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OA/ID Number: 21538

FolderID:

Folder Title:

Disability--Childhood Disability Rule

Stack:

S

Row:

96

Section:

5

Shelf:

1

Position:

2

FAX COVER



Income Maintenance Branch

Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503



To: CHRISTINA HO

Organization: DPC

Fax Number: 6-7431

From: JOANNE CIANCI

Date/Time: 09/01/00

Number of Pages: Cover + 8

Notes:

Christina,

Attached is SSA's Draft Fact Sheet and Q&A on the Childhood Reg. Please let me know if you and Andrea have any comments or suggestions.

I would like to get back to SSA early next week.

- Joanne

Income Maintenance Fax Number: (202) 395-0851
Voice Confirmation: (202) 395-4686

DRAFT

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not for distribution

**FACTSHEET
"FINAL FINAL" CHILD DISABILITY
REGULATIONS**

These are final rules responding to public comments on the interim final rules we have been using since 2/11/97.

The final rules will be published in September. However, we plan a "delayed implementation date" of 1/2/2001. Will give us time to provide training and instructions to all of our adjudicators and to revise our forms and notices.

The Interim final rules will continue to apply until the effective date of these final rules. (When the final rules become effective, we will apply them to new applications filed on or after the effective date of the rules and to claims pending at any step in our administrative process.)

Major features. Revisions based primarily on public comments, input from medical experts in childhood disability and advocates, the 1997 top-to-bottom review, and our experience adjudicating claims.

- Same standard as the 1997 interim final rules interpreting P.L. 104-193. Based on our listing of impairments: Meet, "medically" equal, or functionally equal ("marked" limitations in 2 domains or an "extreme" limitation in 1).
- Better general instructions on evaluation of functioning at all steps in our process. Reorganized and expanded existing rules based on public and expert input, and our longstanding instructions and training. Stresses comparison of child with other children the same age who don't have medical impairments and need to evaluate the overall effects of multiple medical impairments.
- Functional equivalence simplified and clarified. Based largely on public comments that asked us to do this. For example:
 - Reference to specific listings no longer required. Based on a single standard of "listing-level" severity.
 - Only 1 method for determining functional equivalence to the listings (prior rules had 4 that were to some extent redundant).
- Changes in domains:
 - All domains apply to all children (in prior rules, children age 1-3 were evaluated in fewer domains), including better rules for evaluating physical impairments.

--Domains revised to more clearly reflect the functional impacts of impairments. For example, "motor functioning" becomes "moving about and manipulating objects."

--Added a new domain for evaluating physical impairments based on prior methods.

- Emphasis on evaluation of the whole child helps in evaluating children who have multiple medical problems, or medical problems with multiple effects.
- Includes regulatory language to codify provisions from the 1997 Balanced Budget Act on when we can do low birth weight CDRs (may be later than age 1) and extended time limit for conducting age-18 redeterminations.

Another feature is that we tried to put these very technical rules into plain English that will be more accessible to families.

Projected effect:

- Children who should be allowed or denied under current (interim final) rules should get the same decision under the final rules.
- However, we project more accurate allowance and denial decisions because rules are clearer and easier to use.
- Based on a small pilot, we project a net of about 4,000 additional allowances in each of the next 5 years. Last year, we allowed about 140,000 children.
- In 12/99, there were about 850,000 children on the rolls.

to we really want to put in fact sheet

Why are the final rules being published now? Why has it taken so long?

- We believe that it is vitally important that all children who meet the SSI eligibility requirements receive their benefits. Because of this commitment, we placed a higher priority on carefully considering the comments we received on the interim final rules than on publishing the final regulations quickly.
- The final rules respond to extensive comments on the interim final rules that we received from a wide range of child-serving professional organizations as well as advocacy, legal, and family groups. Their comments, together with our experience and other actions, support adjustments made in the interim final regulations that we publish today as the final childhood disability regulations. *any HHS comments?*
- SSA believes that the final regulations are fair and fulfill this commitment to children.

