Service Bulletin MD90–32–045, dated July 21, 2000, are acceptable for compliance with paragraph (d) of this AD.

Spares

(g) As of the effective date of this AD, no person may install a MLG brake assembly having P/N 5012193R, 5012193–1, 5012193–2, or 5012193–3 on any airplane, unless the MLG brake assembly is inspected and any applicable corrective action has been accomplished according to this AD.

Alternative Methods of Compliance

(h) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, Los Angeles Aircraft Certification Office (ACO), FAA. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, Los Angeles ACO.

Note 3: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Los Angeles ACO.

Special Flight Permits

(i) Special flight permits may be issued in accordance with sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

Issued in Renton, Washington, on August 27, 2002.

Ali Bahrami,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 02–22436 Filed 9–3–02; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG–108697–02]

RIN 1545–BA60

Required Distributions From Retirement Plans; Hearing

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of public hearing on proposed rulemaking.

SUMMARY: This document contains a notice of public hearing on proposed regulations relating to required minimum distributions for defined benefit plans and annuity contracts providing benefits under qualified plans, individual retirement plans, and section 403(b) contracts.

DATES: The public hearing is being held on Wednesday, October 9, 2002 at 10 a.m. The IRS must receive outlines of the topics to be discussed at the hearing by Wednesday, September 25, 2002.

ADDRESSES: The public hearing is being held in room 4718, Internal Revenue Building, 1111 Constitution Avenue, NW., Washington, DC. Due to building security procedures, visitors must enter at the Constitution Avenue entrance. In addition, all visitors must present photo identification to enter the building.

Mail outlines to: Regulations Unit CC:ITA:RU, (REG–108697–02), room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Hand deliver outlines Monday through Friday between the hours of 8 a.m. and 5 p.m. to: Regulations Unit CC:ITA:RU, (REG–108697–02), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC. Submit electronic outlines of oral comments directly to the IRS Internet site at *http://www.irs.gov/regs.*

FOR FURTHER INFORMATION CONTACT: Concerning submissions of comments, the hearing, and/or to be placed on the building access list to attend the hearing contact Sonya M. Cruse (202) 622–7805 (not a toll-free number).

SUPPLEMENTARY INFORMATION: The subject of the public hearing is the notice of proposed regulations (REG–108697–02) that was published in the **Federal Register** on Wednesday, April 17, 2002 (67 FR 18834).

The rules of 26 CFR 601.601(a)(3) apply to the hearing.

Persons who have submitted written comments and wish to present oral comments at the hearing, must submit an outline of the topics to be discussed and the amount of time to be devoted to each topic (signed original and eight (8) copies) by Wednesday, September 25, 2002.

A period of 10 minutes is allotted to each person for presenting oral comments.

After the deadline for receiving outlines has passed, the IRS will prepare an agenda containing the schedule of speakers. Copies of the agenda will be made available, free of charge, at the hearing.

Because of access restrictions, the IRS will not admit visitors beyond the immediate entrance area more than 30 minutes before the hearing starts.

For information about having your name placed on the building access list to attend the hearing, see the **FOR FURTHER INFORMATION CONTACT** section of this document.

Cynthia E. Grigsby,

Chief, Regulations Unit, Associate Chief Counsel (Income Tax and Accounting).

[FR Doc. 02–22465 Filed 8–29–02; 11:51 am]

BILLING CODE 4830–01–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AJ60

Schedule for Rating Disabilities; The Spine

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: This document proposes to amend the Department of Veterans Affairs (VA) Schedule for Rating Disabilities by revising that portion of the Musculoskeletal System that addresses disabilities of the spine. The intended effect of this action is to update this portion of the rating schedule to ensure that it uses current medical terminology and unambiguous criteria, and that it reflects medical advances that have occurred since the last review.

DATES: Comments must be received on or before November 4, 2002.

ADDRESSES: Mail or hand-deliver written comments to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave., NW., Room 1154, Washington, DC 20420; or fax comments to (202) 273–9289; or e-mail comments to *OGCRegulations@mail.va.gov.* Comments should indicate that they are submitted in response to ''RIN 2900–AJ60.'' All comments received will be available for public inspection in the Office of Regulations Management, Room 1158, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays).

FOR FURTHER INFORMATION CONTACT: Caroll McBrine, M.D., Consultant, Policy and Regulations Staff (211A), Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC 20420, (202) 273–7215.

SUPPLEMENTARY INFORMATION: VA proposes to amend its Schedule for Rating Disabilities by revising that portion of the Musculoskeletal System that addresses disabilities of the spine. VA published an advance notice of proposed rulemaking in the **Federal**

Register on December 28, 1990 (55 FR 53315), advising the public that it was preparing to revise and update the schedule for rating disabilities of the orthopedic system. What is referred to as ''The Orthopedic System'' in the title of the advance notice of proposed rulemaking is part of the Musculoskeletal System portion of the rating schedule. The rest of the Musculoskeletal System portion addresses muscle injuries. The revision of the Muscle Injuries portion of the Musculoskeletal System was published as a final rule in the **Federal Register** of June 3, 1997 (62 FR 30235).

