analyzed this proposed rule under that Order and have determined that it does not have implications for federalism.

6. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

7. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this proposed rule would not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

8. Taking of Private Property

This proposed rule would not cause a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

9. Civil Justice Reform

This proposed rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

10. Protection of Children From Environmental Health Risks

We have analyzed this proposed rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This proposed rule is not economically significant and would not create an environmental risk to health or risk to safety that might disproportionately affect children.

11. Indian Tribal Governments

This proposed rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it would not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

12. Energy Effects

We have analyzed this proposed rule under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use.

13. Technical Standards

This proposed rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

14. Environment

We have analyzed this proposed rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) 42 U.S.C. 4321–4370f), and have made a preliminary determination that this action is one of a category of actions which do not individually or cumulatively have a significant effect on the human environment. This proposed rule involves the establishment of a safety zone around an OCS facility to protect life, property and the marine environment. This proposed rule is categorical excluded from further review, under figure 2–1, paragraph (34)(g), of the Commandant Instruction. A preliminary environmental analysis checklist supporting this determination and the Categorical Exclusion Determination are available in the docket where indicated under **ADDRESSES**. We seek any comments or information that may lead to the discovery of a significant environmental impact from this proposed rule.

List of Subjects in 33 CFR Part 147

Continental shelf, Marine safety, Navigation (water).

For the reasons discussed in the preamble, the Coast Guard proposes to amend 33 CFR part 147 as follows:

PART 147—SAFETY ZONES

■ 1. The authority citation for part 147 continues to read as follows:

Authority: 14 U.S.C. 85; 43 U.S.C. 1333; and Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 147.863 to read as follows:

§ 147.863 Turritella FPSO System Safety Zone.

(a) *Description.* The Turritella, a Floating Production, Storage and Offloading (FPSO) system is proposed to be installed in the deepwater area of the Gulf of Mexico at Walker Ridge 551. The FPSO can swing in a 360 degree arc around the center point of the turret buoy's swing circle at 26°25′38.74″ N, 90°48′45.34″ W, and the area within 500 meters (1640.4 feet) around the stern of the FPSO when it is moored to the turret buoy is a safety zone. If the FPSO detaches from the turret buoy, the area within 500 meters (1640.4 feet) around the center point at 26°25′38.74″ N, 90°48′45.34″ W is a safety zone.

(b) *Regulation.* No vessel may enter or remain in this safety zone except the following:

(1) An attending vessel;

(2) A vessel under 100 feet in length overall not engaged in towing; or

(3) A vessel authorized by the Commander, Eighth Coast Guard District.

Dated: June 7, 2015.

David R. Callahan,

Rear Admiral, U.S. Coast Guard, Commander, Eighth Coast Guard District.

[FR Doc. 2015–18397 Filed 7–27–15; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AP08

Schedule for Rating Disabilities; Dental and Oral Conditions

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend the portion of the VA Schedule for Rating Disabilities (VASRD or rating schedule) that addresses dental and oral conditions. The purpose of these changes is to incorporate medical advances that have occurred since the last amendment, update current medical terminology, and provide clear evaluation criteria for application of this portion of the rating schedule. The proposed rule reflects advances in medical knowledge, recommendations from the Dental and Oral Conditions Work Group (Work Group), which is comprised of subject matter experts from both the Veterans Benefits Administration (VBA) and the Veterans Health Administration (VHA), and comments from experts and the public gathered as part of a public forum. The public forum, focusing on revisions to the dental and oral conditions section of the VASRD, was held on January 25—26, 2011.

DATES: Comments must be received by VA on or before September 28, 2015.

ADDRESSES: Written comments may be submitted through *www.regulations.gov;* by mail or hand-delivery to Director, Regulations Management (02REG), Department of Veterans Affairs, 810 Vermont Ave. NW., Room 1068, Washington, DC 20420; or by fax to (202) 273–9026. Comments should indicate that they are submitted in response to ''RIN 2900–AP08—Schedule for Rating Disabilities; Dental and Oral Conditions.'' Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1068, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461–4902 for an appointment. (This is not a toll free number). In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at *www.regulations.gov*.

FOR FURTHER INFORMATION CONTACT: Ioulia Vvedenskaya, Medical Officer, Part 4 VASRD Regulations Staff (211C), Compensation Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Ave. NW., Washington, DC 20420, (202) 461–9700. (This is not a toll-free telephone number.)

SUPPLEMENTARY INFORMATION: As part of VA's ongoing revision of the VA Schedule for Rating Disabilities (VASRD or rating schedule), VA proposes changes to 38 CFR 4.150, which pertains to dental and oral conditions. The proposed changes will (1) update the medical terminology of certain dental and oral conditions, (2) add medical conditions not currently in the rating schedule, and (3) refine evaluation criteria based on medical advances that have occurred since the last revision and current understanding of functional changes associated with or resulting from disease or injury (pathophysiology).