Additional Information

- The top to bottom review indicated that SSA and the State agencies making disability determinations for us had done a good job of implementing the new provisions, but found some problems. Commissioner Apfel immediately ordered several corrective actions to address these concerns, including re-reviewing certain types of cases. Before these reviews began, we provided additional training to all our adjudicators on how to evaluate mental impairments other than mental retardation, and on the evaluation of speech disorders. We also issued a Social Security Ruling (SSR) on the evaluation of speech disorders in combination with cognitive limitations.
- The Balanced Budget Act of 1997, Pub. L. 105-33, enacted on August 5, 1997, contained two amendments that affect these final rules. The amendments were retroactive to August 22, 1996, the date of enactment of Pub. L. 104-193. These final rules also address those changes which:
 - allow us to perform age-18 redeterminations at any time in lieu of a CDR, not just during the one-year period beginning on the individual's 18th birthday; and
 - allow us to wait until after age 1 to do a CDR on a child for whom low birth weight is a contributing factor material to disability if we determine that the child's impairment is not expected to improve by age 1 and we schedule a CDR for after age 1.

What has changed from the Interim final rules?

- Better general instructions on evaluation of functioning at all steps in our process. Reorganized and expanded existing rules based on public and expert input, and our longstanding instructions and training. Stresses comparison of child with other children the same age who don't have medical impairments and need to evaluate the overall effects of multiple medical impairments.
- Functional equivalence simplified and clarified based largely on public comments that asked us to do this. For example:
 - Reference to specific listings no longer required. Based on a single standard of "listing-level" severity.
 - Only 1 method for determining functional equivalence to the listings (prior rules had 4 that were to some extent redundant).
- Changes in domains:
 - All domains apply to all children (in prior rules, children age 1-3 were evaluated in fewer domains), including better rules for evaluating physical impairments.
 - Domains revised to more clearly reflect the functional impacts of impairments. For example, "motor functioning" becomes "moving about and manipulating objects."
 - Added a new domain for evaluating physical impairments, using both prior guidance and new guidance based on public comments.
- Emphasis on evaluation of the whole child helps in evaluating children who have multiple medical problems, or medical problems with multiple effects.
- Includes regulatory language to codify provisions from the 1997 Balanced Budget Act on when we can do low birth weight CDRs (may be later than age 1) and extended time limit for conducting age-18 redeterminations.

Are people generally satisfied with the final regulations? Is the Congress generally satisfied that SSA has now correctly implemented the SSI childhood disability sections of the welfare reform legislation?

- In general, we believe the public is ^{likely} satisfied. The combination of keeping the standard the same while improving the functional equivalence step and the domains of functioning hits just the right balance. Combining this with our careful, inclusive approach, we do not expect any strong opposition to the final rules. While some people would prefer a looser standard, generally they will recognize that our interpretation is an appropriate one. *we believe*
- We would defer to the Congress with regard to their assessment concerning SSA's implementation of welfare reform. In addition, since the rules have just been published, it would be premature to speculate on their reaction. *probably*

*would it some
issue of timing
apply to me
public
how does
really know
their
reaction
if
published?
maybe
add*

Is the childhood disability standard about right?

- so there are many people*
- Yes, we believe it is. Although many commenters stated that our interpretation of the phrase "marked and severe functional limitations" in the interim final rules did not properly reflect Congressional intent, we disagree. These final rules continue to define the term "marked and severe functional limitations," when used as a phrase, to mean the standard for disability in the Act for children claiming SSI benefits based on disability. We continue to define this standard in the final rules as being based on a level of severity that meets or medically or functionally equals the severity required by the listings.
 - We continue to define listing-level severity, as required by the Act, as "marked" limitation in two domains or an extreme limitation in one domain. Therefore, although we delinked our policy of functional equivalence from reference to specific listings, we continue to use the phrase "functionally equals the listings," to underscore that the impairment(s) must be of listing-level severity.

What was the effect of the change in childhood rules? How many more children will be eligible under the final rule?