In addition to publishing an advance notice, VA also contracted with an outside consultant to recommend changes to the evaluation criteria to ensure that the schedule uses current medical terminology and unambiguous criteria, and that it reflects medical advances that have occurred since the last review. The consultant convened a panel of non-VA specialists to review that portion of the rating schedule dealing with the musculoskeletal system in order to formulate recommendations. The comments of the consultants regarding disabilities of the spine are incorporated into the discussions below.

In response to the advance notice of proposed rulemaking, VA received one comment focusing on the spine. The commenter suggested VA adopt an evaluation system with eight progressive grades of spine disability that would be based on a variety of findings, including muscle guarding, radiculopathy, muscle atrophy and other impairments of the lower extremities, instability of the spine, cauda equina syndrome, paraplegia, and bowel and bladder involvement. The commenter's proposed system would assign one evaluation based on presence or absence of these factors. While such a grading system may be useful for clinical purposes, it is not feasible for rating purposes because it assigns one grade or level of disability that is based not only on orthopedic disabilities of the spine, but also on gastrointestinal, genitourinary, and neurologic disabilities, all of which have specific separate evaluation criteria in the Digestive, Genitourinary, and Neurologic System sections of the rating schedule. For this reason, we do not propose to adopt the eight-grade method of categorizing spine disabilities. However, we do propose to revise the evaluation criteria for rating disabilities of the spine by establishing a general rating formula that will apply to all diseases and injuries of the spine. Intervertebral disc syndrome was addressed in a separate rulemaking, RIN 2900–AI22. The final revision of intervertebral disc syndrome was published in the **Federal Register** on August 22, 2002 at 67 FR 54345. This proposed regulatory amendment would make editorial changes to the evaluation criteria for intervertebral disc syndrome to make them compatible with the new general rating formula. This does not, however, represent any substantive change to the recently adopted evaluation criteria for intervertebral disc syndrome.

We propose to add a note following the general rating formula that would direct the rating agency to separately evaluate any associated objective neurologic abnormalities, including, but not limited to, bowel or bladder impairment, and sensory or motor loss of the extremities. Such evaluations would be based on criteria in the Digestive, Genitourinary, and Neurologic System portions of the rating schedule, depending on the specific findings. Bowel and bladder impairment and sensory or motor loss in extremities are among the neurologic impairments that most commonly result from disease or injury of the spine. However, a great variety of neurologic disabilities might stem from diseases and injuries of the spine. In view of this fact, and the many different sets of evaluation criteria that might be needed, it would be impractical to repeat them all in the orthopedic part of the schedule.

The current rating schedule provides diagnostic codes for eleven spine conditions. Four codes represent diagnoses of spine disabilities: Vertebral fracture (diagnostic code 5285); intervertebral disc syndrome (diagnostic code 5293); sacroiliac injury and weakness (diagnostic code 5294); lumbosacral strain (diagnostic code 5295). The seven remaining codes concern findings of ankylosis (bony fixation) or limitation of motion of the spine rather than diagnoses. The codes representing ankylosis or limitation of motion of the spine include current diagnostic codes 5286 (ankylosis of entire spine), 5287 (ankylosis of cervical spine), 5288 (ankylosis of dorsal spine), 5289 (ankylosis of lumbar spine), 5290 (limitation of motion of cervical spine), 5291 (limitation of motion of dorsal spine), and 5292 (limitation of motion of lumbar spine). Evaluations involving ankylosis are assigned based on whether the ankylosis is favorable or unfavorable, without defining those terms, and with separate evaluations provided for lumbar, dorsal and cervical spine. Evaluations involving limitation of motion of the lumbar, dorsal and cervical spine are based on such indefinite criteria as ''slight,'' ''moderate,'' or ''severe'' limitation of motion. We propose to delete the seven diagnostic codes (5286 through 5292) that involve findings of ankylosis or limitation of motion of the spine because, rather than representing conditions or diagnoses, they are findings that are common to a variety of spinal conditions. The general rating formula we are proposing will include objective criteria for evaluating limitation of motion and ankylosis and will eliminate indefinite criteria and terminology. We also propose to define favorable ankylosis and unfavorable ankylosis in a note which will be explained in a separate paragraph of this summary.

Our contract consultants recommended that we add spinal stenosis (narrowing of the spinal canal, with associated symptoms) and spondylolisthesis or segmental instability to the updated schedule. Consistent with our consultants' recommendations, we propose to add these and several other spine disabilities that are distinct from those currently listed in the rating schedule and that occur frequently enough to warrant inclusion.