Schedule of Ratings—Dental and Oral Conditions

Section 4.150 currently lists 16 diagnostic codes encompassing conditions involving dental and oral injury or disease. VA proposes to revise these codes, through addition, removal, and other revisions to reflect current medical science, terminology, and functional impairment.

VA proposes to add two notes at the beginning of § 4.150 to clarify updated medical terminology used later in the diagnostic codes. The first note would provide guidance to disability rating personnel regarding the evidence necessary to support the objective findings described in various diagnostic codes. The note states that, for VA compensation purposes, diagnostic imaging studies include, but are not limited to, conventional radiography (X-ray), computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), radionuclide bone scanning, or ultrasonography. The second note regards rating of residuals that, though part of the disease process for a dental or oral condition, cause functional incapacity which cannot be evaluated within the dental and oral conditions system. The note directs disability rating personnel to evaluate the particular functional impairment separately (*e.g.,* loss of vocal articulation, loss of smell, loss of taste, neurological impairment, respiratory dysfunction, and other impairments), and then apply § 4.25 to combine the evaluation with those assigned under the schedule of ratings for dental and oral conditions.

Diagnostic Code 9900, ''Maxilla or Mandible, Chronic Osteomyelitis or Osteoradionecrosis of:''

Current diagnostic code 9900 ''Maxilla or mandible, chronic osteomyelitis or osteoradionecrosis of,'' directs that such conditions be rated as chronic osteomyelitis under diagnostic code 5000. VA proposes to add osteonecrosis of the maxilla or mandible (jaw) as one of the diseases listed under diagnostic code 9900. Osteonecrosis of the jaw, commonly called ONJ, occurs when the jaw bone is exposed (not covered by the gums) and begins to deteriorate from a lack of bloodflow. Without adequate blood flow, the bone begins to weaken, break down, and die, which usually, causes pain. ONJ is associated with cancer treatments, infection, steroid use, or potent antiresorptive therapies that help prevent the loss of bone mass. Examples of potent antiresorptive therapies include bisphosphonates such as alendronate (*Fosamax*); risedronate (*Actonel*); and ibandronate (*Boniva*). While ONJ is linked with these conditions, it also can occur without clearly identifiable risk factors. *Osteonecrosis of the Jaw,* American College of Rheumatology *http://www.rheumatology.org/practice/clinical/patients/diseases_and_conditions/onj.asp* (last updated Sept. 2012). This proposed addition will facilitate assignment of appropriate disability evaluations to veterans who are suffering from osteonecrosis of the jaw (maxilla or mandible).

Diagnostic Codes 9902 ''Mandible, Loss of Approximately One-Half,'' 9906 ''Ramus, Loss of Whole or Part of,'' and 9907 ''Ramus, Loss of Less Than One-Half the Substance of, Not Involving Loss of Continuity''

Current diagnostic codes 9902 ''Mandible, loss of approximately one-half''; 9906 ''Ramus, loss of whole or part of''; and 9907 ''Ramus, loss of less than one-half the substance of, not involving loss of continuity'' address impairments associated with various degrees of mandible loss. Loss of approximately one-half of the mandible, involving temporomandibular articulation, is currently evaluated at 50 percent; if temporomandibular articulation is not involved, it is evaluated at 30 percent. Loss of whole or part of the ramus, involving loss of temporomandibular articulation bilaterally, is currently evaluated at 50 percent; the same disability presented unilaterally is currently evaluated at 30 percent. Without loss of temporomandibular articulation, loss of whole or part of the ramus is evaluated at 30 percent bilaterally and 20 percent unilaterally. Loss of less than one-half the substance of the ramus, not involving loss of continuity, is currently evaluated at 20 percent bilaterally and 10 percent unilaterally.

The mandible is viewed as a single functional unit that consists of the mandibular body and the mandibular rami. The anterior portion of the mandible, called the body, is horseshoe-shaped and runs horizontally. At the posterior ends of the body are two vertical extensions called rami (singular, ramus). The Work Group recognized that, because the ramus is a portion of the mandible, impairments of the ramus should be rated as impairments of the mandible as a whole. Therefore, proposed diagnostic code 9902, ''Mandible, loss of, including ramus, unilaterally or bilaterally,'' combines evaluations currently done under diagnostic codes 9902, 9906, and 9907 to better reflect the current understanding of anatomy, physiology, and disability due to the disease or injury of the mandible, including the rami. Furthermore, the disabling effect of the loss of different portions of the mandible has been combined in light of its anatomy and the usual reconstruction goals. The proposed rating criteria also reflect the function of the portions of the mandible, providing higher evaluations for the loss of the joint than for areas that do not disrupt continuity. Mehta R.P. *et al., Mandibular Reconstruction in 2004: An Analysis of Different Techniques,*

http://www.ncbi.nlm.nih.gov/pubmed/15252248.

