statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78) or you may visit *http://DocketsInfo.dot.gov.*

Small Business Regulatory Enforcement Fairness Act

The Small Business Regulatory Enforcement Fairness Act (SBREFA) of 1996 requires FAA to comply with small entity requests for information or advice about compliance with statutes and regulations within its jurisdiction. If you are a small entity and you have a question regarding this document, you may contact your local FAA official, or the person listed under the **FOR FURTHER INFORMATION CONTACT** heading at the beginning of the preamble. You can find out more about SBREFA on the Internet at *http://www.faa.gov/regulations_policies/rulemaking/sbre_act/.*

List of Subjects in 14 CFR Part 406

Administrative procedure and review, Commercial space transportation, Enforcement, Investigations, Penalties, Rules of adjudication.

The Amendment

■ In consideration of the foregoing, the Federal Aviation Administration amends part 406 of Title 14, Code of Federal Regulations as follows:

PART 406—INVESTIGATIONS, ENFORCEMENT, AND ADMINISTRATIVE REVIEW

■ 1. The authority citation for part 406 continues to read as follows:

Authority: 49 U.S.C. 70101–70121.

■ 2. Amend § 406.9 by revising paragraph (a) to read as follows:

§ 406.9 Civil penalties.

(a) *Civil penalty liability.* Under 49 U.S.C. 70115(c), a person found by the FAA to have violated a requirement of the Act, a regulation issued under the Act, or any term or condition of a license or permit issued or transferred under the Act, is liable to the United States for a civil penalty of not more than $110,000 for each violation, as adjusted for inflation. A separate violation occurs for each day the violation continues.

* * * * *

Issued in Washington, DC, on May 25, 2010.

J. Randolph Babbitt,

Administrator.

[FR Doc. 2010–13218 Filed 6–1–10; 8:45 am]

BILLING CODE 4910–13–P

SOCIAL SECURITY ADMINISTRATION

20 CFR Part 404

[Docket No. SSA–2008–0016]

RIN 0960–AG20

Revised Medical Criteria for Evaluating Hearing Loss

AGENCY: Social Security Administration.

ACTION: Final rules.

SUMMARY: We are revising the criteria in the Listing of Impairments (the listings) that we use to evaluate claims involving hearing loss under titles II and XVI of the Social Security Act (Act). The revisions reflect our adjudicative experience, advances in medical knowledge, treatment, and methods of evaluating hearing loss, and public comments we received in response to a Notice of Proposed Rulemaking (NPRM).

DATES: These rules are effective August 2, 2010.

FOR FURTHER INFORMATION CONTACT: Tiya Marshall, Social Insurance Specialist, Office of Medical Listings Improvement, Social Security Administration, 6401 Security Boulevard, Baltimore, Maryland 21235–6401, (410) 965–9291. For information on eligibility or filing for benefits, call our national toll-free number, 1–800–772–1213, or TTY 1–800–325–0778, or visit our Internet Web site, Social Security Online, at *http://www.socialsecurity.gov.*

SUPPLEMENTARY INFORMATION:

Electronic Version

The electronic file of this document is available on the date of publication in the **Federal Register** at *http://www.gpoaccess.gov/fr/index.html.*

Background

We are revising and making final the rules for evaluating hearing loss we proposed in an NPRM we published in the **Federal Register** on August 13, 2008 (73 FR 47103). The preamble to the NPRM discussed the changes from the current rules and our reasons for proposing those changes. To the extent that we are adopting the proposed rules as published, we are not repeating that information here. Interested readers may refer to the preamble to the NPRM, available at *http://www.regulations.gov.*

We are making a number of changes from the NPRM as a result of public comments. We explain those changes in our summary of the public comments and our responses later in this preamble.

Why are we revising the listings for hearing loss?

We are revising the listings for hearing loss to update the medical criteria, provide more information about how we evaluate hearing loss, and reflect our adjudicative experience. The listings for hearing loss are in the special senses and speech body system, which also includes listings for visual disorders, disturbances of labyrinthine-vestibular function, and loss of speech. In the NPRM, we proposed changes only to the listings for hearing loss and their accompanying introductory text. We published final rules revising the listings for visual disorders in the **Federal Register** on November 20, 2006 (71 FR 67037). We intend to separately publish proposed rules for disturbances of labyrinthine-vestibular function and loss of speech.

When will we use these final rules?

We will use these final rules beginning on their effective date. We will continue to use the current listings until the date these final rules become effective. We will apply the final rules to new applications filed on or after the effective date of the final rules and to claims that are pending on and after the effective date.[1]

How long will the rules in the special senses and speech body system be in effect?

We are extending the effective date of the special senses and speech body system in parts A and B of the listings until 5 years after the effective date of these final rules, except we intend to revise the Disturbance of labyrinthine-vestibular function and Loss of speech listings before then. The rules will remain in effect only until that date unless we extend them. We will continue to monitor the rules and may revise them before the end of the 5-year period.

Public Comments on the NPRM

In the NPRM, we provided the public with a 60-day comment period, which ended on October 14, 2008. We received 17 public comment letters. The comments came from national medical organizations, advocacy groups, a national group representing Social

[1] This means that we will use these final rules on and after their effective date in any case in which we make a determination or decision. We expect that Federal courts will review our final decisions using the rules that were in effect at the time we issued the decisions. If a court reverses the Commissioner's final decision and remands a case for further administrative proceedings after the effective date of these final rules, we will apply these final rules to the entire period at issue in the decision we make after the court's remand.

Security disability consultants, a national group representing disability examiners in the State agencies that make disability determinations for us, individual State agencies, and members of the public.

We provide below summaries of the significant comments that were relevant to this rulemaking and our responses to those comments. We tried to present the commenters' concerns and suggestions accurately and completely.

Some commenters supported the proposed changes and noted provisions with which they agreed. We appreciate those comments, but have not summarized or responded to them below because they do not require a response. Some commenters also sent us comments on subjects that were unrelated to the proposed rules; for example, several commenters suggested changes to the rules we use to evaluate claims involving vertigo and speech disorders. As we have already noted, we intend to publish a separate NPRM for disturbances of labyrinthine-vestibular function and loss of speech.[2]

Establishing the Existence and Severity of Impairments That Cause Hearing Loss

Three commenters thought that our proposed requirements to establish that a person has a medically determinable impairment that causes hearing loss were unclear. The commenters pointed out that we referred to both audiometric testing within 2 months of a complete otologic examination and "subsequent" audiometric testing. Another commenter asked whether we would use otoscopy (a description of the appearance of the external ear canals and an evaluation of the tympanic membrane) performed by an audiologist to establish a medically determinable impairment.

We agreed with the commenters that the proposed provisions could have been clearer and revised and reorganized proposed 2.00B1 and 102.00B1 in response to these comments. Proposed (now final) 2.00B1 and 102.00B1 provided information about two issues regarding evidence under these listings: How we establish a medically determinable impairment that causes hearing loss and how we establish the severity of that impairment. We generally require both a complete otologic examination and audiometric testing within 2 months of the complete otologic examination to establish a medically determinable impairment. After that, we do not require a complete otologic examination to assess the severity of the hearing loss; audiometry is sufficient. Otoscopy is part of the complete otologic examination, and we require otoscopy before audiometry to determine if there are any conditions that would prevent valid testing.

We will not substitute otoscopy performed by an audiologist for a complete otologic examination performed by a licensed physician (medical or osteopathic doctor) to establish a medically determinable impairment. We also will not use audiometric testing that was performed without otoscopy to find that a hearing impairment meets or medically equals a listing.

In revising proposed 2.00B1 and 102.00B1 in response to these comments and a comment we summarize below, we realized that our proposal to require both a complete otologic examination and audiometric testing to establish a medically determinable impairment would be unnecessary in some cases. For example, there are some impairments, such as congenital abnormalities, that are clearly observable by otologic examination. In the final rules, therefore, we provide that we "generally" require a complete otologic examination and audiometry to establish that you have a medically determinable impairment that causes your hearing loss.

Several commenters recommended that we use audiometric testing performed more than 2 months from the complete otologic examination in determining whether there is a medically determinable impairment that causes hearing loss. Some of these commenters recommended alternative periods. A commenter also asked whether a report of audiometry in a person's existing medical evidence (that is, one that we did not purchase by consultative examination (CE)) would be acceptable if there were no recent otologic examination.