In order to add these spine disabilities and still group evaluation criteria for all injuries and disabilities of the spine together in one section of the rating schedule, we propose to move all diagnostic codes for spinal disabilities and assign them new diagnostic codes ranging from diagnostic code 5235 through diagnostic code 5243. We propose to provide new diagnostic codes for the following conditions that are already in the Schedule: 5235 for vertebral fracture, 5236 for sacroiliac injury and weakness, 5237 for lumbosacral strain, and 5243 for intervertebral disc syndrome. The disabilities we propose to add are: spinal stenosis (a narrowing of the central spinal canal that causes pressure on the spinal cord and/or nerve roots, most commonly due to degenerative arthritis or degenerative disc disease) (diagnostic code 5238), spondylolisthesis or segmental instability (slipping of all or part of one vertebra forward on another vertebra that may compress spinal nerves) (diagnostic code 5239), ankylosing spondylitis (a rheumatic disease that affects the spine and sacroiliac joints and that may have extra-articular (outside the joints) findings) (diagnostic code 5240), and spinal fusion (diagnostic code 5241). We also propose to add degenerative arthritis of the spine (diagnostic code 5242), a common condition that will ordinarily be evaluated under the general rating

formula for diseases and injuries of the spine. There is currently a single diagnostic code (5003) for degenerative arthritis of any joint, with evaluation criteria based on X-ray findings, or X-ray findings plus limitation of motion. The general rating formula we are proposing will provide criteria for evaluating degenerative arthritis of the spine except when X-ray findings, as discussed under diagnostic code 5003, are the sole basis of its evaluation.

Diagnostic code 5285 is currently titled ''Vertebra, fracture of, residuals.'' Our contract consultants recommended that we include dislocation of a vertebra under this diagnostic code because it may result in the same type of disability as a fracture, and we accordingly propose to move this disability to diagnostic code 5235, as previously explained, and rename it ''Vertebral fracture or dislocation.'' There are currently two defined evaluation levels for vertebral fractures under this code: 100 percent, based on the criteria ''With cord involvement, bedridden, or requiring long leg braces'; and 60 percent, based on the criteria ''Without cord involvement; abnormal mobility requiring neck brace (jury mast).'' There is also a direction to rate other cases based on limitation of motion or muscle spasm, with 10 percent to be added to the rating if there is demonstrable deformity of the vertebral body.

Our contract consultants suggested we assign a 100-percent rating for vertebral fracture or dislocation if an individual is ''non-ambulatory,'' rather than if he or she requires long leg braces, because devices other than leg braces are commonly used. But because a veteran who is non-ambulatory may warrant any of several different evaluations, depending on the specific findings, we do not propose to adopt the consultants' suggestion. Instead, to ensure that all disabilities resulting from fracture or dislocation of the spine are taken into account in the evaluation, we propose to evaluate all disabilities of the spine, including fractures and dislocations of the spine, using a general formula that will be based on the orthopedic findings such as limitation of motion, ankylosis, muscle spasm, guarding, and tenderness, present in the individual case. The neurologic disabilities such as bowel or bladder impairment that result from spinal fracture or dislocation will be separately evaluated, as discussed above.

Vertebral fracture with abnormal mobility requiring a neck brace, which is one of the criteria in the current schedule for a 60-percent evaluation for vertebral fracture, is a condition that ordinarily occurs only during the acute or convalescent phase of an injury. This temporary condition can therefore be evaluated under the provisions of 38 CFR 4.28 (''Prestabilization rating from date of discharge from service''), 4.29 (''Ratings for service-connected disabilities requiring hospital treatment or observation''), or 4.30 (''Convalescent ratings''), and we propose to remove it from the evaluation criteria.

Our contract consultants also recommended deleting the 60 percent level of evaluation for vertebral fracture without cord involvement because such a condition is not itself disabling. Under the proposed general rating formula, fractures without cord involvement would be rated on the basis of findings of limitation of motion, ankylosis, muscle spasm, guarding, and tenderness, at an evaluation level of zero, 10, 20, 30, 50 or 100 percent, depending on the extent and severity of findings.

The consultants stated that fracture or dislocation of the vertebrae is disabling only when there are residuals, and pointed out that completely asymptomatic fractures of vertebrae are not rare. A recent medical textbook on disability evaluation stated that vertebral fractures with loss of height of the vertebral body of 50-percent or less ordinarily do not require surgery, heal uneventfully, and are compatible with the resumption of normal activities after healing (''Disability Evaluation,'' 292–3 (Stephen L. Demeter, M.D., Gunnar B.J. Anderson, M.D., Ph.D., and George M. Smith, M.D., 1996)). We therefore propose to remove the current direction to add 10-percent to an evaluation for vertebral fracture based on demonstrable deformity of the vertebral body. Instead, we propose to make ''vertebral body fracture with loss of 50-percent or more of the height'' one of the criteria for a 10-percent evaluation. This will apply to vertebral fractures of that extent only when there are symptoms such as pain, stiffness, or aching in the area of the fracture. Otherwise, disability due to a vertebral body compression fracture would be evaluated at any appropriate level of evaluation, depending on the findings. This will ensure that evaluations are based on the actual signs and symptoms present, rather than solely on the presence of X-ray abnormalities, a finding not always indicative of actual disability.