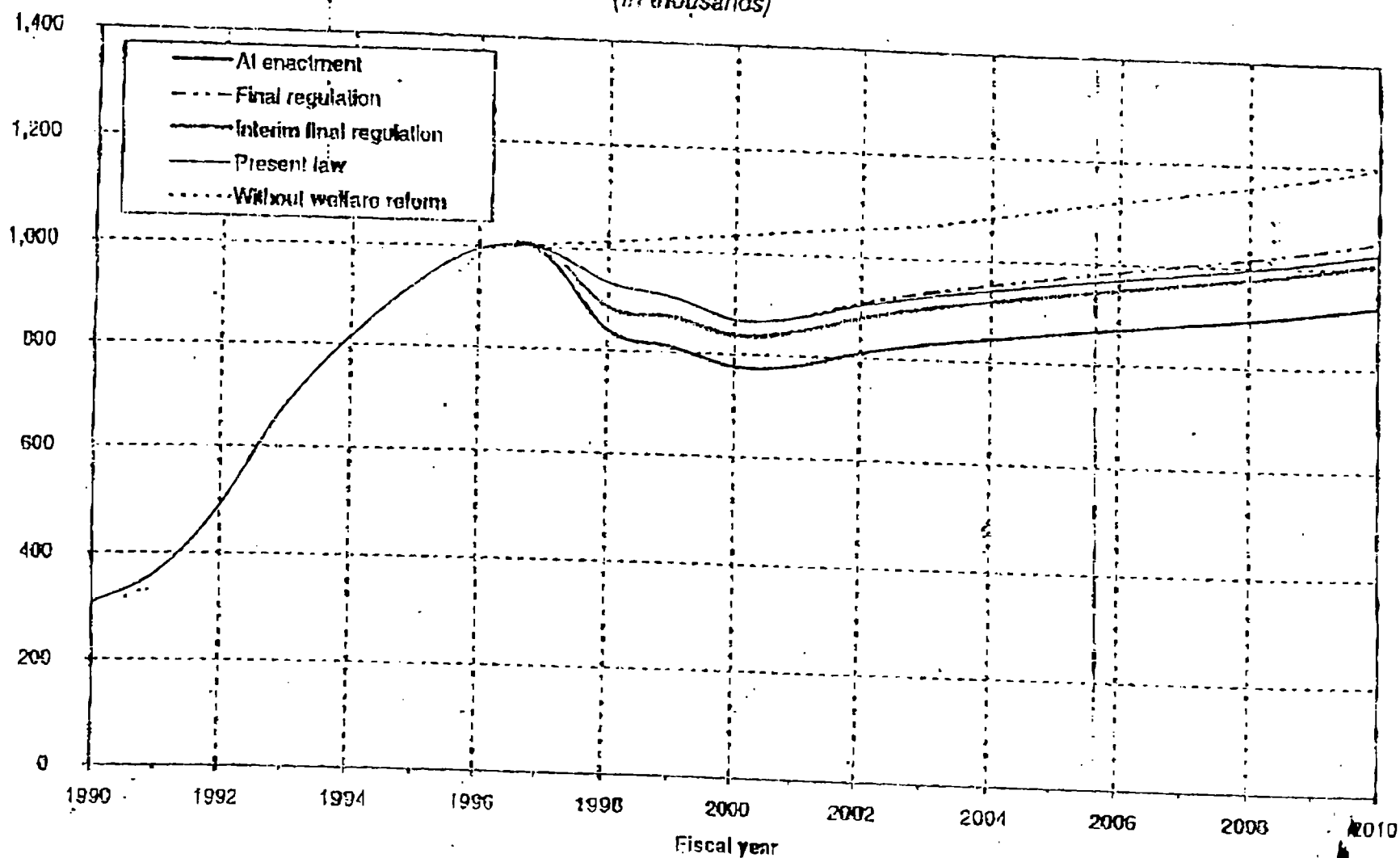
- SSA originally projected about 135,000 children would lose eligibility under the interim final rules after all appeals.
- This figure was revised to 100,000 with the actions taken as a result of the top-to-bottom review. *One time?*
- Based on a small pilot, we project a net of about 4,000 additional allowances in each of the next 5 years under the final rule. Last year, we allowed about 140,000 children. *Compared to what?*

Additional Information

- There were approximately 1 million SSI childhood recipients on the rolls as of August 1996. As of December 1999, there were about 850,000 children on the rolls.