We did not adopt these comments because the proposed (now final) rules already allow use of audiometric testing performed more than 2 months from the date of the otologic examination in determining whether you have a medically determinable impairment that causes hearing loss. The rules provide that the testing "should" be performed within 2 months of the complete otologic examination to allow our adjudicators to use evidence that is outside the period in appropriate cases. Such cases could include the situation mentioned by one of the commenters in which there is properly performed audiometric testing in a person's evidence that is not within 2 months of an otologic examination. We use the word "should" in these rules to indicate our preference and "must" to indicate an absolute requirement. We prefer the 2-month rule because it ensures the most accurate and reliable findings about the existence of the impairment.

In the NPRM, we invited the public to comment on a proposed change to our prior rule that provided that an otolaryngologic examination should precede audiometric testing. The proposed rules for adults and children provided that a person could have audiometric testing either before or after the complete otologic examination to establish a medically determinable impairment. Two commenters recommended that this audiometric testing always precede the complete otologic examination. They indicated that physicians generally need the results of audiometric testing to make comprehensive findings about a person's hearing loss. They believed that such a rule would be more efficient because a physician would likely order audiometric testing if he or she did not already have it.

After considering these comments, we decided to make final the proposed rule that allows audiometric testing either before or after complete otologic examination. We believe this rule will provide flexibility for our adjudicators to establish the existence of a medically determinable impairment as soon as practicable. The purpose of the rule is only to establish the presence of some medically determinable impairment that would account for the hearing loss, and as we explained in the preamble to the NPRM, there are advantages to audiometric testing before or after the otologic examination. In addition, we realized that, in some cases, we could establish the medically determinable impairment based on the otologic examination alone. As we indicated above, we made a revision in final 2.00B1 and 102.00B1 to recognize this possibility.[3]

Otologic Examinations

A commenter recommended that we specify that otolaryngologists certified by the American Board of Otolaryngology should perform otologic

[2] While we included the sections on vertigo associated with disturbances of labyrinthine-vestibular function and loss of speech in the NPRM, we indicated that we were not proposing any substantive changes. 73 FR at 47104. Although we are not responding to comments on those sections, we will consider them as we develop NPRMs for the disorders they address.

[3] The revision is also consistent with the statement we made in the NPRM that "[h]aving the otologic examination precede the audiometric testing can help identify conditions that could interfere with the audiometric testing." 73 FR 47103, 47105 (2008).

examinations. We partially adopted the comment by specifying in final 2.00B1b and 102.00B1b that a licensed physician (medical or osteopathic doctor) must perform the complete otologic examination to establish whether a person has a medically determinable impairment. For our purposes, licensed physicians have the necessary education, training, and experience to perform the otologic examination.

One commenter recommended that we remove from proposed 2.00B1b and 102.00B1b the description of the pinnae (the outer, visible parts of the ears) from the requirements for a complete otologic examination. The commenter believed that the pinnae do not contribute to hearing disability. We did not adopt the comment because abnormalities of the pinnae are associated with a number of conditions that affect hearing, and such abnormalities may be signs of a medically determinable impairment. Abnormalities of the pinnae can also influence how sound waves are directed to the middle ear.

Another commenter said that our description of an otologic examination was incomplete. The commenter said that otologists do, and should, examine the nasopharynx, nose, oral pharynx, mouth, and neck when they evaluate hearing loss. While we agree that otologists do examine these areas, we do not include them in these final rules because we are describing only findings that we need to determine whether a person has a medically determinable impairment that could cause hearing loss. A physician does not need to examine the areas suggested by the commenter to establish such an impairment.

Otoscopic Examinations

Two commenters recommended that we specify who may perform the otoscopic examination described in final 2.00B2b and 102.00B2b. We adopted the recommendation by stating in 2.00B2b and 102.00B2b that the medical professional described in final 2.00B1c and 102.00B1c must conduct the audiometric testing. In addition, in response to a comment pointing out that "otoscopic inspection" is the term usually used when audiologists conduct otoscopic examinations, we explain in final 2.00B2b and 102.00B2b that our term "otoscopic examination" includes "otoscopic inspection." This addition clarifies that audiologists and other non-physicians may do the otoscopic examination that we require before audiometric testing.

One commenter said that the requirement for an evaluation of the tympanic membrane immediately before an audiometric examination might add expense and time to a CE. The commenter was especially concerned that, when the otoscopic examination shows cerumen (earwax), we would need to ask a physician or audiologist to remove it before we could continue with the audiological testing. In particular, the commenter was concerned about cerumen that only partially obscures the view of the tympanic membrane. The commenter said that this condition does not necessarily equate to invalid audiometric testing. We agree that cerumen can, but does not always, interfere with audiometric testing, and we will rely on the person who conducts the test to decide whether to remove cerumen. We will address this issue in our internal operating instructions.

Audiometric Testing

One commenter recommended that we clarify the provision in proposed 2.00B1d and 102.00B1d (final 2.00B1c and 102.00B1c) that permitted audiometric testing by a non-audiologist "under the supervision of" an otolaryngologist. The commenter recommended that we require non-audiologists to conduct testing only under "direct" supervision, in accordance with Medicare regulations requiring the physician to be present in the office suite when the service is being performed and to assist if necessary. We adopted the recommendation. We will provide guidance to our adjudicators on how to apply the rule in our instructions and training.

Two commenters recommended that we accept the results of audiometric testing conducted independently by hearing aid specialists—also called Hearing Instrument Specialists (HIS)—in addition to the professionals described in proposed 2.00B1d and 102.00B1d. We did not adopt this comment because the educational and other qualifications required for licensure or certification as an HIS are less comprehensive than those of otolaryngologists and audiologists and can vary from place to place. Therefore, we cannot be assured that all HISs would have the expertise needed to independently perform the audiometric testing we require under these listings. If an HIS conducts the testing under the direct supervision of an otolaryngologist, the evidence would be acceptable audiometric testing both for establishing a medically determinable impairment and for assessing its severity. We may also consider an HIS' evidence when we assess severity in the same way that we consider evidence from other sources who are not acceptable medical sources as defined in §§ 404.1513(d) and 416.913(d) of our regulations and Social Security Ruling (SSR) 06–3p.[4]

Another commenter recommended that we accept the results of audiometric testing conducted solely by clinical audiologists. We did not adopt this comment because otolaryngologists have the requisite education, training, and experience to perform and supervise the audiometric testing we require.

A few commenters questioned our requirement in proposed 2.00B2a and 102.00B2f(i) for audiometric testing in a soundproof booth. Some of these commenters suggested we revise our rules to require testing in a sound-treated booth or room. We agreed with these commenters and made this change in final 2.00B2a and 102.00B2f(i).

One commenter noted that several types of sound are used for audiometric testing in a sound field. The commenter also noted that air and bone conduction testing is not sound field testing and asked us to clarify the type of sound that we require for air and bone conduction testing. The type of sound used for air and bone conduction testing is referred to as "pure tone" sound. Our rules require that air and bone conduction testing be conducted in accordance with the most recently published standards of the American National Standards Institute (ANSI). Those standards describe the type of sound that should be used. Therefore, we do not believe it is necessary to specify the type of sound used.

One commenter asked us to clarify how we would evaluate tests that report a vibrotactile (VT) response, rather than a hearing response, at 500 Hertz (Hz) during bone conduction testing, or no response at one or more frequencies during air or bone conduction testing. A VT response may occur during bone conduction testing when the person does not have an auditory response but perceives the sensation from the oscillator; we consider a VT response to be a "no response." To address this issue, we added guidance in final 2.00B2c, 102.00B2c(ii), 102.00B2d(ii), 102.00B2e(ii), and 102.00B2f(ii). In the final rule, we now clarify that when there is no response at one or more frequencies during air or bone conduction testing, we will use 5 dB

[4] SSR 06–3p: Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies, 71 FR 45593 (2006), also available at: *http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR2006–03-di-01.html.*

over the limit of the audiometer used for the test to compute the average threshold.

One commenter indicated that our definition of speech reception threshold (SRT) in proposed 2.00B2d and 102.00B2f(iii) was not entirely correct. The commenter stated that SRT is the minimum dB level required to recognize "spondee words 50 percent of the time," not "the minimal decibel (dB) level required * * * to recognize a standard list of words." [5] The commenter also recommended that we replace the term "speech reception threshold" with "spondee threshold" to ensure standardization of testing material. We agreed with the first comment and revised the definition of SRT in final 2.00B2d and 102.00B2f(iii) accordingly. We also added a parenthetical statement in final 2.00B2a and 102.00B2f(i) explaining that SRT is also called "spondee threshold" or "ST." We did not change the term SRT because it is the more common name for this type of testing, and we believe our adjudicators are more likely to see it in the medical evidence.