Our contract consultants recommended adding the words ''surgical or non-surgical'' to the current criteria for ankylosis of the spine. However, because the evaluation would be based on the same criteria whatever the cause of the ankylosis, we do not propose to adopt this suggestion. Instead, we propose to incorporate the current evaluation criteria for ankylosis of the spine into the proposed general rating formula without substantive change. We also propose to add a note following the formula defining unfavorable ankylosis as a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion (*i.e.*, bent forward) or extension (*i.e.*, bent backward), and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the costal margin (ribs) on the abdomen; dyspnea (shortness of breath) or dysphagia (difficulty swallowing); atlantoaxial (the atlas and axis otherwise known as the first and second cervical vertebrae) or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. These signs and symptoms, which may be indications for spinal surgery, represent disability greater than limitation of motion of the spine alone. A spinal segment fixed in neutral position (for purposes of spinal range of motion, generally at zero degrees) is in favorable ankylosis (American Medical Association *Guides to the Evaluation of Permanent Impairment,* 2nd ed., (1984)).

Our contract consultants recommended deleting zero percent and ten percent evaluations for ''slight'' limitation of motion under current diagnostic codes 5290, 5291, and 5292 because such minor conditions are difficult to distinguish from normal and do not result in significant impairment. The current evaluation criteria for limitation of motion of segments of the spine—''slight,'' ''moderate,'' and ''severe''—are subjective. We propose to remove those terms and specify in the general rating formula the exact extent of limitation of motion of either forward flexion or of the combined range of motion (the sum of the range of flexion, extension, left and right rotation, and left and right lateral flexion) that warrants each level of evaluation. This will ensure consistent evaluations.

We further propose to add a note following the general rating formula that would specify the normal ranges of motion for the cervical and thoracolumbar spine and a new plate (Plate V) with diagrams demonstrating the ranges of motion. We propose to define the normal range of motion for the cervical spine as: forward flexion, zero to 45 degrees; extension, zero to 45

degrees; left and right lateral flexion, zero to 45 degrees; and left and right rotation, zero to 80 degrees. We propose to define the normal range of motion for the thoracolumbar spine as: flexion, zero to 90 degrees; extension, zero to 30 degrees; left and right lateral flexion, zero to 30 degrees; and left and right rotation, zero to 30 degrees. These ranges of motion are based on the American Medical Association *Guides to the Evaluation of Permanent Impairment,* 2nd ed., (1984), which is the last edition of the *Guides* that measured range of motion of the spine using a goniometer. Subsequent editions of the *Guides* use an inclinometer for spine measurements, in part, they state, because it is difficult to measure movements of the small joints of the spine using a goniometer. The Veterans Health Administration (VHA) has advised us that obtaining consistent and accurate measurements of the range of motion of the spine using an inclinometer is technically difficult and that measurement by means of a goniometer is the current and preferred method of measurement in VHA because of ease of use and accuracy. Since measurement of the movement of the small or individual joints of the spine is not required by the evaluation criteria, and uniformity and consistency of measurements of range of motion are important for VA compensation purposes, we propose to require the use of a goniometer to determine the range of motion of the spine and to establish the normal range of motion based on measurements using a goniometer. Since goniometer measurements are shown in five degree increments, we propose to add a note to specify that each range of motion measurement be rounded to the nearest five degrees.

We propose that the general rating formula provide criteria for the cervical and thoracolumbar spinal segments only, excluding a separate set of criteria for the thoracic (or dorsal) segment of the spine. The thoracic segment of the spine consists of the twelve thoracic vertebrae. Because the thoracic and lumbar segments ordinarily move as a unit, it is clinically difficult to separate the range of movement of one from that of the other. This combination of segments is also used in the 1984 AMA *Guides.* We also propose to replace the term ''dorsal'' with the term ''thoracic'' throughout this section, in keeping with current medical terminology.

The current rating schedule states that ratings for ankylosis or limitation of motion shall not be assigned for more than one spinal segment by reason of involvement of only the first or last vertebrae of an adjacent segment. Because we propose to eliminate a separate evaluation for the thoracic spine, the vertebrae involved are the last cervical vertebra (C–7), and the first thoracic vertebra (T–1). Disability in both segments could exist, even if only C–7 or T–1 is involved. Separate evaluations for the cervical spine and the thoracolumbar spine should not be precluded in this situation if disability in both segments exists. Therefore, we propose to eliminate this provision.

Current diagnostic code 5295 (lumbosacral strain) supports evaluations from zero to forty percent, based on pain, muscle spasm, limitation of motion, listing of the spine, loss of lateral motion with osteoarthritic changes, etc. We propose to move this disability to diagnostic code 5237 and evaluate lumbosacral strain under the general rating formula, which would include criteria adequate for its evaluation.