The reconstruction of oromandibular defects (mandibular reconstruction) presents a significant surgical challenge. Mandibular deformities and defects may result from trauma, infections, prior radiation exposure, and neoplasms (tumors); most mandibular deformities result from surgical excision of tumors. The mandible plays a major role in airway protection and support of the tongue, lower dentition (teeth), and the muscles of the floor of the mouth permitting chewing, swallowing, speaking, and respiration. It also defines the contour of the lower third of the face. Interruption of mandibular continuity, therefore, produces both a cosmetic and functional deformity. The resulting dysfunction after loss of part of the mandible varies from minimal to major. In order to achieve successful mandibular reconstruction, the reconstructive surgeon must attempt to restore bony continuity and facial contour, maintain tongue mobility, and attempt to restore sensation to the affected areas. In addition, oral and dental rehabilitation postoperatively is important to improve the patient's ability to manipulate the food bolus, swallow, and articulate speech. Jesse E. Smith et al., *Mandibular Plating,* Medscape, *http://emedicine.medscape.com/article/881542-overview* (last updated Dec. 19, 2014).

In light of these disabling effects of mandibular loss and advances in reconstruction of the oral cavity, VA proposes additional levels of disability to recognize greater functional impairment where mandibular loss cannot be replaced by prostheses. VA proposes a 70 percent evaluation for the loss of one-half or more of the mandible, involving temporomandibular articulation, where the loss is not replaceable by prosthesis. VA proposes a 50 percent evaluation for the same anatomical loss, where it is replaceable by prosthesis. VA proposes a 40 percent evaluation for the loss of one-half or more of mandible, not involving temporomandibular articulation, where the loss is not replaceable by prosthesis, and a 30 percent evaluation for the same anatomical loss, where it is replaceable by prosthesis. VA differentiates the evaluations involving one-half or more of the mandible, whether or not involving temporomandibular articulation, on the basis of whether or not they are replaceable by prosthesis because large, complex defects where a prosthesis is not suitable present greater functional and cosmetic impairments.

VA proposes a 70 percent evaluation for the loss of less than one-half of the mandible, involving temporomandibular articulation, where the loss is not replaceable by prosthesis. VA proposes a 50 percent evaluation for the same anatomical loss, where it is replaceable by prosthesis. VA proposes a 20 percent evaluation for the loss of less than one-half of mandible, not involving temporomandibular articulation, where the loss is not replaceable by prosthesis, and a 10 percent evaluation for the same anatomical loss, where it is replaceable by prosthesis. VA differentiates the evaluations involving less than one-half of the mandible, whether or not involving temporomandibular articulation, on the basis of whether or not they are replaceable by prosthesis because large, complex defects where a prosthesis is not suitable present greater functional and cosmetic impairments.

Consequently, VA proposes to delete existing diagnostic codes 9906 ''Ramus, loss of whole or part of:'' and 9907 ''Ramus, loss of less than one-half the substance of, not involving loss of continuity:'' while incorporating relevant evaluation criteria into revised diagnostic code 9902 ''Mandible, loss of, including ramus, unilaterally or bilaterally.''

Diagnostic Code 9903 ''Mandible, Nonunion of, Confirmed by Diagnostic Imaging Studies:''

Current diagnostic code 9903 addresses impairments associated with nonunion of the mandible. Severe and moderate nonunion of the mandible are currently rated at 30 percent and 10 percent, respectively, and evaluation is dependent upon the degree of motion and relative loss of masticatory function. However, the current rating criteria do not reflect modern medical terminology because a nonunion occurs when the mandible does not heal in an appropriate time frame and the result is mobility of the fracture segments present after an adequate healing phase. In addition, if the mandibular fragments are not immobilized properly immediately after fracture, or treatment is delayed, a fibrous union (*i.e.,* nonunion) is formed and radiographic evidence is often needed to make this determination. Edward W. Chang et al., *General Principles of Mandible Fracture and Occlusion,* Medscape, *http://emedicine.medscape.com/article/868375-overview* (last updated Mar. 28, 2014).

Therefore, VA proposes to re-title diagnostic code 9903 as ''Mandible, nonunion of, confirmed by diagnostic imaging studies:'' and base newly developed rating criteria on a better understanding of anatomy, physiology, and functional impairment of the mandibular nonunion. Under proposed diagnostic code 9903, mandibular nonunion would warrant a 30 percent evaluation with the presence of false motion, which is considered severe, or a 10 percent evaluation if there is no false motion, which is considered moderate. In addition, VA proposes to delete the note under current diagnostic code 9903.

Diagnostic Code 9904 ''Mandible, Malunion of:''

Currently, malunion of mandible where severe, moderate, and slight displacement is present is rated at 20, 10, and 0 percent, respectively, and is dependent upon degree of motion and relative loss of masticatory function. However, the current rating criteria do not reflect modern medical terminology because malunion refers to improper alignment of the healed bony segments where the normal anatomic structure is not restored because of unsatisfactory reduction and the result is abnormal occlusion (*i.e.,* open bite) and joint function. Edward W. Chang et al., *General Principles of Mandible Fracture and Occlusion,* Medscape, *http://emedicine.medscape.com/article/868375-overview* (last updated Mar. 28, 2014).