One commenter recommended that we require certain specific Department of Veterans Affairs' recordings of 50-word lists, presented at 70 dB in quiet, for measuring the word recognition ability of persons with hearing loss not treated with cochlear implantation. Another commenter also recommended that, for children, the word list should be appropriately normed. We did not adopt the first recommendation because there are several appropriate tests available to measure a person's word recognition ability, and we want to provide our adjudicators with flexibility in obtaining this evidence to determine disability. We adopted the suggestion to provide that word lists for children must be appropriately normed. In the NPRM, we said that the lists must be "standardized." We intended this word to include the idea that the tests must be appropriately normed for age. However, to be clearer, we are adding the words "age-appropriate" in response to this comment.

One commenter asked us to clarify whether the word recognition testing in proposed 2.00B2e and 102.00B2f(iv) should be done using live presentation or recorded material. Another commenter suggested we require testing with recorded material, unless there is documentation indicating why live presentation was necessary. In the proposed rules, we did not specify the method of presentation because we will accept either method; however, we added text to final 2.00B2e and 102.00B2f(iv) to clarify this intent. Although word recognition testing usually uses recorded material, we do not believe that the method of presentation will affect our ability to determine whether a person has a listing-level hearing loss. Therefore, we did not adopt the second comment.

Two commenters recommended that we require word recognition testing conducted with background noise, not only in quiet (see final 2.00B2e, 2.00B3b, 102.00B2f(iv), and 102.00B3b). These commenters also recommended that the words be presented at a normal conversational level. We did not adopt the comments. We require testing under optimal circumstances (that is, in quiet and at a level of amplification that allows us to measure a person's maximum ability to discriminate words) to ensure that the impairment is of listing-level severity.

One commenter suggested that we replace the term "amplification level" in proposed 2.00B2e and 102.00B2f(iv) with "presentation level." The commenter asked whether we require that word recognition testing be done at the "phonetically balanced maximum" (PB Max), which the commenter believed is equivalent to the "most comfortable level" (MCL). Another commenter recommended that we use the term "supra-threshold" instead of specifying the level of amplification we require for word recognition testing.

We did not adopt the first suggestion because we believe that "amplification level" describes more precisely the test parameters we require for word recognition testing. With respect to the second comment, we note that PB Max and MCL are not the same. PB Max is the hearing level at which the maximum percentage of words is correctly repeated during testing with a list of phonetically balanced monosyllabic words, such as "chew" and "knees." It may not be the listener's MCL, which is the hearing level at which speech is most comfortable for the listener. As we indicate in final 2.00B2e and 102.00B2f(iv), the words must be presented at a level of amplification that will measure a person's "maximum ability" to discriminate words, usually 35 to 40 dB above the SRT. This level of amplification is often a person's PB Max; when it is not, it is still sufficient for us to determine whether there is listing-level hearing loss. However, in response to this comment, we clarified in final 2.00B2e and 102.00B2f(iii) that, if a person cannot be tested at 35 to 40 dB above his or her SRT, the person who performs the test should report the word recognition testing score at the highest comfortable level of amplification. We did not adopt the comment to refer to testing at 35 to 40 dB above the SRT as "supra-threshold" testing because we prefer to specify our criteria for word recognition testing.

We received several comments about acoustic immittance assessment (AIA), that is, a tympanogram and acoustic reflex testing. In the proposed rules, we required an AIA for children from birth to the attainment of age 5. One commenter recommended that we require an AIA for adults to rule out conductive pathology, which is amenable to treatment, and to aid in detecting situations in which a person may be feigning a serious hearing loss. Another commenter questioned our proposal to require an AIA for children because listing 102.10A uses only air conduction thresholds. A third commenter recommended that we require high-frequency tympanometry for children under age 5 months.

We did not adopt the comment to require an AIA for adults because the bone conduction criterion in final listing 2.10A ensures that there is a significant sensorineural component to the hearing loss. Sensorineural hearing loss results from permanent damage to the inner ear or to the nerve pathways from the inner ear to the brain. Persons with the degree of sensorineural hearing loss required in final listing 2.10A do not usually obtain significant improvement with hearing aids. We also believe that an AIA is unnecessary to detect deception because the professionals referenced in final 2.00B1c who may conduct audiometric testing are trained to detect whether a person is feigning hearing loss and to recognize test results that may suggest such deception. We agreed with the second commenter that we do not need an AIA to determine disability for children under age 5 and did not include it in final 102.00B2c(i), 102.00B2d(i), and 102.00B2e(i). We proposed to require an AIA for these children to identify conditions that would prevent valid audiometric testing. However, the otoscopic examination we require will detect any conditions revealed by AIA. Since we removed the requirement for an AIA for children under age 5 we are not adopting the third comment.

Two commenters recommended that we require audiologists who conduct audiometric testing for us to complete hearing checklists recommended in a 2005 National Research Council report

[5] Spondee words, such as "baseball" and "airplane," have equal stress on each syllable.

("NRC report").[6] The commenters said the checklists would ensure the quality of the data collected and provide useful information for evaluating disability at later steps in the sequential evaluation process. We considered these checklists at the time we developed the proposed rules and determined we did not need them. We believe we have adequately specified in these final rules the information we need to evaluate whether a person's hearing impairment meets or medically equals one of the hearing listings. Finally, we also specify qualifications for audiologists that will ensure the quality of the data they collect.

Issues Specific to Audiometric Testing of Children

One commenter recommended that we should strongly prefer audiometric testing by an experienced pediatric audiologist when evaluating hearing loss in children. While we generally agree with the comment, we did not make any changes in the final rules because we do not believe it is necessary to include this guidance in the regulations. We have a general preference for obtaining evidence from appropriate specialists in childhood cases, and we believe that our internal operating instructions are sufficient for this purpose.[7]

One commenter recommended that we reference the American Academy of Audiology's pediatric protocols for audiological evaluation of children. We did not adopt the comment because we believe the audiometric testing we require in these final rules is sufficient for evaluating hearing loss in children.

Two commenters wrote about our statement in proposed 102.00B2a that we would not purchase physiologic hearing tests for children and would instead consider "other evidence" when such testing was not done or when it was done, we could not obtain the results. One of these commenters requested clarification of what "other evidence" we would consider and asked whether we may purchase physiologic testing that does not require sedation. The other commenter stated that physiologic testing would be necessary for infants, some toddlers, and some children with certain developmental disorders that preclude participation in behavioral testing. This commenter also recommended that we should use all information gathered during testing to evaluate functioning if the impairment does not meet or medically equal a listing.

When we evaluated these comments, we determined that our guidance in proposed 102.00B2a was unclear and contrary to our intent because it implied that a hearing impairment could meet listing 102.10 without physiological or behavioral testing. The proposed guidance was not for determining whether hearing loss met a listing; we intended it to apply only to evaluations of medical and functional equivalence. To clarify that listing 102.10 requires physiologic testing, we removed the word "generally" from proposed 102.00B2a and removed the proposed guidance indicating that we will evaluate a person's hearing loss based on other evidence in the case record.

We also removed unnecessary and potentially confusing language in 102.00B2a. In the proposed rules, we said that we would use other evidence when physiologic testing had not been done or we could not obtain the results of testing that had been done. However, there was a third possibility: We have the results of physiologic testing, but we need new testing. Since our intent was only to say that we would not purchase physiologic testing, we simplified the rule to say just that. This rule applies regardless of whether such testing requires sedation.

We did not adopt the comment that recommended we use all information gathered during testing to evaluate functioning if the impairment does not meet or medically equal a listing. We already use all of the relevant information we gather in connection with testing when we determine whether a child's impairment(s) functionally equals the listings. We have other rules that explain how we consider medical and other evidence when we evaluate a child's functioning. *See* §§ 416.924a and 416.926a, and SSR 09–2p.[8]

One commenter recommended that we require otoacoustic emissions (OAE) testing in addition to the physiologic testing we required in proposed 102.00B2c(i) for children from birth to the attainment of age 6 months to identify children with auditory dyssynchrony or auditory neuropathy. Another commenter pointed out that, when testing indicates that an infant may have auditory neuropathy (that is, normal OAE but no response on Auditory Brainstem Response (ABR) testing), we should presume the child disabled until it is possible to perform age-appropriate behavioral testing, generally by age 6 months. We did not adopt these comments. Test results showing normal OAE, but no response on ABR testing are uncommon and nearly always involve children who have other impairments that we would find disabling under the criteria of a listing in another body system. We will evaluate the small number of children who do not have such other impairments on an individual basis. If we cannot make a fully favorable determination in those cases, we will defer them until the child is age 6 months and can participate in behavioral testing.

