma)*: With bone marrow or stem cell transplantation. * * *

* * * * *

8.06 *Hidradenitis suppurativa, acne conglobata.*

* * * * *

9.00 Endocrine System

* * * Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

* * * * *

9.03 *Hyperparathyroidism.* With:

A. Generalized decalcification of bone on appropriate medically acceptable imaging study and elevation of plasma calcium to 11 mg. per deciliter (100 ml.) or greater; or

* * * * *

11.00 Neurological

A. *Epilepsy.* In epilepsy, regardless of etiology, degree of impairment will be determined according to type, frequency, duration, and sequelae of seizures. * * *

Under 11.02 and 11.03, the criteria can be applied only if the impairment persists despite the fact that the individual is following prescribed antiepileptic treatment. Adherence to prescribed antiepileptic therapy can ordinarily be determined from objective clinical findings in the report of the physician currently providing treatment for epilepsy. Determination of blood levels of phenytoin sodium or other antiepileptic drugs may serve to indicate whether the prescribed medication is being taken. * * *

* * * * *

11.02 *Epilepsy—convulsive epilepsy, (grand mal or psychomotor), documented by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once a month in spite of at least 3 months of prescribed treatment.*

* * * * *

11.03 *Epilepsy—nonconvulsive epilepsy (petit mal, psychomotor, or focal), documented by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment.*

* * * * *

11.15 [Reserved.]

* * * * *

11.17 *Degenerative disease not listed elsewhere, such as Huntington's chorea, Friedreich's ataxia, and spino-cerebellar degeneration.* With:

A. Disorganization of motor function as described in 11.04B; or * * *

* * * * *

13.08 Thyroid gland:

A. Anaplastic (undifferentiated) carcinoma of the thyroid; or

B. Carcinoma with metastases beyond the regional lymph nodes, not controlled by prescribed therapy.

* * * * *

14.00 Immune System

* * * * *

B. * * *

The documentation needed to establish the existence of a connective tissue disorder is medical history, physical examination, selected laboratory studies, appropriate medically acceptable imaging, and, in some instances, tissue biopsy. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment. * * *

* * * * *

14.08 *Human immunodeficiency virus (HIV) infection.*

* * * * *

M. * * *

6. Sinusitis documented by appropriate medically acceptable imaging.

* * * * *

100.00 Growth Impairment

* * * * *

B. *Bone age determinations* should include a full descriptive report of medically acceptable imaging specifically obtained to determine bone age and must cite the standardization method used. Where appropriate medically acceptable imaging must be obtained currently as a basis for adjudication under 100.03, views or scans of the left hand and wrist should be ordered. In addition appropriate medically acceptable imaging of the knee and ankle should be obtained when cessation of growth is being evaluated in an older child at, or past, puberty. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myeolgraphy, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

* * * * *

102.00 Special Senses and Speech

A. *Visual impairments in children.* Impairment of visual acuity should be determined with use of the standard Snellen test chart. Where this cannot be used, as in very young children, a complete description of the findings should be provided, using other appropriate methods of examination, along with a description of the techniques used for determining the visual acuity for distance. * * *

* * * * *

102.02 *Impairments of visual acuity.*

* * * * *

103.00 Respiratory System

* * * * *

B. * * *

* * * * *

* * * If the spirogram was generated by any means other than direct pen linkage to a mechanical displacement-type spirometer, the testing device must have had a recorded calibration performed previously on the day of the spirometric measurement.

* * * * *

D. * * *

Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

E. * * *

The diagnosis is established by the requirement for continuous or nocturnal supplemental oxygen for more than 30 days, in association with characteristic changes on medically acceptable imaging and clinical signs of respiratory dysfunction, including retractions, rales, wheezing, and tachypnea.