The proposed general rating formula for diseases and injuries of the spine would apply to spinal stenosis, spondylolisthesis, lumbosacral strain, spinal fracture or dislocation, spinal fusion of single or multiple levels, ankylosing spondylitis, sacroiliac injury and weakness, degenerative arthritis (see also diagnostic code 5003) and, in part, intervertebral disc syndrome, which was revised in a separate rulemaking. The rating formula would be used when any of these conditions results in symptoms such as pain (with or without radiation), stiffness, or aching of the spine due to residuals of injury or disease. It would provide evaluation levels of zero, ten, twenty, thirty, forty, fifty, and one hundred percent, based on limitation of motion of the spine, either limitation of forward flexion alone, or limitation of the combined range of motion; the severity of ankylosis; and on the extent of muscle spasm, guarding, or localized tenderness. We propose no change from the current schedule in the overall possible range of evaluations for limitation of motion or ankylosis, but propose more objective criteria in order to ensure more consistent evaluations.

Because of the new general rating formula we are proposing, we also propose to revise the introductory language used under intervertebral disc syndrome. It currently states, ''Evaluate intervertebral disc syndrome (preoperatively or postoperatively) either on the total duration of incapacitating episodes over the past 12 months or by combining under § 4.25 separate evaluations of its chronic orthopedic and neurologic manifestations along with evaluations for all other disabilities, whichever method results in the higher evaluation.'' We propose to change it to ''Evaluate intervertebral disc syndrome (preoperatively or postoperatively) either on the total duration of incapacitating episodes over the past 12 months or by combining under § 4.25 evaluations under the General Rating Formula for Diseases and Injuries of the Spine along with evaluations for all other disabilities, whichever method results in the higher evaluation.''

We propose to provide additional rating guidance through the use of several notes following the rating formula. The first note would direct that any associated objective neurologic abnormalities, including, but not limited to, bowel or bladder impairment, be separately evaluated. The second note would define, for VA compensation purposes, the normal ranges of motion for the cervical and thoracolumbar spinal segments and state that the normal combined range of motion for the cervical spine is 340 degrees and for the lumbar spine is 240 degrees and would state that the normal ranges of motion for each component of spinal motion provided are the maximum that can be used for calculation of the combined range of motion. The third note would state that in exceptional cases, an examiner may state that because of age, body habitus (physique, posture, and position), neurologic disease, or other factors not the result of disease or injury of the spine, the range of motion of the spine in a particular individual should be considered normal for that individual even though it does not conform to the normal range of motion stated in Note 2. Provided that the examiner furnishes an explanation, the examiner's assessment that the range of motion is normal for that individual will be accepted. The fourth note would state that for evaluation purposes, measurement of range of motion would be rounded to the nearest 5 degrees. The fifth note would define favorable and unfavorable ankylosis, for VA compensation purposes, as described above. The sixth note would direct that disability of the thoracolumbar and cervical spine segments be evaluated separately, except when there is unfavorable ankylosis of both segments, which will be rated as a single disability. This exception is proposed because unfavorable ankylosis of a single segment can be compensated for to some extent by the other spinal segment, even if it is favorably ankylosed. However, if both segments are ankylosed in an unfavorable position, no compensation is possible,

and the overall disability is total. Separately combining unfavorable ankylosis of each segment would result in an evaluation of only 70 percent, a level which is not commensurate with the extent of disability.

Paperwork Reduction Act

This document contains no provisions constituting a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501–3520).

Executive Order 12866

This document has been reviewed by the Office of Management and Budget under Executive Order 12866, Regulatory Planning and Review, dated September 30, 1993.

Regulatory Flexibility Act

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

Catalog of Federal Domestic Assistance Numbers

The Catalog of Federal Domestic Assistance program numbers are 64.104 and 64.109.

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

Approved: July 18, 2002.

Anthony J. Principi,

Secretary of Veterans Affairs.

For the reasons set forth in the preamble, VA proposes to amend 38 CFR part 4 (subpart B) as follows:

PART 4—SCHEDULE FOR RATING DISABILITIES

Subpart B—Disability Ratings

1. The authority citation for part 4, subpart B continues to read as follows:

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

2. In § 4.71a, the table ''The Spine'' is revised and is transferred so that it precedes the table ''The Hip and Thigh'; and Plate V is added immediately following the table ''The Spine'', to read as follows:

§ 4.71a Schedule of ratings—musculoskeletal system.