One commenter suggested that it would be helpful to list some of the other types of physiologic testing—such as Brainstem Auditory Evoked Response (BAER)—in addition to ABR testing. We did not adopt the recommendation. We cite only the ABR because, as the commenter noted, ABR testing is the most commonly used physiologic test and is the one that adjudicators are most likely to see.

One commenter recommended that we determine the pure tone air and bone conduction thresholds in children by testing at 3000 Hz in addition to 500, 1000, 2000, and 4000 Hz. We did not adopt the comment because, as we explained in the NPRM,[9] our adjudicative experience has shown that testing is often not done at 3000 Hz. Moreover, several commenters on the April 13, 2005, Advance Notice of Proposed Rulemaking[10] recommended that we remove the current requirement to test at 3000 Hz. We agreed with those commenters and believe the findings we require in these final rules are adequate for our purposes.

One commenter noted that we provided in proposed 102.00B2g that we can consider normal results from hearing screening tests, such as OAE, to determine that a child's hearing loss is not "severe" when these test results are consistent with the other evidence in the case record. The commenter asked whether we could use normal results from a pure tone screen by a speech-language pathologist in the same way. We can use such evidence in the same way as other screening tests. In response to this comment, we revised the guidance in final 102.00B2g to include

[6] National Research Council (NRC): Committee on Disability Determination for Individuals with Hearing Impairments. (2005). *Hearing Loss: Determining Eligibility for Social Security Benefits.* Action Recommendation 4–5. (Complete citation at 73 FR at 47110.)

[7] *See,* for example, Program Operations Manual Systems (POMS) DI 25205.015, available at: *https://secure.ssa.gov/apps10/poms.nsf/lnx/0425205015!opendocument.*

[8] SSR 09–2p: Title XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations, 74 FR 7625 (2009), also available at: *http://www.socialsecurity.gov/OP_Home/rulings/ssi/02/SSR2009–02-ssi-02.html.*

[9] 73 FR 47107 (2008).

[10] 70 FR 19353 (2005).

pure tone testing as a type of screening test.

Validity of Audiometric Testing

One commenter commented on our proposed requirements for otoscopic examination together with pure tone average and SRT testing to document the validity of audiometry and suggested that we instead require only a statement of reliability, validity, or inter-test reliability. The commenter believed that such a statement would also cover issues such as patient cooperation and the attention of a child. We partially adopted the comment:

We do not consider test results in isolation. Therefore, in response to this comment and another comment we describe later, we added a sentence in final 2.00B1a and 102.00B1a stating that we will consider your test scores together with any other relevant information we have about your hearing, including information from outside of the test setting. This is our basic policy for considering any test results.

In final 2.00B2b and 102.00B2b, we provide that the person who performs the audiometry should report on any factors in addition to the factors observable on otoscopy that can affect the interpretation of the test results. As this commenter suggested, we used patient cooperation as an example in the adult rule and a child's ability to maintain attention as an example in the childhood rule. It is common practice to report such observations, so the provisions in the final rules will not be an additional burden on our CE providers. We also expect to find such observations in existing reports of audiometric testing.

We did not adopt the general statement the commenter suggested, because general statements about reliability and validity are too vague to assure us that the results of audiometric testing are reliable and valid.

One commenter asked whether adjudicators must reject the results of all audiometric testing when the person's SRT is not within 10 dB of the average pure tone air conduction thresholds at 500, 1000, and 2000 Hz. In proposed 2.00B2d and 102.00B2f(iii), we indicated only that the reason for such a discrepancy should be documented. Another commenter suggested that we highlight or strengthen the guidance in these sections. In response to these comments, we revised the guidance in final 2.00B2d and 102.00B2f(iii) to explain that, if we cannot determine a medical basis for the discrepancy we will not use the results of the testing to determine that a person's hearing loss meets the listing. We also clarified that we require an explanation of the discrepancy, by using "must" in the final rule instead of the proposed "should."

Two commenters recommended that we require a check of the cochlear implant before testing to ensure that it is turned on and functioning properly. One of these commenters also recommended that we require corroborating behavioral evidence that correlates with the Hearing in Noise Test (HINT) results to ensure the validity and reliability of the testing. In the NPRM, we said that word recognition testing "must be conducted in quiet in a sound field with your implant adjusted to your normal settings." [11] We intended this requirement to include verification that the person's cochlear implant is turned on and functioning properly. However, to be clearer, we added in final 2.00B3b and 102.003B3b a requirement that the person's implant must be functioning properly. In response to the second comment and another comment we have already described, we added sentences in final 2.00B1a and 102.00B1a providing that we consider test results together with all relevant evidence in the case record.

Issues Regarding Audiometric Testing of Persons Who Are Not Fluent in English

Several commenters responded to our request in the NPRM for suggestions about other methods we could use to evaluate the word recognition ability of persons who are not fluent in English.[12] One commenter noted that our proposed rules did not recognize recorded speech testing in foreign languages. As we have already noted in response to an earlier comment, we accept word recognition testing using recorded material, and that includes recorded material in a foreign language. While considering this comment, however, we noticed that we inadvertently omitted requirements for word recognition testing when a person is not fluent in English from the proposed rules, although we included the requirements in the preamble to the NPRM.[13] We have included the omitted text in the final rules. As in the preamble to the NPRM, the final rules explain that testing of a person who is not fluent in English should be conducted using an appropriate word list for the language in which the person is most fluent, and the person conducting the testing should be fluent in the language used for the test.

Another commenter suggested that we consider a person's contact with treating sources, other health care professionals, and other third parties, such as past employers, to see whether the person is able to communicate with them either directly or through the use of an interpreter. We did not add this guidance. In some cases, the persons referenced by the commenter are already included in the clause "other persons who speak the language in which you are the most fluent" in final 2.00B4 and 102.00B4. In other cases, we do not need to consider the person's ability to communicate with such persons when we evaluate word recognition ability under the final listings.

A third commenter approved of our guidance in proposed 2.00B4 and 102.00B4 regarding word recognition testing for a person who is not fluent in English, but thought it might be difficult to obtain the testing we need. We understand this concern and to address it include the guidance in final 2.00B4 and 102.00B4 concerning medical equivalence.

Another commenter recommended that we include physiologic testing, such as frequency-specific evoked potentials, for persons who do not speak English. We did not adopt this suggestion because this testing does not test word recognition ability.

One commenter noted that, while the HINT is available in 12 languages, our requirement that a person who performs audiometric testing "must be fluent" in the claimant's native language would create a problem for obtaining the test. As we explained above, the person administering the test "should" be fluent in the language. We do not have an absolute rule that the person who administers the test must be fluent in the language, although that is our preference. We also provide that the inability to measure a person's word recognition ability means only that his or her hearing impairment cannot meet final listing 2.11B or 102.11B. If a person with a severe impairment(s) has difficulty understanding words in the language in which he or she is most fluent and we are unable to measure his or her word recognition ability, we will consider whether the degree of difficulty (either alone or in combination with another impairment(s)) medically equals final listing 2.11B or 102.11B. If not, we consider the person's difficulty understanding words when we assess residual functional capacity for adults or functional equivalence for children.

One commenter suggested that we should acknowledge in the childhood

[11] 73 FR at 47111.

[12] 73 FR at 47106.

[13] 73 FR at 47105–06.

listings that the "speech education and articulation" of children in bilingual or multilingual environments differs from those of children in monolingual environments. The commenter believed that most speech tests conducted for children who are bilingual or multilingual would be invalid. We did not adopt this comment. We agree that children who are bilingual or multilingual do not always develop in the same way as children who are monolingual, but we do not agree that all speech testing of such children is invalid. Moreover, we do not rely on test scores alone, but consider all of the relevant evidence when we evaluate a child's functioning. *See* § 416.924a(a)(1)(ii).

Listing Criteria for Hearing Loss Not Treated With Cochlear Implantation

We received several comments about the criteria in proposed listings 2.10 and 102.10. One commenter said that we should change the criteria in listings 2.10B and 102.10B2 from a word recognition score of 40 percent or less in the better ear to a score of 70 percent or less. Another commenter noted that our proposed listings did not address the variability in word recognition scores, that is, that a score higher than 40 percent might not be statistically different from a score of 40 percent or less. Some commenters also recommended various changes to listing 102.10A. They recommended that we:

- Use the average air conduction threshold criteria in Table 7–2 of the NRC report;
- Use the speech and language criteria in Tables 7–2 and 7–3 of the NRC report;
- Change the criterion for children from birth to age 5 in proposed listing 102.10A to 25–30 dB, and use the same criterion for children ages 5–12; and
- Use an unaided air conduction threshold of 50 dB for children ages 12–18.