* * * * *

103.04 *Cystic fibrosis.*

* * * * *

B. * * *

3. Appropriate medically acceptable imaging evidence of extensive disease, such as thickening of the proximal bronchial airways or persistence of bilateral peribronchial infiltrates;

* * * * *

103.05 *Lung transplant.* Consider under a disability for 12 months following the date of surgery; thereafter, evaluate the residual impairment(s).

104.00 Cardiovascular System

A. * * *

When you have a medically determinable impairment that is not listed, an impairment that does not meet the requirements of a listing, or a combination of impairments no one of which meets the requirements of a listing, we will consider a determination whether your impairment(s) medically equals or, as appropriate, functionally equals the listings. (See §§ 404.1526, 416.926, and 416.926a.)

* * * * *

E. * * *

Findings of cardiomegaly shown by appropriate medically acceptable imaging evidence must be accompanied by other evidence of chronic heart failure or ventricular dysfunction. ''Appropriate'' means that the imaging technique used is the proper one to support the evaluation and diagnosis of the impairment. * * *

* * * * *

105.00 Digestive System

* * * * *

B. *Documentation of gastrointestinal impairments* should include pertinent operative findings, appropriate medically acceptable imaging studies, endoscopy, and biopsy reports. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment. * * *

* * * * *

105.05 *Chronic liver disease.* * * *

A. Inoperable biliary atresia demonstrated by appropriate medically acceptable imaging or surgery; or

* * * * *

C. Esophageal varices (demonstrated by endoscopy or other appropriate medically acceptable imaging); or

* * * * *

105.09 *Liver transplant.* Consider under a disability for 12 months following the date of surgery; thereafter, evaluate the residual impairment.

* * * * *

107.00 Hemic and Lymphatic System

* * * * *

C. *Acute leukemia (including T-cell lymphoblastic lymphoma).* Initial diagnosis of acute leukemia or T-cell lymphoblastic lymphoma must be based upon definitive bone marrow pathologic evidence. * * *

* * * * *

107.11 *Acute leukemia (including T-cell lymphoblastic lymphoma).*

* * * * *

111.00 Neurological

A. *Convulsive epilepsy* must be substantiated by at least one detailed description of a typical seizure. Report of recent documentation should include a neurological examination with frequency of episodes and any associated phenomena substantiated.

Young children may have convulsions in association with febrile illnesses. Proper use of 111.02 and 111.03 requires that epilepsy be established. Although this does not exclude consideration of seizures occurring during febrile illnesses, it does require documentation of seizures during nonfebrile periods.

There is an expected delay in control of epilepsy when treatment is started, particularly when changes in the treatment regimen are necessary. Therefore, an epileptic disorder should not be considered to meet the requirements of 111.02 or 111.03 unless it is shown that convulsive episodes have persisted more than three months after prescribed therapy began.

B. *Nonconvulsive epilepsy.* * * *

* * * * *

111.02 *Major motor seizure disorder.*

A. *Convulsive epilepsy.* In a child with an established diagnosis of epilepsy, the occurrence of more than one major motor seizure per month despite at least three months of prescribed treatment. * * *

* * * * *

B. *Convulsive epilepsy syndrome.* In a child with an established diagnosis of epilepsy, the occurrence of at least one major motor seizure in the year prior to application despite at least three months of prescribed treatment. * * *

* * * * *

3. Significant mental disorder; or

* * * * *

111.03 *Nonconvulsive epilepsy.* * * *

* * * * *

113.00 Neoplastic Diseases, Malignant

* * * * *

B. *Documentation.* * * * If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen, along with all pertinent laboratory reports or reports from appropriate medically acceptable imaging. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment. * * *

* * * * *

114.00 Immune System

* * * * *

B. * * *

* * * * *

The documentation needed to establish the existence of a connective tissue disorder is medical history, physical examination, selected laboratory studies, appropriate medically acceptable imaging, and, in some instances, tissue biopsy. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. ''Appropriate'' means that the technique used is the proper one to support the evaluation and diagnosis of the impairment. * * *

* * * * *

114.08 *Human immunodeficiency virus (HIV) infection.*

* * * * *

N. * * *

6. Sinusitis documented by appropriate medically acceptable imaging.

* * * * *

[FR Doc. 02–9737 Filed 4–23–02; 8:45 am]

BILLING CODE 4191–02–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1, 301 and 602

[TD 8989]

RIN 1545–AY56

Guidance Necessary To Facilitate Electronic Tax Administration

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final and temporary regulations.