Attachment: OAct graph of the estimated effects of P.L. 104-193 on the average numbers of disabled children in payment status

Estimated effect of P.L. 104-193 on average numbers of disabled children in payment status
during year based on assumptions underlying the
SSI 2000 Annual Report, fiscal years 1990-2010
(in thousands)



TOTAL P.09

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HERE IS A COPY OF SSA'S BRIEFING MATERIALS.

PLEASE LET ME KNOW IF YOU HAVE ANY
QUESTIONS.

THANKS,
JOANNE

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FINAL CHILDHOOD REGULATIONS

June 2000

Delay implementation to allow for training

06/29/2000

Final Childhood Regulations

1

ID:

AUG 02'00

4:35 No.001 P.02

Since ^{COSS}you last met with us

- Initial SSA paper 02/2000
- Advocates/Experts involved
- DDS/RO input obtained
- Rules drafted to address:
 - concerns in original public comments
 - and current expression of those concerns
- Rules tested

06/29/2000

Final Childhood Regulations

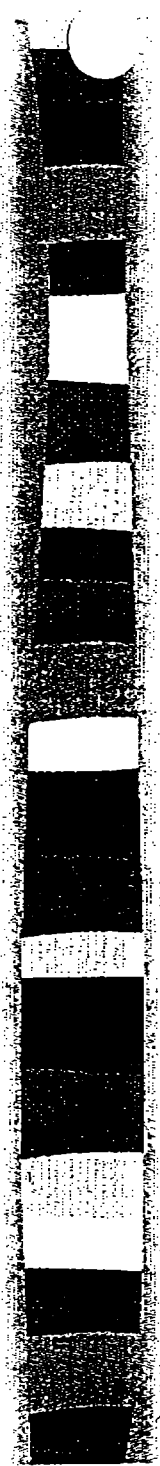
Comments on Interim Final Rules

■ 174 Commenters

- Advocacy organizations
- Parents, other private citizens
- Legal aid groups
- Impairment-specific organizations
- State/local family services agencies (no DDSs)

Key Issues in Comments

- “Other factors” *must meet functional listing
“reminder” items to consider when reviewing a kids case
→ Not clear what to do w/ these factors or when to
include them*
- Combined impairments *- Need to explain better the effect of
combinations of impairments*
- Maladaptive behavior
- Functional equivalence



Comments - “Other Factors”

- How used
- More factors needed
- Symptoms
- Combined impairments
- Age-appropriate

Comments - Functional Equals

4 methods for eval. functional equivalence
~ Some overlap; not clear

- Simplify
- Separate cognitive & communicative - Lots of comments re need to sep.
- Use all areas for all ages - only 3 domains used for young children - argue that it is a sep. brain function (SSA says not so clear)...
- Combined impairments
- More physical - liked addition of motor function, but still thought it was too narrow.
- Clarify terms (e.g., "marked," "extreme")
- Apply standard error of measurement to test results (eg apply the "minus" side to tests such as IQ)
- Use standardized tests - particularly the standardized test of functioning

Final Rules

- Disability standard unchanged
(2 marked or 1 extreme)
- “Broad areas of development or
functioning” →→ “domains”

SSA did not
want to go back
to old standard (IFA)
n has changed to
tighten the rule

Major Provisions

■ Clarify/reorganize rules. *Condensed 3 sections into 1* Emphasize:

- Compare to children of same age without impairments; *age appropriate terms*
- Combined impairments; *effort not to compartmentalize impairments ~ look at entire child*
- More factors *~ some redundancy*

■ Revise functional equals

Functional Equals

■ Simplified

- One method replaces four ~ based on domains
2 marked or
1 extreme

- De-linked from specific listings
~ equal "the" listings

- Revised domains specifically for functional equals

No longer a linkage to mental disorders listings

- Better definitions of "marked" and "extreme"