We did not adopt any of these suggestions because we believe they would require us to find some adults and children who do not have listing-level impairments disabled under the listings. We set the levels of hearing loss in these final rules for adults and children at levels that reflect very serious hearing loss; we use the listings only to deem persons disabled without considering any other factors that may contribute to their inability to work or to function age-appropriately in the case of children. It is important to remember, however, that we do not deny benefits to anyone solely because his or her impairment(s) does not meet a listing. We may still find that a person's impairment(s) is disabling based on medical equivalence or based on an individualized assessment when we evaluate an adult's residual functional capacity, age, education, and work experience, or functional equivalence in children.

One commenter requested that we include listing criteria for adults with precipitous hearing loss who have an impairment(s) that does not meet the pure tone criteria in listing 2.10A but who have significant limitations in the ability to discriminate words. The commenter also requested that we include criteria for children over age 5 who have an unaided hearing threshold of 50 dB in the better ear and normal speech and language development but do not have the ability to listen accurately in distant and noise-challenged situations. The commenter suggested we use the HINT or HINT–C for children to evaluate these persons.

We did not adopt these comments because we had already proposed criteria for determining when a limitation in word recognition ability is of listing-level severity in listings 2.10B and 102.10B2. The final rules, which are the same as the proposed rules, require results from a phonetically balanced monosyllabic word list for persons who do not have cochlear implants, regardless of the type or level of their hearing loss. We specify this type of test because it is the one most often used in clinical practice.

One commenter recommended that we consider first-time hearing aid users under a disability for 1 year because they may need a period of rehabilitation and training to use the aid effectively. This commenter also recommended a 1-year period of disability for persons with sudden hearing loss, rapidly deteriorating hearing, or fluctuating hearing because they may need time to adjust to the challenges of communication. We did not adopt these recommendations because some persons with the conditions described by the commenter will not have impairments that meet our definition of disability, including the 12-month duration requirement.

One commenter noted that visual reinforcement audiometry (VRA), which we indicate is the usual method of testing for children from age 6 months to the attainment of age 2, is only an estimate of the hearing threshold. The commenter recommended that we raise the average air conduction threshold in proposed listing 102.10A to ensure that children in this age range are truly disabled. While we acknowledge that VRA provides only an estimate of hearing loss, it is the most reliable method for testing children from age 6 months to the attainment of age 2, and we believe that—even as an estimate—an average air conduction threshold of 50 dB or greater in the better ear does indicate listing-level severity in these young children.

One commenter noted an inconsistency between our definition of "marked" limitation in speech in proposed 102.00B5a and our definition of the term in SSR 98–1p.[14] The commenter recommended that we use unintelligibility on the first attempt 67 percent (two-thirds) of the time as the threshold for a marked limitation instead of 60 percent. We adopted the comment by changing the rule to "at least 50 percent (half) of the time but no more than 67 percent (two-thirds) of the time." This is the same range that we use in our definitions of "marked" in SSR 98–1p and other rules, that is, one-half to two-thirds.

One commenter recommended that we consider children with "marked mental retardation" who cannot be evaluated for speech or language to be disabled when their impairment meets the hearing criterion alone. We were not certain what the commenter intended by "marked mental retardation" because the American Psychiatric Association (APA) and World Health Organization (WHO) currently use the terms "mild," "moderate," "severe," and "profound" to describe the levels of the disorder.[15] We assume that the commenter meant at least "moderate" mental retardation, which in the APA's definition is mental retardation generally with an IQ of 35–55; the WHO's is similar, with an IQ of 35–49. In either case, the mental retardation by itself meets listing 112.05C in the mental disorders listings, and depending on the facts of the case, may meet listing 112.05B. It is not necessary for a child to also have hearing loss to qualify under either of those listings.

Listing Criteria for Hearing Loss Treated With Cochlear Implantation

We received several comments about our proposal to find disability for 1 year

[14] SSR 98–1p: "Policy Interpretation Ruling: Title XVI: Determining Medical Equivalence in Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech," 63 FR 15248 (1998), also available at: *http://www.socialsecurity.gov/OP_Home/rulings/ssi/02/SSR98-01-ssi-02.html.*

[15] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM–IV–TR).* Washington, DC (2000); World Health Organization, Division of Mental Health and Substance Abuse, *ICD–10 Guide for Mental Retardation,* Geneva (1996), available at: *http://www.who.int/mental_health/media/en/69.pdf. See* also: *http://apps.who.int/classifications/apps/icd/icd10online/.*

following cochlear implantation under listing 2.11A and, for some children, listing 102.11A.[16] The commenters said that the 1-year period was arbitrary and that it may be insufficient because it does not account for variation in treatment outcomes or allow for maximal improvement. The commenters recommended that we extend the period by various amounts of time ranging from 18 months to 3 years. Another commenter suggested that we provide the option of extending the period of disability past 1 year as necessary, particularly for persons who also have vision impairments and may require a longer period of adjustment because of their multiple impairments.

We did not adopt these comments. While some persons will still have listing-level impairments 1 year after implantation, many will have improved, so we must reexamine their status to see whether they remain disabled. Our rule is not arbitrary: most therapy programs following cochlear implantation involve a period of rehabilitation and training for about 1 year.

Moreover, the 1-year rule does not mean that disability automatically ends after 1 year. Under the Act and our regulations, we generally cannot find that a person's disability has ended unless his or her impairment has medically improved and the person is no longer disabled.[17] After 1 year, we must consider whether the impairment(s) is disabling under the criteria in listing 2.11B or 102.11B, or if not, under other listings or our other disability criteria.

Two commenters sent us questions about various adjudication scenarios involving cochlear implants. With one exception, we did not add more detailed guidance to the rules to address these situations because they are uncommon and we can address them in training and other instructions. We did clarify that we count the 1-year period for which we presume disability from the date of the initial implantation procedure when a person has had more than one implant. This rule will apply regardless of whether the person had an implant in the other ear or replacement of the initial implant. See final 2.00B3a and 102.00B3a and final listings 2.11 and 102.11.

[16] Like the proposed rule, final listing 102.11A provides for a finding of disability after cochlear implantation until age 5 or for 1 year after implantation "whichever is later." We will find that some children are disabled under this listing for more than 1 year.

[17] See sections 223(f) and 1614(a)(4) of the Act, and §§ 404.1594, 416.994, and 416.994a of our regulations.

Two commenters were concerned about our requirement in proposed listings 2.11B and 102.11B that we use the HINT or HINT–C to evaluate a person's hearing loss after cochlear implantation. The commenters indicated that we would have difficulty obtaining a HINT or HINT–C because most audiologists do not have the test. One commenter was concerned that residents of rural areas might be disadvantaged because these tests are available primarily at medical centers that perform cochlear implants. The second commenter, who acknowledged that the HINT is the accepted standard for assessing hearing outcome after cochlear implantation, indicated that the original CD version of this test was noted to have limitations and has been replaced with computerized software versions (such as the HINT for Windows and the HINT®Pro) that contain improvements and enhancements. The commenter asked what version of the HINT we would accept. The commenter further noted that literature from the manufacturer of the HINT®Pro indicates that this test is normed for anyone who reads at a first grade level and for children as young as age 6. The commenter asked whether this test could also be used for children between the ages of 5 and 6 and for adults who have literacy problems. The commenter also stated that other speech-in-noise tests are used more frequently and asked whether we would use the results of those other tests.

We do not share the commenters' concerns about the availability of the HINT or HINT–C. As one of the commenters noted, the HINT is the accepted standard for assessing hearing outcome after cochlear implantation, and we believe this testing is likely to be in the evidence we obtain from a person's medical sources. If not, or if we need more recent testing, we believe that in most instances we will be able to purchase it from these sources or from audiologists who do have the HINT or HINT–C. We acknowledge there may be a few cases in which we will not be able to get testing for a resident of a rural area. In those cases, we will use other evidence to determine whether the person is disabled.

In response to the concerns raised by the second commenter, we are providing in final 2.00B3b and 102.00B3b that we will use "any version" of the HINT or, for children, any age-appropriate version of the HINT or HINT–C. We will use results only from the HINT or HINT–C to determine that an impairment meets one of the final listings. We can use results from other tests to determine whether the impairment(s) medically equals a listing or to assess residual functional capacity in adults or functional equivalence in children. With respect to the age and literacy issues, we can use versions of the HINT that have been normed for children as young as age 6 to test children between age 5 and 6 and, when appropriate, to test adults with literacy problems.