* * * * *

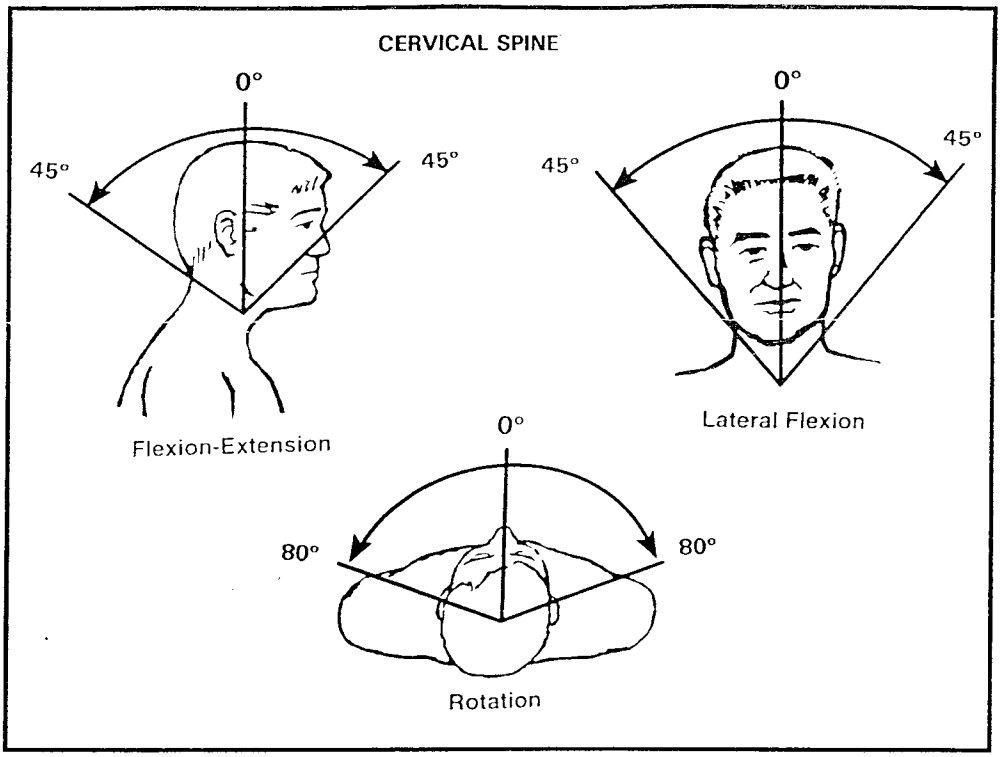
THE SPINE

	Rating
5235 Vertebral fracture or dislocation.	
5236 Sacroiliac injury and weakness.	
5237 Lumbosacral strain.	
5238 Spinal stenosis.	
5239 Spondylolisthesis or segmental instability.	
5240 Ankylosing spondylitis.	
5241 Spinal fusion.	
5242 Degenerative arthritis of the spine (see also diagnostic code 5003).	
5243 Intervertebral disc syndrome:	
Evaluate intervertebral disc syndrome (preoperatively or postoperatively) either on the total duration of incapacitating episodes over the past 12 months or by combining under § 4.25 evaluations under the General Rating Formula for Diseases and Injuries of the Spine along with evaluations for all other disabilities, whichever method results in the higher evaluation	
With incapacitating episodes having a total duration of at least six weeks during the past 12 months	60
With incapacitating episodes having a total duration of at least four weeks but less than six weeks during the past 12 months	40
With incapacitating episodes having a total duration of at least two weeks but less than four weeks during the past 12 months	20
With incapacitating episodes having a total duration of at least one week but less than two weeks during the past 12 months	10
Note (1): For purposes of evaluations under diagnostic code 5243, an incapacitating episode is a period of acute signs and symptoms due to intervertebral disc syndrome that requires bed rest prescribed by a physician and treatment by a physician.	
Note (2): If intervertebral disc syndrome is present in more than one spinal segment, provided that the effects in each spinal segment are clearly distinct, evaluate each segment on the basis of incapacitating episodes or under the General Rating Formula for Diseases and Injuries of the Spine, whichever method results in a higher evaluation for that segment.	
General Rating Formula for Diseases and Injuries of the Spine (including spinal stenosis, spondylolisthesis, lumbosacral strain, fracture or dislocation, spinal fusion, ankylosing spondylitis, sacroiliac injury and weakness, degenerative arthritis (see also diagnostic code 5003), and disc disease (if not evaluated based on incapacitating episodes):	
With symptoms such as pain (whether or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease and:	
Unfavorable ankylosis of the entire spine	100
Unfavorable ankylosis of the entire thoracolumbar spine	50
Unfavorable ankylosis of the entire cervical spine; or, forward flexion of the thoracolumbar spine 30 degrees or less; or, favorable ankylosis of the entire thoracolumbar spine	40
Forward flexion of the cervical spine 15 degrees or less; or, favorable ankylosis of the entire cervical spine	30
Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees; or, forward flexion of the cervical spine greater than 15 degrees but not greater than 30 degrees; or, the combined range of motion of the thoracolumbar spine not greater than 120 degrees; or, the combined range of motion of the cervical spine not greater than 170 degrees; or, muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis	20