Incorporated provision from training for top to bottom
Not "new" just more info

- Clarified/expanded test guidance

Did not adopt comment on functional impairment std of error

Need to look beyond the test score to look at other forms of functionality

Final Childhood Regulations

06/29/2000

ID:

AUG 02'00

4:39 No.001 P.10

Functional equivalence domains

currently 5 domains

Built in principles & methods (eg episodic illness)

- 6 domains -- all ages *Added domain on physical imp.*
- New domain (health & physical well-being)
- Descriptions of functioning/limitations
~ use by adjudicators & ALJs (sets a "healthy" standard)
- Communication addressed in appropriate domains

Current Areas

Motor Functioning

Social Functioning

Cognition/Comm.

Personal Functioning

Responsiveness to
Stimuli

Concentration,
Persistence, or Pace

Draft Domains

Moving About/
Manipulating Objects

Interacting/Relating With
Others

Acquiring/Using
Information

Not adopting
public comment to
separates

Caring For Yourself

Attending/Completing
Tasks

Health & Physical Well-
Being

Pilot May 2 - 11

■ DDS, RO, DQB, OHA, CO staff

■ 180 cases ~ all functional equivalence cases

■ Old and new rules

■ Some denials s/h/b allowances even under existing rules

■ Simplification of rules should reduce erroneous denials (see OCACT Estimates slide)

- Agree w/ decision under current rules
(Found some that had been adjudicated incorrectly)

- Reviewed under new rules

Finding
- Fewer errors made under new rules

Quicker & more efficient
- Same evidence is necessary

No cases resulted in a different decision

Pilot participant reactions

- Positive changes
- Easier to understand/apply
- Age-appropriate activity/limitation descriptions helpful
- Need training
- Revise SSA-538 - *Adjudicators describe how they came to their decision.*
"Childhood Disability Evaluation Form"

Impact - NCDDDD Concerns

DDS Leadership

- Costs (e.g., training, productivity; startup and ongoing)
- Concerns discussed 05/23
- Most concerns answered

Impact - Advocate Reactions

- Expected to be positive
- Believe all will support these rules
- Some may wish for other revisions

Impact - OCACT Estimates

- Simpler rules will reduce decisional errors 25%
- Most decisional errors are denials
- Net effect 4000 additional awards/year
- Major rule in years 4 & 5?
(\$60mill./\$75mill. plus Medicaid)

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A vertical strip of film showing a series of black and white frames, likely a sequence of a film strip. The frames are arranged in a vertical column, with some frames showing a dark, textured background and others showing a lighter, more detailed scene. The film strip is slightly curved and has a grainy texture.

- | | | |
|-----|------|------|
| 10. | 1000 | 4.01 |
| 11. | 1000 | 1000 |

Comments - Functional Equals

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(\$60mill./\$75mill. plus Medicaid)

8/21/2000

Domain 6

Make sure nothing lost from former methods.

specific functions

broad Domains

episodic impairments

limitations related to treatment/medication effects

comments — based mostly on mental listings, not as much on physical listings.
 shortness of breath / seizures ~ just motor functioning.

Somatic effects of any impairment
 Why ~ just medical equivalency?
 This gives you a way of showing
 one marked limitation in this
 combine if marked from another
 But

[Why ~ all domains moderate
 listing level - severity]

If ~~anything~~ more kids will be eligible (b/c the rule is more accurate)

- MR but

Intelligence disorders v. lang. disorders

expressive pragmatics

Borderline LD

will be allowed under new rules.

Psychiatric disorders

- behavioral aspects of these.

↳ address kids who don't act out too.

Physical → winners + losers.

would have been some kids found disabled (chronic illness, freq. of treatment) but now they need to be marked + have another marked.

6th Domain → anorexia

It's been combined before

hard to communicate to adjudicators
that some aspects of ~~cognition~~
communication had to do w/
cognitive things too

Groups: Jonathan Stein

Bob Lukens
(contract to write
these rules)

Marty Ford

Tom Yates

R. Bob Cook

Leah Lockeson TCMR

Because we've always done it that way
- Bell + Suspenders theory

Timeline
developing instructional + training
material by end of this ~~mo.~~
training Nov. or Dec.
publication by end of this Mo.
Brief Congress → Brian
conversation on rollout
strategy.