Therefore, VA proposes to base newly developed rating criteria on a better understanding of anatomy, physiology, and functional impairment of the mandibular malunion. Under proposed diagnostic code 9904, mandibular malunion with displacement causing severe or moderate anterior or posterior open bite resulting in displacement would warrant 20 and 10 percent evaluations respectively. A 0 percent evaluation would be assigned for mandibular malunion resulting in displacement that does not cause anterior or posterior open bite. In addition, VA proposes to delete the note under diagnostic code 9904. The proposed rating criteria are based on measurable signs of functional impairment and incorporate all elements of disability evaluation in cases of mandibular malunion.

Diagnostic Code 9905 ''Temporomandibular Disorder.''

Diagnostic code 9905 is currently titled ''Temporomandibular articulation, limited motion of,'' which represents outdated medical terminology. The term TMJ is actually an abbreviation for the longer anatomical term—temporomandibular joint. Unfortunately, over the years, the term

TMJ has developed into a long misunderstood and yet commonly used acronym in the vocabulary of both doctors and patients alike. As a result of this common misappropriation of terminology, in the last several years there has been a concerted effort on the part of the medical profession to change the acronym to TMD (temporomandibular disorder) in an effort to more accurately reflect that which is more often being discussed. The American Association of Oral and Maxillofacial Surgeons (AAOMS) has recognized TMD as appropriate terminology for the group of disorders affecting the temporomandibular joint.

VA proposes to retitle diagnostic code 9905 as ''Temporomandibular disorder (TMD),'' which is consistent with current medical terminology. TMD refers to a collection of medical and dental conditions affecting the temporomandibular joint and/or the muscles of mastication, as well as contiguous tissue components. Although specific etiologies such as degenerative arthritis and trauma underlie some TMD, as a group these conditions have no common etiology or biological explanation and comprise a diverse group of health problems whose signs and symptoms are overlapping, but not necessarily identical. *Temporomandibular Disorders (TMD),* American Academy of Orofacial Pain, *https://s3.amazonaws.com/ClubExpressClubFiles/508439/documents/AAOP_Brochure_-_TMD_Revision_3-27-2014.pdf?AWSAccessKeyId=AKIAIB6I23VLJX7E4J7Q&Expires=1435244199&response-content-disposition=inline%3B%20filename%3DAAOP_Brochure_-_TMD_Revision_3-27-2014.pdf&Signature=Jb117XxOWMO%2FT5tFkXgZ9MobBG0%3D* (last visited Jun. 25, 2015).

Under current diagnostic code 9905, motion limitation for temporomandibular articulation is measured solely as loss of interincisal opening and lateral excursive distance, where ratings for limited interincisal movement are not combined with ratings for limited lateral excursion. Current diagnostic code 9905 provides for the following evaluations: A 40 percent evaluation with interincisal range from 0 to 10 mm (millimeters); a 30 percent evaluation with interincisal range from 11 to 20 mm; a 20 percent evaluation with interincisal range from 21 to 30 mm; a 10 percent evaluation with interincisal range from 31 to 40 mm; and a 10 percent evaluation with lateral excursion of 0 to 4 mm.

The understanding of what constitutes disability due to TMD and how to quantify the contributory components has evolved. Charles F. Guardia et al., *Temporomandibular Disorders,* Medscape, *http://emedicine.medscape.com/article/1143410-overview#showall* (last updated Jan. 7, 2014). The Work Group developed rating criteria that takes into account restriction of diet and limitation of mouth opening in the evaluation of functional impairment due to TMD.

In addition, VA proposes to revise the rating criteria according to the current indicators of normal range of mouth opening measured by vertical (inter-incisal) opening. *Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region,* American Association of Oral and Maxillofacial Surgeons, *http://www.astmjs.org/impairment.html.* Under proposed diagnostic code 9905, 10 mm of maximum unassisted vertical opening with dietary restrictions to all mechanically altered foods would warrant a 50 percent evaluation; 10 mm of maximum unassisted vertical opening without dietary restrictions to mechanically altered foods would warrant a 40 percent evaluation; 20 mm of maximum unassisted vertical opening with dietary restrictions to all mechanically altered foods would warrant a 40 percent evaluation; 20 mm of maximum unassisted vertical opening without dietary restrictions to mechanically altered foods would warrant a 30 percent evaluation; 29 mm of maximum unassisted vertical opening with dietary restrictions to full liquid and pureed foods would warrant a 40 percent evaluation; 29 mm of maximum unassisted vertical opening with dietary restrictions to soft and semi-solid foods would warrant a 30 percent evaluation; 29 mm of maximum unassisted vertical opening without dietary restrictions to mechanically altered foods would warrant a 20 percent evaluation; 34 mm of maximum unassisted vertical opening with dietary restrictions to full liquid and pureed foods would warrant a 30 percent evaluation; 34 mm of maximum unassisted vertical opening with dietary restrictions to soft and semi-solid foods would warrant a 20 percent evaluation; 34 mm of maximum unassisted vertical opening without dietary restrictions to mechanically altered foods would warrant a 10 percent evaluation. VA proposes retaining the current criteria at 10 percent for lateral excursion limited to 0 to 4 mm, in addition to adding the 10 percent evaluation for 34 mm of maximum unassisted vertical opening without dietary restrictions to mechanically altered foods.