THE SPINE—Continued

	Rating
Forward flexion of the thoracolumbar spine greater than 60 degrees but not greater than 85 degrees; or, forward flexion of the cervical spine greater than 30 degrees but not greater than 40 degrees; or, combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees; or, combined range of motion of the cervical spine greater than 170 degrees but not greater than 335 degrees; or, muscle spasm, guarding, or localized tenderness not resulting in abnormal gait or abnormal spinal contour; or, vertebral body fracture with loss of 50 percent or more of the height	10
No muscle spasm, guarding, or localized tenderness, and any limitation of motion less severe than the criteria for a 10-percent evaluation	0
Note (1): Evaluate any associated objective neurologic abnormalities, including, but not limited to, bowel or bladder impairment, separately, under an appropriate diagnostic code.	
Note (2): (*See* also Plate V.) For VA compensation purposes, normal forward flexion of the cervical spine is zero to 45 degrees, extension is zero to 45 degrees, left and right lateral flexion are zero to 45 degrees, and left and right lateral rotation are zero to 80 degrees. Normal forward flexion of the thoracolumbar spine is zero to 90 degrees, extension is zero to 30 degrees, left and right lateral flexion are zero to 30 degrees, and left and right lateral rotation are zero to 30 degrees. The combined range of motion refers to the sum of the range of forward flexion, extension, left and right lateral flexion, and left and right rotation. The normal combined range of motion of the cervical spine is 340 degrees and of the thoracolumbar spine is 240 degrees. The normal ranges of motion for each component of spinal motion provided in this note are the maximum that can be used for calculation of the combined range of motion.	
Note (3): In exceptional cases, an examiner may state that because of age, body habitus, neurologic disease, or other factors not the result of disease or injury of the spine, the range of motion of the spine in a particular individual should be considered normal for that individual, even though it does not conform to the normal range of motion stated in Note (2). Provided that the examiner supplies an explanation, the examiner's assessment that the range of motion is normal for that individual will be accepted.	
Note (4): Round each range of motion measurement to the nearest five degrees.	
Note (5): For VA compensation purposes, unfavorable ankylosis is a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the costal margin on the abdomen; dyspnea or dysphagia; atlantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. Fixation of a spinal segment in neutral position (zero degrees) always represents favorable ankylosis.	
Note (6): Separately evaluate disability of the thoracolumbar and cervical spine segments, except when there is unfavorable ankylosis of both segments, which will be rated as a single disability.	

BILLING CODE 8320–01–P



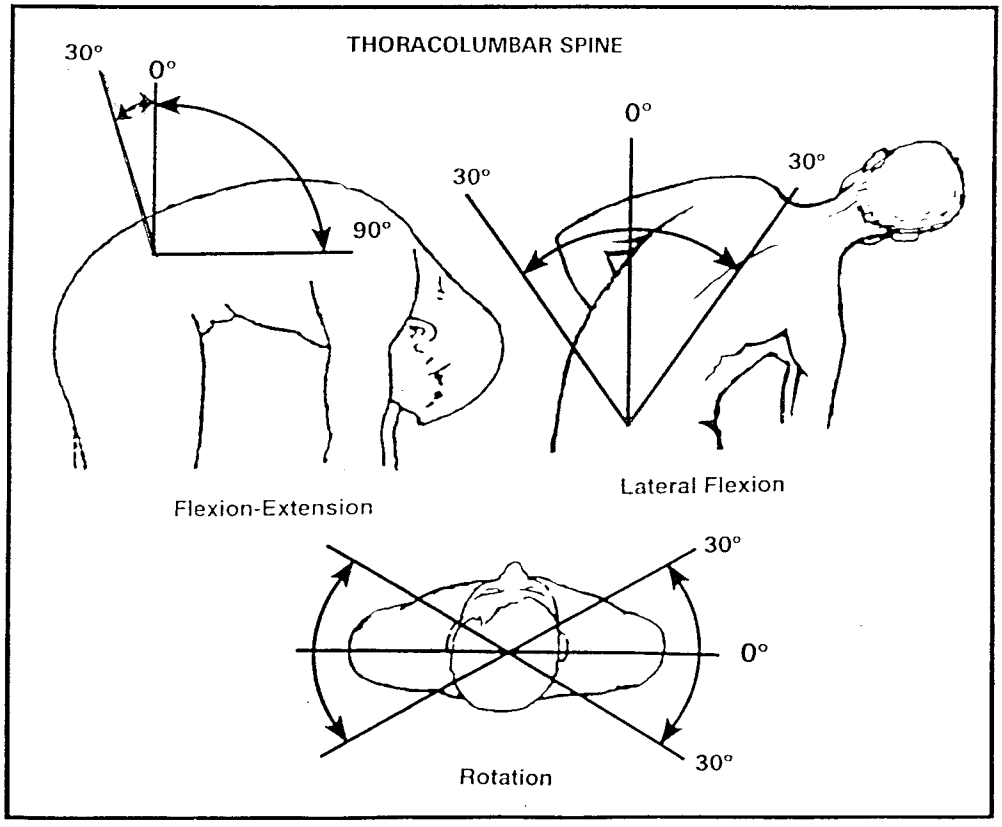


PLATE V
RANGE OF MOTION OF CERVICAL AND THORACOLUMBAR SPINE

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

[FR Doc. 02–22440 Filed 9–3–02; 8:45 am]

BILLING CODE 8320–01–C

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

[Docket No. 020816198–2198–01; I.D. 071202A]

RIN 0648–AP41

Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Fishery Management Plan for the Shrimp Fishery off the Southern Atlantic States; Amendment 5

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Proposed rule; request for comments.