SUMMARY: This document contains regulations designed to eliminate regulatory impediments to the electronic filing of Form 1040, ''U.S. Individual Income Tax Return.'' These regulations generally affect taxpayers who file Form 1040 electronically and who are required to file any of the following forms: Form 56, ''Notice Concerning Fiduciary Relationship''; Form 2120, ''Multiple Support Declaration''; Form 2439, ''Notice to Shareholder of Undistributed Long-Term Capital Gains''; Form 3468, ''Investment Credit''; and Form T (Timber), ''Forest Activities Schedules.'' The text of the temporary regulations also serves as the text of the proposed regulations set forth in the notice of proposed rulemaking on this subject in the Proposed Rules section in this issue of the **Federal Register**.

EFFECTIVE DATE: These regulations are effective April 24, 2002.

FOR FURTHER INFORMATION CONTACT: James C. Gibbons, (202) 622–4910 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

These regulations are being issued without prior notice and public procedure pursuant to the Administrative Procedure Act (5 U.S.C. 553). For this reason, the collections of information contained in these regulations have been reviewed and, pending receipt and evaluation of public comments, approved by the Office of Management and Budget under control number 1545–1783. Responses to these collections of information are mandatory.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

For further information concerning these collections of information, and where to submit comments on the collections of information and the accuracy of the estimated burden, and suggestions for reducing this burden, please refer to the preamble to the cross-referencing notice of proposed rulemaking published in the Proposed Rules section of this issue of the **Federal Register**.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Background

This document contains amendments to the Income Tax Regulations (26 CFR part 1) and the Procedure and Administration Regulations (26 CFR part 301) designed to eliminate regulatory impediments to the electronic filing of Form 1040.

In 1998, Congress enacted the Internal Revenue Service Restructuring and Reform Act of 1998 (RRA 1998), Public Law 105–206 (112 Stat. 685) (1998). Section 2001(a) of RRA 1998 states that the policy of Congress is that paperless filing should be the preferred and most convenient means of filing Federal tax returns. Section 2001(a) of RRA 1998 also sets a long-range goal for the IRS to have at least 80 percent of all Federal tax returns filed electronically by 2007. Section 2001(b) of RRA 1998 requires the IRS to establish a 10-year strategic plan to eliminate barriers to electronic filing. To the extent practicable, this plan is to provide for electronic filing of electronically prepared returns for taxable years beginning after 2001.

The temporary regulations amend the Procedure and Administration Regulations to provide a regulatory statement of IRS authority to prescribe what return information or documentation must be filed with a return, statement or other document required to be made under any provision of the internal revenue laws or regulations. The regulations give the IRS maximum flexibility in prescribing (1) what needs to be filed in support of a return or claim, and (2) the form of the filing, *e.g.,* electronic versus paper. The regulations permit the IRS to prescribe required return information in forms, instructions, or other appropriate guidance.

In addition, the IRS identified five regulatory provisions that impede electronic filing by requiring the taxpayer to either include a third-party signature, or attach a document generated by a third party. The temporary regulations amend those provisions to eliminate the impediments.

Although the regulatory impediments to the electronic filing of Form 1040 are eliminated by the temporary regulations, the IRS may instruct a taxpayer who files Form 1040 on paper to attach a document that would not be required in the case of a Form 1040 filed electronically.

Explanation of Provisions

1. General Provision

Section 6001(a) of the Internal Revenue Code (Code) provides that every person liable for any tax, or for the collection thereof, will keep such records, render such statements, make such returns, and comply with such