The additional criteria were added to integrate the use of mechanically altered foods that allows for more accurate assessment of functional capacity in cases of temporomandibular disorder that requires texture-modified diets. Furthermore, properly prepared texture-modified diets can help improve or maintain the nutritional status of a patient who requires a texture-modified diet. Evidence-Based Nutrition Practice Guidelines and Evidence-Based Toolkits developed by the Academy of Nutrition and Dietics (formerly American Dietetic Association) defines mechanically altered foods as altered by blending, chopping, grinding or mashing so that they are easy to chew and swallow (*i.e.,* full liquid, puree, soft and semisolid foods). Academy of Nutrition and Dietics, Level 2 Nutrition Therapy for Dysphagia: Mechanically Altered Foods, *http://nutritioncaremanual.org/vault/editor/Docs/Level%202%20NT%20for%20Dysphagia_MechAltered.pdf* (last visited Jun. 3, 2015).

In addition to the existing note, VA proposes to add two notes under diagnostic code 9905 to provide comprehensive guidance to disability rating personnel. The existing note would be redesignated as Note (1). Note (2) would provide that the normal maximum unassisted range of vertical jaw opening is from 35 to 50 mm, which is based on current guidelines to the evaluation of impairment of the oral and maxillofacial region. *Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region,* American Association of Oral and Maxillofacial Surgeons, *http://www.astmjs.org/impairment.html* (last visited Jun. 3, 2015). The guidance on consideration of texture-modified diets is provided in proposed note (3). Proposed note (3) would define ''mechanically altered foods'' as altered by blending, chopping, grinding or mashing so that they are easy to chew and swallow, specifically full liquid, puree, soft and semisolid foods. Finally, proposed note (3) instructs disability rating specialists that, in order to warrant a rating elevation based on mechanically altered foods, a physician must record or verify the use of texture-modified diets.

Diagnostic Code 9911 ''Hard Palate, Loss of:''

Current diagnostic codes 9911 ''Hard palate, loss of half or more:'' and 9912 ''Hard palate, loss of less than half of:'' address loss of the hard palate. VA proposes to restructure the current rating criteria and combine evaluations presently done under these two codes

into proposed diagnostic code 9911, titled ''Hard palate, loss of:'' for ease of use. No change to the evaluation criteria is proposed.

Diagnostic Code 9916 ''Maxilla, Malunion or Nonunion of:''

Current diagnostic code 9916 addresses impairments associated with malunion or nonunion of maxilla. Currently, severe displacement due to malunion or nonunion of maxilla warrants a 30 percent evaluation, while moderate and slight displacement warrant 10 and 0 percent evaluations, respectively. However, the current criteria do not reflect modern medical terminology and do not take into account advances in the understanding of anatomy and physiology of maxillary fractures and its residuals. Kris S. Moe et al., *Maxillary and Le Fort Fractures,* Medscape, *http://emedicine.medscape.com/article/1283568-overview* (last updated Dec. 3, 2013).

Therefore, VA proposes to restructure the rating criteria to recognize the various aspects of maxillary fractures and their functional outcomes. Specifically, in cases of nonunion, the mobility of the maxillary fracture segments is the key sign of nonunion; therefore, disability evaluations would be based on the presence or absence of false motion. In cases of malunion, improper alignment of the healed bony segments, which result in abnormal occlusion (*i.e.,* open bite) and joint function, is the principal component of functional impairment due to maxillary malunion; therefore, disability evaluations would be based on the degree of displacement of bony segments, which cause various degrees of open bite.

Under proposed diagnostic code 9916, maxillary nonunion with false motion present would warrant a 30 percent evaluation. A 10 percent evaluation would be assigned for maxillary nonunion without false motion.

Under proposed diagnostic code 9916, maxillary malunion with displacement that causes severe or moderate anterior or posterior open bite would warrant 30 and 10 percent evaluations, respectively. A 0 percent evaluation would be assigned for maxillary malunion with displacement that causes mild anterior or posterior open bite. For the sake of clarity for disability rating personnel, VA proposes to insert a new note stating that, for VA compensation purposes, the severity of maxillary nonunion is dependent upon the degree of abnormal mobility of maxilla fragments following treatment (*i.e.,* presence or absence of false motion), and that maxillary nonunion has to be confirmed by diagnostic imaging studies. Maxillary nonunion is difficult to diagnose without diagnostic imaging studies because fibrosis makes nonunions semi-stable and mimic healed bone upon physical examination. Thus, diagnostic imaging is necessary for a diagnosis of nonunion.