One commenter believed that we should use the same word recognition tests and test-score criteria to evaluate hearing loss in persons who have cochlear implants as we use to evaluate hearing loss in persons who have hearing aids. We did not adopt the comment because the final listings reflect the way that persons are ordinarily tested. Persons who do not have cochlear implants are ordinarily tested with phonetically balanced monosyllabic word lists. The HINT is the accepted test for assessing persons with cochlear implants. The HINT is a sentence test, and persons generally have higher word recognition scores when tested with a sentence test because sentences provide context for the words used. Therefore, we must require a higher word recognition score for cochlear implant users.

Terminology Issues

One commenter recommended that we use the term "audiometric evaluation" rather than "audiometric testing" throughout these final rules to reflect the full scope of the audiologist's identification and assessment of hearing disorders. We did not adopt the comment. While we recognize that the scope of an audiologist's practice is not limited to audiometric testing, the term "audiometric testing" describes the type of evidence we require from audiologists under these listings.

Two commenters recommended that we consistently use the abbreviation dB HL (decibel hearing level) throughout the final rules wherever we used the abbreviation dB (decibel) in the proposed rules. We did not adopt the recommendation because, in these final rules, the "dB HL" designation is relevant only to word recognition testing for persons with cochlear implants. The sound used to test persons with cochlear implants can be delivered by two methods, referred to as "HL" and "SPL" (sound pressure level). Both of these methods are expressed in dB, but a specific dB HL is not the same level of loudness as the same dB SPL. To ensure that we use a consistent standard to evaluate every person with a cochlear implant, we use the abbreviation "dB HL" only in final 2.00B3b and 102.00B3b.

Hearing Loss in Combination With Another Impairment(s)

One commenter wrote to us about persons with hearing loss together with other medical conditions, such as visual or cognitive disorders, that compromise their ability to compensate for their hearing loss. The commenter said that some of these persons have greater difficulty functioning than persons with worse hearing loss but no other impairments. The commenter believed that such persons may not be disabled under our listings, but would still have difficulty responding to the communication challenges of daily living, and that we should consider them disabled. This commenter was also concerned that some persons with hearing loss whose impairments do not meet the criteria of the final listings may have difficulty functioning and should also be considered disabled.

In these final rules, we include revisions only to our listings for hearing loss. We have other listings and other rules that we use to find many persons disabled, including persons like those described by the commenter. In addition, our regulations require us to consider the combined impact of multiple impairments throughout the disability determination process. *See* §§ 404.1523, 416.923, and 416.924. Some persons with a combination of hearing loss and other impairments will have impairments that meet or medically equal listings in other body systems. Others may be found disabled at a later step of the sequential evaluation process.

Accounting for Improvement With Hearing Aids

While most commenters agreed with our proposal to remove the requirement for testing with hearing aids, one commenter believed that we should not determine disability without accounting for any improvement in functioning that a person may derive from the use of such aids. Another commenter suggested that we include some functional criteria in the listings to account for persons who have individualized hearing aids that improve their functioning.

As we explained in the NPRM,[18] we determined that persons with the level of hearing loss specified in the listings do not usually obtain significant improvement in their ability to hear and communicate with the use of hearing aids. In other words, the severity criteria we provide in the final listings make testing with a hearing aid unnecessary. Therefore, we believe that it is appropriate to eliminate the requirement for aided testing and that it is not necessary to add functional criteria to the listings for the evaluation of persons with listing-level hearing loss who have individualized hearing aids.

Need for Listings for Hearing Loss

Citing testimony from our 2005 policy conference regarding the number of persons with deafness who work, one commenter believed that we should not presume that all persons whose hearing impairments meet the criteria in these listings are disabled. The commenter indicated that we should document that the proposed rules correctly identify persons who meet the definition of disability in the Act and our regulations. When we developed our proposed rules for evaluating claims involving hearing loss, we consulted with some of the most renowned experts in the field of hearing disorders. We also received comments from experts who supported our proposed rules. Based on this information, we believe it is appropriate to presume disability in persons whose hearing impairments meet the criteria in these final rules. In addition, the testimony from our policy conference regarding persons with deafness who work did not fully address the issue of work independence (for example, special accommodations) and other factors (such as levels of earnings); therefore, the testimony was not specifically relevant to the issue in this comment. Moreover, when persons with listing-level hearing loss work at the substantial gainful activity level, we find them not disabled at the first step of the sequential evaluation process.

Other Changes From the NPRM

We made a number of nonsubstantive, editorial corrections and changes in the final rules from the language of the NPRM, such as changing some sentences from the passive into the active voice.

What is our authority to make rules and set procedures for determining whether a person is disabled under our statutory definition?

Under the Act, we have full power and authority to make rules and regulations and to establish necessary and appropriate procedures to carry out such provisions. Sections 205(a), 702(a)(5), and 1631(d)(1).

Regulatory Procedures

Executive Order 12866

We have consulted with the Office of Management and Budget (OMB) and determined that these final rules meet the requirements for a significant regulatory action under Executive Order 12866 and were subject to OMB review.

Regulatory Flexibility Act

We certify that these final rules have no significant economic impact on a substantial number of small entities because they affect only individuals. Therefore, a regulatory flexibility analysis was not required under the Regulatory Flexibility Act, as amended.

Paperwork Reduction Act

This rule does not create any new or affect any existing collections, and therefore, does not require Office of Management and Budget approval under the Paperwork Reduction Act.

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

List of Subjects in 20 CFR Part 404

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

Michael J. Astrue,

Commissioner of Social Security.

■ For the reasons set out in the preamble, we amend appendix 1 to subpart P of part 404 of chapter III of title 20 of the Code of Federal Regulations as set forth below:

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

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

Authority: Secs. 202, 205(a), (b), and (d)–(h), 216(i), 221(a) and (i), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405(a), (b), and (d)–(h), 416(i), 421(a) and (i), 422(c), 423, 425, and 902(a)(5)); sec. 211(b), Pub. L. 104–193, 110 Stat. 2105, 2189; sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

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

■ 2. Amend appendix 1 to subpart P of part 404 as follows:
■ a. Revise item 3 of the introductory text before part A of appendix 1.
■ b. Revise section 2.00B of part A of appendix 1.
■ c. Redesignate section 2.00C of part A of appendix 1 as section 2.00E.
■ d. Redesignate section 2.00B2 of part A of appendix 1 as section 2.00C, revise the heading, and designate the undesignated paragraphs as sections 2.00C1, 2.00C2, and 2.00C3.

[18] 73 FR 47106 (2008).

■ e. Redesignate section 2.00B3 of part A of appendix 1 as section 2.00D.
■ f. Remove listing 2.08 of part A of appendix 1.
■ g. Add listings 2.10 and 2.11 to part A of appendix 1.
■ h. Revise section 102.00B of part B of appendix 1.
■ i. Remove listing 102.08 of part B of appendix 1.
■ j. Add listings 102.10 and 102.11 to part B of appendix 1.

The revised text is set forth as follows:

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

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3. Special Senses and Speech (2.00 and 102.00): August 3, 2015.

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Part A

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2.00 SPECIAL SENSES AND SPEECH

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B. How do we evaluate hearing loss?

1. What evidence do we need?

a. We need evidence showing that you have a medically determinable impairment that causes your hearing loss and audiometric measurements of the severity of your hearing loss. We generally require both a complete otologic examination and audiometric testing to establish that you have a medically determinable impairment that causes your hearing loss. You should have this audiometric testing within 2 months of the complete otologic examination. Once we have evidence that you have a medically determinable impairment, we can use the results of later audiometric testing to assess the severity of your hearing loss without another complete otologic examination. We will consider your test scores together with any other relevant information we have about your hearing, including information from outside of the test setting.

b. The complete otologic examination must be performed by a licensed physician (medical or osteopathic doctor). It must include your medical history, your description of how your hearing loss affects you, and the physician's description of the appearance of the external ears (pinnae and external ear canals), evaluation of the tympanic membranes, and assessment of any middle ear abnormalities.

c. Audiometric testing must be performed by, or under the direct supervision of, an otolaryngologist or by an audiologist qualified to perform such tests. We consider an audiologist to be qualified if he or she is currently and fully licensed or registered as a clinical audiologist by the State or U.S. territory in which he or she practices. If no licensure or registration is available, the audiologist must be currently certified by the American Board of Audiology or have a Certificate of Clinical Competence (CCC–A) from the American Speech-Language-Hearing Association (ASHA).