SUMMARY: NMFS issues this proposed rule to implement Amendment 5 to the Fishery Management Plan for the Shrimp Fishery off the Southern Atlantic States (FMP). This proposed rule would establish a limited access program for the rock shrimp fishery in the exclusive economic zone (EEZ) off Georgia and off the east coast of Florida (limited access area), establish a minimum mesh size for a rock shrimp trawl net in the limited access area, require the use of an approved vessel monitoring system (VMS) by vessels allowed to fish for rock shrimp in the limited access program, and require an operator of a vessel in the rock shrimp fishery in the EEZ off the southern Atlantic states (North Carolina through the east coast of Florida) to have an operator permit. The intended effects are to minimize additional increases in harvesting capacity in the rock shrimp fishery; reduce the bycatch of small, unmarketable rock shrimp; enhance compliance with fishery management regulations; improve protection of essential fish habitat, including an area that contains the last 20 acres (8 hectares) of intact Oculina coral remaining in the world; and ensure the long-term economic viability of the rock shrimp industry.

DATES: Comments on this proposed rule must be received no later than 5 p.m., eastern time, on October 21, 2002.

ADDRESSES: Copies of Amendment 5 may be obtained from the South Atlantic Fishery Management Council, One Southpark Circle, Suite 306, Charleston, SC 29407–4699; phone: 843–571–4366; fax: 843–769–4520; e-mail: *safmc@noaa.gov*. Amendment 5 includes a Final Supplemental Environmental Impact Statement, an Initial Regulatory Flexibility Analysis, a Regulatory Impact Review, and a Social Impact Assessment/Fishery Impact Statement.

Written comments on this proposed rule must be mailed to Dr. Peter Eldridge, Southeast Region, NMFS, 9721 Executive Center Drive N., St. Petersburg, FL 33702. Comments also may be sent via fax to 727–570–5583. Comments will not be accepted if submitted via e-mail or Internet.

Written comments regarding the burden-hour estimates or other aspects of the collection-of-information requirements contained in this proposed rule may be submitted to Robert Sadler, Southeast Regional Office, NMFS, 9721 Executive Center Drive N., St. Petersburg, FL 33702, and to the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), Washington, DC 20503 (Attention: NOAA Desk Officer).

FOR FURTHER INFORMATION CONTACT: Dr. Peter J. Eldridge; phone: 727–570–5305; fax: 727–570–5583; e-mail: *Peter.Eldridge@noaa.gov*.

SUPPLEMENTARY INFORMATION: The shrimp fishery off the southern Atlantic states is managed under the FMP. The FMP was prepared by the South Atlantic Fishery Management Council (Council) and is implemented under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) by regulations at 50 CFR part 622.

Limited Access

Background

In its March 2001 preliminary qualitative analysis of federally managed fisheries, NMFS classified the rock shrimp fishery off the southern Atlantic states as one of the fisheries where there are indications of over-capacity. With over-capacity as well as open access to the fishery, any gains in the health of the stocks would likely attract new entrants to the fishery and an increase in harvesting capacity by those already in the fishery. This increased effort due to unrestricted new entry to the fishery could threaten the long-term economic viability of the rock shrimp industry and would increase bycatch in the fishery. Accordingly, Amendment 5 proposes a limited access program for the fishery off Georgia and the east coast of Florida to minimize such adverse impacts. The center of abundance and the concentrated commercial fishery for rock shrimp is off northeast Florida and extends to the waters off Georgia. To further address bycatch in this fishery, NMFS has initiated a voluntary onboard observer program consistent with the recommendation in Amendment 5.

The current requirement for a Federal vessel permit for the rock shrimp fishery in the EEZ off the southern Atlantic states, i.e., from the Virginia/North Carolina border through the east coast of Florida, remains in effect. However, in addition, to participate in the fishery off Georgia and the east coast of Florida, vessel owners would be required to obtain a limited access endorsement for South Atlantic rock shrimp. Limited access endorsements would be required effective 180 days after the final rule containing this measure is published.

Initial Eligibility for Limited Access Endorsements

Initially, the Regional Administrator, Southeast Region, NMFS (RA) would issue limited access endorsements to owners of vessels that had valid Federal permits for South Atlantic rock shrimp on or before December 31, 2000, and that had landings of rock shrimp from the South Atlantic EEZ of at least 15,000 lb (6,804 kg) during any one of the calendar years 1996 through 2000. Vessels that had Federal permits for South Atlantic rock shrimp would be determined solely from NMFS' permit records. Federal permits were required in the fishery beginning November 1, 1996. Claimed landings would be verified from landings data in state or Federal database systems that were submitted on or before January 31, 2001. Only landings when a vessel had a valid Federal permit for rock shrimp, that were harvested from the South Atlantic EEZ, and that were landed and sold in compliance with state and Federal regulations would be used to establish eligibility.

Credit for Historical Landings

For the purpose of initial eligibility for a limited access endorsement for South Atlantic rock shrimp, the owner of a vessel that had a permit for South Atlantic rock shrimp during the qualifying period would retain the rock shrimp landings record of that vessel during the time of his/her ownership, unless, prior to the publication of the final rule implementing this amendment, a sale of the vessel included a written agreement stating that credit for those qualifying landings was transferred to the new owner. Qualifying landings would be landings of at least 15,000 lb (6,804 kg) in any