New Diagnostic Codes

VA also proposes to add two new diagnostic codes in order to account for impairment due to benign and malignant oral lesions (neoplasms). Nader Sadeghi et al., *Malignant Tumors of the Palate,* Medscape, *http://emedicine.medscape.com/article/847807-overview* (last updated Apr. 22, 2015). Surgical resections of benign and malignant tumors often create large defects accompanied by dysfunction and disfigurement, and radiation therapy produces significant morbidity and unique tissue-management problems. Therefore, disabilities resulting from various treatments for benign and malignant neoplasms shall be rated based on residuals such as loss of supporting structures (bone or teeth) and/or functional impairment due to scarring.

Proposed diagnostic code 9917, titled ''Neoplasm, hard and soft tissue, benign,'' directs that such conditions be rated as loss of supporting structures (bone or teeth) and/or functional impairment due to scarring. Proposed diagnostic code 9918, titled ''Neoplasm, hard and soft tissue, malignant,'' directs that such conditions be rated at 100 percent. The note following diagnostic code 9918 would state that the rating of 100 percent shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedure and that, six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. The note would also state that any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of 38 CFR 3.105(e). Lastly, the note would direct rating personnel to evaluate based on residuals, such as loss of supporting structures and/or functional impairment due to scarring, if there has been no local recurrence or metastasis.

Paperwork Reduction Act

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

Regulatory Flexibility Act

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

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a ''significant regulatory action,'' which requires review by the Office of Management and Budget (OMB), unless OMB waives such review, as ''any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order.''

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined, and it has been determined not to be a significant regulatory action under Executive Order 12866. VA's impact analysis can be found as a supporting document at *http://www.regulations.gov,* usually within 48 hours after the rulemaking

document is published. Additionally, a copy of the rulemaking and its impact analysis are available on VA's Web site at *http://www.va.gov/orpm/,* by following the link for VA Regulations Published From FY 2004 Through Fiscal Year to Date.

Unfunded Mandates

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

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.011, Veterans Dental Care, and 64.109, Veterans Compensation for Service-Connected Disability.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Robert L. Nabors, II, Chief of Staff, approved this document on June 30, 2015, for publication.

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

Dated: July 9, 2015.

William F. Russo,

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

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

PART 4—SCHEDULE FOR RATING DISABILITIES

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

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

Subpart B—Disability Ratings

■ 2. Amend § 4.150 by revising the entries for diagnostic codes 9900, 9902–9905, 9911, 9916; adding Notes 1 and 2, diagnostic codes 9917 and 9918; and removing diagnostic codes 9906, 9907, and 9912.

The revisions and addtions read as follows:

§ 4.150 Schedule of ratings—dental and oral conditions.

Note (1): For VA compensation purposes, diagnostic imaging studies include, but are not limited to, conventional radiography (X-ray), computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), radionuclide bone scanning, or ultrasonography.

Note (2): Separately evaluate loss of vocal articulation, loss of smell, loss of taste, neurological impairment, respiratory dysfunction, and other impairments under the appropriate diagnostic code and combine under § 4.25 for each separately rated condition.

9900 Maxilla or mandible, chronic osteomyelitis, osteonecrosis or osteoradionecrosis of:
Rate as osteomyelitis, chronic under diagnostic code 5000.

* * * * * * *

9902 Mandible loss of, including ramus, unilaterally or bilaterally:	
Loss of one-half or more,	
Involving temporomandibular articulation.	
Not replaceable by prosthesis	70
Replaceable by prosthesis	50
Not involving temporomandibular articulation.	
Not replaceable by prosthesis	40
Replaceable by prosthesis	30
Loss of less than one-half,	
Involving temporomandibular articulation.	
Not replaceable by prosthesis	70
Replaceable by prosthesis	50
Not involving temporomandibular articulation.	
Not replaceable by prosthesis	20
Replaceable by prosthesis	10
9903 Mandible, nonunion of, confirmed by diagnostic imaging studies:	
Severe, with false motion	30
Moderate, without false motion	10
9904 Mandible, malunion of:	
Displacement, causing severe anterior or posterior open bite	20
Displacement, causing moderate anterior or posterior open bite	10
Displacement, not causing anterior or posterior open bite	0
9905 Temporomandibular disorder (TMD).	
Interincisal range:	
10 millimeters (mm) of maximum unassisted vertical opening.	
With dietary restrictions to all mechanically altered food	50
Without dietary restrictions to mechanically altered foods	40
20 mm of maximum unassisted vertical opening.	
With dietary restrictions to all mechanically altered foods	40
Without dietary restrictions to mechanically altered foods	30
29 mm of maximum unassisted vertical opening.	
With dietary restrictions to full liquid and pureed foods	40
With dietary restrictions to soft and semi-solid foods	30
Without dietary restrictions to mechanically altered foods	20
34 mm of maximum unassisted vertical opening.	
With dietary restrictions to full liquid and pureed foods	30

With dietary restrictions to soft and semi-solid foods	20
Without dietary restrictions to mechanically altered foods	10
Lateral excursion range of motion:	
0 to 4 mm	10

Note (1): Ratings for limited interincisal movement shall not be combined with ratings for limited lateral excursion.
Note (2): For VA compensation purposes, the normal maximum unassisted range of vertical jaw opening is from 35 to 50 mm.
Note (3): For VA compensation purposes, mechanically altered foods are defined as altered by blending, chopping, grinding or mashing so that they are easy to chew and swallow. There are four levels of mechanically altered foods: full liquid, puree, soft, and semisolid foods. To warrant elevation based on mechanically altered foods, the use of texture-modified diets must be recorded or verified by a physician.