2. What audiometric testing do we need when you do not have a cochlear implant?

a. We generally need pure tone air conduction and bone conduction testing, speech reception threshold (SRT) testing (also referred to as "spondee threshold" or "ST" testing), and word recognition testing (also referred to as "word discrimination" or "speech discrimination" testing). This testing must be conducted in a sound-treated booth or room and must be in accordance with the most recently published standards of the American National Standards Institute (ANSI). Each ear must be tested separately.

b. You must not wear hearing aids during the testing. Additionally, a person described in 2.00B1c must perform an otoscopic examination immediately before the audiometric testing. (An *otoscopic examination* provides a description of the appearance of your external ear canals and an evaluation of the tympanic membranes. In these rules, we use the term to include otoscopic examinations performed by physicians and otoscopic inspections performed by audiologists and others.) The otoscopic examination must show that there are no conditions that would prevent valid audiometric testing, such as fluid in the ear, ear infection, or obstruction in an ear canal. The person performing the test should also report on any other factors, such as your cooperation with the test, that can affect the interpretation of the test results.

c. To determine whether your hearing loss meets the air and bone conduction criteria in 2.10A, we will average your air and bone conduction hearing thresholds at 500, 1000, and 2000 Hertz (Hz). If you do not have a response at a particular frequency, we will use a threshold of 5 decibels (dB) over the limit of the audiometer.

d. The SRT is the minimum dB level required for you to recognize 50 percent of the words on a standard list of spondee words. (Spondee words are two-syllable words that have equal stress on each syllable.) The SRT is usually within 10 dB of the average pure tone air conduction hearing thresholds at 500, 1000, and 2000 Hz. If the SRT is not within 10 dB of the average pure tone air conduction threshold, the reason for the discrepancy must be documented. If we cannot determine that there is a medical basis for the discrepancy, we will not use the results of the testing to determine whether your hearing loss meets a listing.

e. Word recognition testing determines your ability to recognize a standardized list of phonetically balanced monosyllabic words in the absence of any visual cues. This testing must be performed in quiet. The list may be recorded or presented live, but in either case the words should be presented at a level of amplification that will measure your maximum ability to discriminate words, usually 35 to 40 dB above your SRT. However, the amplification level used in the testing must be medically appropriate, and you must be able to tolerate it. If you cannot be tested at 35 to 40 dB above your SRT, the person who performs the test should report your word recognition testing score at your highest comfortable level of amplification.

3. What audiometric testing do we need when you have a cochlear implant?

a. If you have a cochlear implant, we will consider you to be disabled until 1 year after initial implantation.

b. After that period, we need word recognition testing performed with any version of the Hearing in Noise Test (HINT) to determine whether your impairment meets 2.11B. This testing must be conducted in quiet in a sound field. Your implant must be functioning properly and adjusted to your normal settings. The sentences should be presented at 60 dB HL (Hearing Level) and without any visual cues.

4. How do we evaluate your word recognition ability if you are not fluent in English?

If you are not fluent in English, you should have word recognition testing using an appropriate word list for the language in which you are most fluent. The person conducting the test should be fluent in the language used for the test. If there is no appropriate word list or no person who is fluent in the language and qualified to perform the test, it may not be possible to measure your word recognition ability. If your word recognition ability cannot be measured, your hearing loss cannot meet 2.10B or 2.11B. Instead, we will consider the facts of your case to determine whether you have difficulty understanding words in the language in which you are most fluent, and if so, whether that degree of difficulty medically equals 2.10B or 2.11B. For example, we will consider how you interact with family members, interpreters, and other persons who speak the language in which you are most fluent.

C. How do we evaluate vertigo associated with disturbances of labyrinthine-vestibular function, including Meniere's disease?

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2.01 Category of Impairments, Special Senses and Speech

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2.10 Hearing Loss Not Treated With Cochlear Implantation

A. An average air conduction hearing threshold of 90 decibels or greater in the better ear and an average bone conduction hearing threshold of 60 decibels or greater in the better ear (*see* 2.00B2c).

OR

B. A word recognition score of 40 percent or less in the better ear determined using a standardized list of phonetically balanced monosyllabic words (see 2.00B2e).

2.11 Hearing Loss Treated With Cochlear Implantation

A. Consider under a disability for 1 year after initial implantation.

OR

B. If more than 1 year after initial implantation, a word recognition score of 60 percent or less determined using the HINT (*see* 2.00B3b).

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Part B

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102.00 SPECIAL SENSES AND SPEECH

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B. How do we evaluate hearing loss?

1. What evidence do we need?

a. We need evidence showing that you have a medically determinable impairment that causes your hearing loss and audiometric measurements of the severity of your hearing loss. We generally require both a complete otologic examination and audiometric testing to establish that you have a medically determinable impairment that causes your hearing loss. You should have this audiometric testing within 2 months of the complete otologic examination. Once we have evidence that you have a medically determinable impairment, we can use the results of later audiometric testing to assess the severity of your hearing loss without another complete otologic examination. We will consider your test scores together with any other relevant information we have about your hearing, including information from outside of the test setting.

b. The complete otologic examination must be performed by a licensed physician (medical or osteopathic doctor). It must include your medical history, your description of how your hearing loss affects you, and the physician's description of the appearance of the external ears (pinnae and external ear canals), evaluation of the tympanic membranes, and assessment of any middle ear abnormalities.

c. Audiometric testing must be performed by, or under the direct supervision of, an otolaryngologist or by an audiologist qualified to perform such tests. We consider an audiologist to be qualified if he or she is currently and fully licensed or registered as a clinical audiologist by the State or U.S. territory in which he or she practices. If no licensure or registration is available, the audiologist must be currently certified by the American Board of Audiology or have a Certificate of Clinical Competence (CCC–A) from the American Speech-Language-Hearing Association (ASHA).

2. What audiometric testing do we need when you do not have a cochlear implant?

a. *General.* We need either physiologic or behavioral testing (other than screening testing, see 102.00B2g) that is appropriate for your age at the time of testing. *See* 102.00B2c–102.00B2f. We will make every reasonable effort to obtain the results of physiologic testing that has been done; however, we will not purchase such testing.

b. *Testing requirements.* The testing must be conducted in accordance with the most recently published standards of the American National Standards Institute (ANSI). You must not wear hearing aids during the testing. Additionally, a person described in 102.00B1c must perform an otoscopic examination immediately before the audiometric testing. (An *otoscopic examination* provides a description of the appearance of your external ear canals and an evaluation of the tympanic membranes. In these rules, we use the term to include otoscopic examinations performed by physicians and otoscopic inspections performed by audiologists and others.) The otoscopic examination must show that there are no conditions that would prevent valid audiometric testing, such as fluid in the ear, ear infection, or obstruction in an ear canal. The person performing the test should also report on any other factors, such as your ability to maintain attention, that can affect the interpretation of the test results.

c. Children From Birth to the Attainment of Age 6 Months

(i) We need physiologic testing, such as auditory brainstem response (ABR) testing.

(ii) To determine whether your hearing loss meets 102.10A, we will average your hearing thresholds at 500, 1000, 2000, and 4000 Hertz (Hz). If you do not have a response at a particular frequency, we will use a threshold of 5 decibels (dB) over the limit of the audiometer.

d. Children From Age 6 Months to the Attainment of Age 2

(i) We need air conduction thresholds determined by a behavioral assessment, usually visual reinforcement audiometry (VRA). We can use ABR testing if the behavioral assessment cannot be completed or if the results are inconclusive or unreliable.

(ii) To determine whether your hearing loss meets 102.10A, we will average your hearing thresholds at 500, 1000, 2000, and 4000 Hz. If you do not have a response at a particular frequency, we will use a threshold of 5 dB over the limit of the audiometer.

(iii) For this age group, behavioral assessments are often performed in a sound field, and each ear is not tested separately. If each ear is not tested separately, we will consider the test results to represent the hearing in the better ear.

e. Children From Age 2 to the Attainment of Age 5

(i) We need air conduction thresholds determined by a behavioral assessment, such as conditioned play audiometry (CPA), tangible or visually reinforced operant conditioning audiometry (TROCA, VROCA), or VRA. If you have had ABR testing, we can use the results of that testing if the behavioral assessment cannot be completed or the results are inconclusive or unreliable.

(ii) To determine whether your hearing loss meets 102.10A, we will average your hearing thresholds at 500, 1000, 2000, and 4000 Hz. If you do not have a response at a particular frequency, we will use a threshold of 5 dB over the limit of the audiometer.

(iii) For this age group, behavioral assessments are often performed in a sound field and each ear is not tested separately. If each ear is not tested separately, we will consider the test results to represent the hearing in the better ear.

f. Children From Age 5 to the Attainment of Age 18

(i) We generally need pure tone air conduction and bone conduction testing, speech reception threshold (SRT) testing (also referred to as "spondee threshold" or "ST" testing), and word recognition testing (also referred to as "word discrimination" or "speech discrimination" testing). This testing must be conducted in a sound-treated booth or room and must be in accordance with the most recently published ANSI standards. Each ear must be tested separately.