Mon. →

Barry, Brian,

→ Note to Bruce + Barbara

- Key points:

- outlining what the D's are here

- Def'n of disability
- simplifying process
- holistic eval of process
- focus

they've been working
up the groups.

Joanne's
#

5-3385

Blurb → on the
muddy

8/22/2000

SSI Kids Reg Rollout

Jay Grossman

Brian & Sankar

Bryan

Coyne

- SSI wanted to have it in March final
last community wanted it finalized
- Community wants to stay quiet
- Low-key
- As if whole thing is in
flux. Our forces in
Cory. will overtake this

Cong. Mervyn Dymally
asked & Sacramento

effective
Jan 1

- Put it on the web page
Jan 1, 2001 → have to brief Cong.
- MT

publish

Bring End of

Q's & A's ready to go

cleared COB. Jan.

3348
N4222
108

Questions/Issues with SSI Childhood Disability Final Rule

General Questions

- How many kids lost benefits as the result of the PRWORA changes?
- Has there been a reduction in applications?
- Who are the kids expected to be found eligible as a result of this final rule?
- Clarify the intent of Domain 6. What is its effect?
- Clarify cognition/communication policy.

Assessment of Benefits and Costs to Society

- Do the administrative costs estimate use the OACT assumptions? If not, estimates must be updated before this is released.
- How many adjudicators? What is the training cost per adjudicator? What does training entail? Duration?

Final Rule

- What is the schedule for revising SSA-538 and other notices?
 - SSA states they “expect the court’s review of the Commissioner’s final decision would be made in accordance with the rules in effect at the time of the final decision.” This seems approp., but what if the kid is now eligible? Can SSA state its “expectation” of Court action. (p 31)
 - In section 416.924a(a)(1)(iii), “Medical sources,” SSA states it will consider information provided by nonmedical sources. Was this in the interim final? Does it matter since this has been a long-standing policy. (p 42)
 - Final section 416.924b(b) is identical to section 416.924a(b) of the interim rules. SSA is not reprinting. Shouldn’t they reprint since the section number has changed? (p 55)
 - Did SSA adequately address concerns regarding the separation of communication from cognition? (p 60, 168-170)
 - Eliminated the “cognitive/communicative” domain. Address communication in each domain as appropriate. (p 64)
 - Resolve inconsistency with other information in the case record by questioning other individuals who can provide us with information about a child’s day-to-day functioning, or by purchasing a consultative examination. When does this information take precedence? (p 83)
 - Received a comment suggesting that we update both the adult and the childhood mental disorders listings. SSA states it is considering an update. How is this different from the recent final rule on mental disorders? (p 109)
 - SSA considers the need for an adaptation when it consider how seriously a child’s functioning is limited. Is this consistent with the proposed changes to the musculoskeletal listings? (p 149)
 - Clarify the Hickman v. Apfel ruling. The Court’s decision that medical equivalence is decided based solely on evidence from medical sources interprets the “medical evidence only” language of the regulation more narrowly than SSA intended. Is it correct that SSA plans to address this through another reg? (p 154)
 - SSA received a comment requesting examples of medical equivalence, similar to the examples of functional equivalence given in the final rule. SSA did not include the examples
- will cover
admission
+ alcohol
treatment

p. 94

Does the early childhood development literature/science support giving these domains of functionality equal weight?

p. 62

What's the effect of de-linking the functional equivalence analysis from the listings and does it satisfy commenters

p. 63

what is the debate/reasoning behind adding the physical effects of physical and mental impairments as a domain?

p. 77

Why should scores take precedence over subjective estimate of functioning relative to chronological age? I thought functioning would take precedence over reliance on test scores.

p. 88

How will professionals interpret testing?

p. 127

Confusion about the two meanings of severe—one is "marked and severe" the other is "severe" as used in the sequential analysis?