* * * * * * *

9911 Hard palate, loss of:	
Loss of half or more, not replaceable by prosthesis	30
Loss of less than half, not replaceable by prosthesis	20
Loss of half or more, replaceable by prosthesis	10
Loss of less than half, replaceable by prosthesis	0

* * * * * * *

9916 Maxilla, malunion or nonunion of:	
Nonunion,	
with false motion	30
without false motion	10
Malunion,	
with displacement, causing severe anterior or posterior open bite	30
with displacement, causing moderate anterior or posterior open bite	10
with displacement, causing mild anterior or posterior open bite	0

Note: For VA compensation purposes, the severity of maxillary nonunion is dependent upon the degree of abnormal mobility of maxilla fragments (i.e., presence or absence of false motion), and maxillary nonunion must be confirmed by diagnostic imaging studies.

9917 Neoplasm, hard and soft tissue, benign.	
Rate as loss of supporting structures (bone or teeth) and/or functional impairment due to scarring.	
9918 Neoplasm, hard and soft tissue, malignant	100

Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals such as loss of supporting structures (bone or teeth) and/or functional impairment due to scarring.

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

■ 3. Amend Appendix A to Part 4 by revising the entries for diagnostic codes 9900, 9902, 9903, 9905, 9911, 9916; adding diagnostic codes 9904, 9917 and 9918; and removing diagnostic codes 9906, 9907, and 9912 to read as follows:

APPENDIX A TO PART 4—TABLE OF AMENDMENTS AND EFFECTIVE DATES SINCE 1946

Sec.	Diagnostic Code No.	
* * *	*	* * * *
* * *	*	* * * *
	9900	Criterion September 22, 1978; criterion February 17, 1994; title [*effective date of final rule*].
* * *	*	* * * *
	9902	Criterion February 17, 1994; evaluation [*effective date of final rule*]; title *[effective date of final rule*].
	9903	Criterion February 17, 1994; evaluation [*effective date of final rule*]; title [*effective date of final rule*].
	9904	Criterion [*effective date of final rule*].
	9905	Criterion September 22, 1978; evaluation February 17, 1994; evaluation [*effective date of final rule*]; title [*effective date of final rule*].
	9906	Removed [*effective date of final rule*].
	9907	Removed [*effective date of final rule*].
* * *	*	* * * *
	9911	Criterion and title [*effective date of final rule*].
	9912	Removed [*effective date of final rule*].
* * *	*	* * * *
	9916	Added February 17, 1994; criterion [*effective date of final rule*].
	9917	Added [*effective date of final rule*].
	9918	Added [*effective date of final rule*].

APPENDIX A TO PART 4—TABLE OF AMENDMENTS AND EFFECTIVE DATES SINCE 1946—Continued

Sec.	Diagnostic Code No.					
*	*	*	*	*	*	*

■ 4. Amend Appendix B to Part 4 by revising the entries for diagnostic codes 9900, 9902, 9903, 9905, and 9911; adding 9917 and 9918; and removing 9906, 9907, and 9912.

The revisions read as follows:

APPENDIX B TO PART 4—NUMERICAL INDEX OF DISABILITIES

Diagnostic Code No.						
*	*	*	*	*	*	*

DENTAL AND ORAL CONDITIONS

9900 ..... Maxilla or mandible, chronic osteomyelitis, osteonecrosis or osteoradionecrosis of.						
*	*	*	*	*	*	*
9902 ..... Mandible loss of, including ramus, unilaterally or bilaterally.						
9903 ..... Mandible, nonunion of, confirmed by diagnostic imaging studies.						
*	*	*	*	*	*	*
9905 ..... Temporomandibular disorder (TMD).						
*	*	*	*	*	*	*
9911 ..... Hard palate, loss of.						
*	*	*	*	*	*	*
9917 ..... Neoplasm, hard and soft tissue, benign.						
9918 ..... Neoplasm, hard and soft tissue, malignant.						
*	*	*	*	*	*	*

■ 5. Amend Appendix C to Part 4 by revising the entries for diagnostic codes 9900, 9902, 9903, 9905, and 9911; adding 9917 and 9918; and removing 9906, 9907, and 9912.