(ii) To determine whether your hearing loss meets the air and bone conduction criterion in 102.10B1 or 102.10B3, we will average your hearing thresholds at 500, 1000, 2000, and 4000 Hz. If you do not have a response at a particular frequency, we will use a threshold of 5 dB over the limit of the audiometer.

(iii) The SRT is the minimum dB level required for you to recognize 50 percent of the words on a standard list of spondee words. (Spondee words are two-syllable words that have equal stress on each syllable.) The SRT is usually within 10 dB of the average pure tone air conduction hearing thresholds at 500, 1000, and 2000 Hz. If the SRT is not within 10 dB of the average pure tone air conduction threshold, the reason for the discrepancy must be documented. If we cannot determine that there is a medical basis for the discrepancy, we will not use the results of the testing to determine whether your hearing loss meets a listing.

(iv) Word recognition testing determines your ability to recognize an age-appropriate, standardized list of phonetically balanced monosyllabic words in the absence of any visual cues. This testing must be performed in quiet. The list may be recorded or presented live, but in either case, the words should be presented at a level of amplification that will measure your maximum ability to discriminate words, usually 35 to 40 dB above your SRT. However, the amplification level used in the testing must be medically appropriate, and you must be able to tolerate it. If you cannot be tested at 35 to 40 dB above your SRT, the person who performs the test should report your word recognition testing score at your highest comfortable level of amplification.

g. *Screening testing.* Physiologic testing, such as ABR and otoacoustic emissions (OAE), and pure tone testing can be used as hearing screening tests. We will not use these tests to determine that your hearing loss meets or medically equals a listing, or to assess functional limitations due to your hearing loss, when they are used only as screening tests. We can consider normal results from hearing screening tests to determine that your hearing loss is not "severe" when these test results are consistent with the other evidence in your case record. *See* § 416.924(c).

3. What audiometric testing do we need when you have a cochlear implant?

a. If you have a cochlear implant, we will consider you to be disabled until age 5, or for 1 year after initial implantation, whichever is later.

b. After that period, we need word recognition testing performed with any age-appropriate version of the Hearing in Noise Test (HINT) or the Hearing in Noise Test for Children (HINT–C) to determine whether your impairment meets 102.11B. This testing must be conducted in quiet in a sound field. Your implant must be functioning properly and adjusted to your normal settings. The sentences should be presented at 60 dB HL (Hearing Level) and without any visual cues.

4. How do we evaluate your word recognition ability if you are not fluent in English?

If you are not fluent in English, you should have word recognition testing using an appropriate word list for the language in which you are most fluent. The person conducting the test should be fluent in the language used for the test. If there is no appropriate word list or no person who is fluent in the language and qualified to perform the test, it may not be possible to measure your word recognition ability. If your word recognition ability cannot be measured, your hearing loss cannot meet 102.10B2 or 102.11B. Instead, we will consider the facts of your case to determine whether you have difficulty understanding words in the language in which you are most fluent, and if so, whether that degree of difficulty medically equals 102.10B2 or 102.11B. For example, we will consider how you interact with family members, interpreters, and other persons who speak the language in which you are most fluent.

5. What do we mean by a marked limitation in speech or language as used in 102.10B3?

a. We will consider you to have a marked limitation in speech if:

(i) Entire phrases or sentences in your conversation are intelligible to unfamiliar listeners at least 50 percent (half) of the time but no more than 67 percent (two-thirds) of the time on your first attempt; and

(ii) Your sound production or phonological patterns (the ways in which you combine speech sounds) are atypical for your age.

b. We will consider you to have a marked limitation in language when your current and valid test score on an appropriate comprehensive, standardized test of overall language functioning is at least two standard deviations below the mean. In addition, the evidence of your daily communication functioning must be consistent with your test score. If you are not fluent in English, it may not be possible to test your language performance. If we cannot test your language performance, your hearing loss cannot meet 102.10B3. Instead, we will consider the facts of your case to determine whether your hearing loss medically equals 102.10B3.

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102.01 Category of Impairments, Special Senses and Speech

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102.10 Hearing Loss Not Treated With Cochlear Implantation

A. For children from birth to the attainment of age 5, an average air conduction hearing threshold of 50 decibels or greater in the better ear (see 102.00B2).

OR

B. For children from age 5 to the attainment of age 18:

1. An average air conduction hearing threshold of 70 decibels or greater in the better ear and an average bone conduction hearing threshold of 40 decibels or greater in the better ear (see 102.00B2f); or

2. A word recognition score of 40 percent or less in the better ear determined using a standardized list of phonetically balanced monosyllabic words (see 102.00B2f); or

3. An average air conduction hearing threshold of 50 decibels or greater in the better ear and a marked limitation in speech or language (see 102.00B2f and 102.00B5).

102.11 Hearing Loss Treated With Cochlear Implantation

A. Consider under a disability until the attainment of age 5 or for 1 year after initial implantation, whichever is later.

OR

B. Upon the attainment of age 5 or 1 year after initial implantation, whichever is later, a word recognition score of 60 percent or less determined using the HINT or the HINT–C (*see* 102.00B3b).

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FEDERAL MEDIATION AND CONCILIATION SERVICE

29 CFR Part 1404

RIN 3076–AA12

Arbitration Services

AGENCY: Federal Mediation and Conciliation Service.

ACTION: Final rule.

SUMMARY: This final rule amends the Federal Mediation and Conciliation Service (FMCS) rules pertaining to arbitration services. It revises rules addressing the removal of arbitrators from the FMCS roster, the process relating to complaints about arbitrators, procedures for requesting lists and panels, arbitrators' inactive status, the selection by parties and appointment of arbitrators, and arbitrators' obligation to provide FMCS with certain case information. The final rule also provides that FMCS may decline to service any request by a party for an arbitration list or panel based on the party's non-payment of arbitrator fees. In addition, the final rule raises the annual listing fee for all arbitrators on the FMCS roster. The changes will promote more efficient and effective procedures involving arbitrator retention and arbitration services. The increased annual listing fee more accurately reflects FMCS's costs of maintaining and responding to requests for arbitrators' biographical data. The final rule withdraws the proposed revisions to § 1404.9(b).

DATES: This final rule is effective July 2, 2010.

FOR FURTHER INFORMATION CONTACT: Vella M. Traynham, Director, Office of Arbitration Services, FMCS, 2100 K Street, NW., Washington, DC 20427. Telephone: (202) 606–5111.

SUPPLEMENTARY INFORMATION: Pursuant to 29 U.S.C. 171(b) and 29 CFR part 1404, FMCS maintains a roster of qualified labor arbitrators to hear disputes arising under collective bargaining agreements and provide fact finding and interest arbitration. FMCS amends its rules pertaining to such arbitration services as follows: The revised rule relating to the removal of arbitrators from the roster provides that FMCS will give written notice of removal to the affected arbitrator. The revised rule relating to complaints against arbitrators provides that complaints should be in writing and directed to the director of the office of arbitration services, and should cite specific sections of the professional code or FMCS rules allegedly violated by the arbitrator. The revised rule on arbitrators' inactive status clarifies the applicable annual listing fee and suggests that arbitrators use inactive status to assist them in certain scheduling circumstances. The revised rule on procedures for requesting panels and lists provides that FMCS may decline to service any request from a party for arbitration lists or panels based on the party's non-payment of arbitrator fees. The revised rule on the selection by parties and appointment of arbitrators provides that arbitrators must provide FMCS with certain information upon being selected by a party. The revised rules describe the methods of arbitrator selection that FMCS will accept, where the parties' collective agreement is silent on the manner of selection. These changes are intended to make FMCS's arbitration procedures more efficient and effective.

FMCS also amends Appendix to Part 1404 to increase the annual listing fee from $100 to $150 for all arbitrators on the FMCS roster. With increasing frequency, parties have been requesting that FMCS furnish arbitration panels that are individualized to the dispute at issue. This requires detailed research and review of arbitrators' biographies. The increased listing fee reflects the cost in staff time necessary to be responsive to these requests as well as the costs associated with updating arbitrator biographies.

This rule is not a significant regulatory action for the purposes of Executive Order 12866 and has not been reviewed by the Office of Management and Budget. As required by the Regulatory Flexibility Act, I certify that this rule will not have a significant impact on a substantial number of small entities. This regulation does not have any federalism or tribal implications.

Background: On August 6, 2008, FMCS published a Notice of Proposed