The revisions and additions read as follows:

APPENDIX C TO PART 4—ALPHABETICAL INDEX OF DISABILITIES

						Diagnostic Code No.
*	*	*	*	*	*	*
Limitation of motion:						
Temporomandibular						9905
*	*	*	*	*	*	*
Mandible:						
Including ramus, unilaterally or bilaterally						9902
*	*	*	*	*	*	*
Loss of:						
Palate, hard						9911
*	*	*	*	*	*	*
Maxilla or mandible, chronic osteomyelitis, osteonecrosis or osteoradionecrosis of						9900
*	*	*	*	*	*	*
Neoplasms:						
Benign:						
*	*	*	*	*	*	*
Hard and soft tissue						9917

APPENDIX C TO PART 4—ALPHABETICAL INDEX OF DISABILITIES—Continued

	Diagnostic Code No.
* * * * * * *	
Malignant:	
* * * * * * *	
Hard and soft tissue	9918
* * * * * * *	
Nonunion:	
Mandible, confirmed by diagnostic imaging studies	9903
* * * * * * *	

[FR Doc. 2015–17266 Filed 7–27–15; 8:45 am]
BILLING CODE 8320–01–P

POSTAL REGULATORY COMMISSION

39 CFR Part 3017

[Docket No. RM2015–14; Order No. 2602]

Procedures Related to Commission Views

AGENCY: Postal Regulatory Commission.

ACTION: Proposed rulemaking.

SUMMARY: The Commission is proposing rules which establish the Commission's process for developing views to the Secretary of State on certain international mail matters. The proposed rules focus on those proposals concerning international mail that could affect a market dominant rate or classification. The Commission invites public comment on the proposed rules.

DATES: *Comments are due:* August 27, 2015. *Reply comments are due:* September 11, 2015.

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

SUPPLEMENTARY INFORMATION:

Table of Contents

I. Introduction
II. New Commission Responsibility Under the Postal Accountability and Enhancement Act (PAEA)
III. The Proposed Rules
IV. Section-by-Section Analysis
V. Administrative Actions
VI. Ordering Paragraphs

I. Introduction

This rulemaking addresses the Commission's process for developing views to the Secretary of State on certain international mail matters pursuant to 39 U.S.C. 407(c)(1).

The Commission develops its views mainly in the context of the United States' membership in the Universal Postal Union (UPU), the Secretary of State's lead role in international mail matters, and UPU procedures for regulating international mail. For purposes of developing its views, the Commission focuses on those proposals that could affect a market dominant rate or classification.

II. New Commission Responsibility Under the Postal Accountability and Enhancement Act (PAEA)

Under section 407(c)(1) of the PAEA, the Secretary of State, before concluding a treaty, convention, or amendment establishing a market dominant rate or classification, shall request the Commission's views on the consistency of such rate or classification with modern rate-setting criteria.[1] In the context of the UPU, the term ''rate'' typically refers to terminal dues.[2]

Since enactment of the PAEA, the Secretary of State has requested—and the Commission has transmitted—its views on relevant proposals considered at two UPU Congresses.[3] The Commission also has transmitted views to the Secretary of State on relevant proposals considered at the initial meeting of the Postal Operations Council following the 2008 and 2012 Congresses.[4]

III. The Proposed Rules

The development of the Commission's views entails review and analysis of numerous proposals, which typically are posted on the UPU Web site pursuant to a series of deadlines that begin about 6 months before a Congress convenes. In July 2012, based on an interest in obtaining public input, the Commission established a public inquiry docket to solicit comments on the general principles that should guide the development of its views in response to the anticipated request from the Secretary of State.[5]

The Commission proposes formalizing the general approach it adopted in 2012 by enacting rules providing for establishment of an umbrella public inquiry docket associated with each UPU Congress and related meetings. Each docket will be established on or about 150 days before the date the UPU Congress is scheduled to convene. This timeframe is designed to allow adequate time for commenters to prepare submissions (on general principles or on specific proposals, to the extent such proposals are available). It also should allow the Commission sufficient time to consider the comments and prepare its views.

The proposed rules also reflect the Commission's commitment to having the public inquiry docket serve as a mechanism for handling related matters, such as informing the public about the availability of relevant proposals, the Commission's views, or other documents. It also allows available documents to be incorporated into one

[1] *See* Postal Accountability and Enhancement Act, Public Law 109–435, 120 Stat. 3198 (2006), section 405(a). 39 U.S.C. 407(c)(1) refers to a product subject to subchapter I of chapter 36 of the title 39, United States Code. A product subject to the referenced chapter is a market dominant product. Section 407(c)(1) also refers to the standards and criteria established by the Commission under section 3622. In this Order, the phrase ''modern rate regulation'' is used in place of statutory language referring to standards and criteria established pursuant to 39 U.S.C. 3622.

[2] Terminal dues are the fees paid among postal operators for the processing and delivery of inbound letters, large envelopes, and small packets weighing up to 4.4 pounds. They are set every 4 years by the UPU.

[3] The first UPU Congress following enactment of the PAEA was held in July 2008 in Geneva, Switzerland; the second was held in September and October 2012 in Doha, Qatar.

[4] In addition, the Commission has posted supplemental views on its Web site.

[5] *See* Docket No. PI2012–1, Order No. 1420, Notice Providing Opportunity to Comment on Development of Commission Views Pursuant to 39 U.S.C. 407(c)(1), July 31, 2012. Comments submitted in that docket are available on the Commission's Web site.