p. 120

Why aren't moderate limitations in more than two areas considered to meet the definition (shy not let it be a sliding scale)

p. 136

Why include school psychologists as acceptable medical sources, but not others (see p. 133)?

p. 168

Explain the debate over the need to separate cognitive/communicative functionality.

p. 299

What does this mean? How is the consideration of health and physical well-being different in the functional analysis v. the medical equivalence analysis

p. 221—lays out sequential analysis

p. 252—std for disability, def'n of marked and extreme

p. 3 → mention that this is in response to process as well

5

because it is outside the "scope of this rulemaking process." Is this because it focuses on the medical standard, while the reg focuses on functional equivalence? (p 156)

- Why so many references to SEM? It is not clear how it is being used or if SSA thinks it is an appropriate measure.
- Is the discussion of Congress creating laws to "override" Supreme Court decisions appropriate? (p 185-186)
- Is there a TDD number to call request the SSA publication? (p 192)
- **Must include cost estimate in the preamble. The stand-alone piece is not sufficient.**
- **Must include statement regarding unfunded mandates (even though State costs are below the threshold)**
- Status of the RAND study? (p 201)
- Was Sec. 416.901(e) expanded? It is not shown as being edited. Check cross references. (p 217)
- Changes to Sections 906, 911, 913 and 919 are not discussed in the preamble. Should they be? (p 218) ☐ ✓
- What happened to the old Sec. 913(d).
- Are the adaptations consistent with the musculoskeletal rule?

The remaining other notices/forms
to be consistent w/ this
(will be ready Jan. 2)

Step 1: SGA?

Step 2: impairments are severe?

Step 3: medically or functionally equals in severity the listings (and duration requirement)

Social Security Administration

§ 416.926a

findings. We will compare the symptoms, signs, and laboratory findings about your impairment(s), as shown in the medical evidence we have about your claim, with the medical criteria shown with the listed impairment. If your impairment is not listed, we will consider the listed impairment most like your impairment to decide whether your impairment is medically equal. If you have more than one impairment, and none of them meets or equals a listed impairment, we will review the symptoms, signs, and laboratory findings about your impairments to determine whether the combination of your impairments is medically equal to any listed impairment.

(b) *Medical equivalence must be based on medical findings.* We will always base our decision about whether your impairment(s) is medically equal to a listed impairment on medical evidence only. Any medical findings in the evidence must be supported by medically acceptable clinical and laboratory diagnostic techniques. We will also consider the medical opinion given by one or more medical or psychological consultants designated by the Secretary in deciding medical equivalence. (See § 416.1016.)

(c) *Who is a designated medical or psychological consultant.* A medical or psychological consultant designated by the Secretary includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. A medical consultant must be a physician. A psychological consultant used in cases where there is evidence of a mental impairment must be a qualified psychologist. (See § 416.1016 for the qualifications we consider necessary for a psychologist to be a consultant.)

[45 FR 55621, Aug. 20, 1980, as amended at 52 FR 33928, Sept. 9, 1987; 56 FR 5561, Feb. 11, 1991]

§ 416.926a Equivalence for children.

(a) *General.* If you are a child and you do not have an impairment that meets the requirements of a listing, we will determine whether you have an impairment or combination of impairments

that is equivalent in severity to any listed impairment in appendix 1 of subpart P of part 404, as set forth in this section. While all possible impairments are not addressed within the Listing of Impairments, within the listed impairments are all the physical and mental functional limitations, i.e., what a child cannot do as a result of an impairment, that are considered severe enough to prevent a child from functioning independently, appropriately, and effectively in an age-appropriate manner. We will compare the symptoms, signs, and laboratory findings about your impairment(s), including, where appropriate, any functional limitations that result from your medically determinable impairment(s), with the corresponding criteria shown for any listed impairment. When we make an equivalence decision, we will consider all relevant evidence in your case record.

(b) *How we determine the equivalence of impairments for children.* Equivalence can be found in three ways:

(1) If you have an impairment that is described in the Listing of Impairments in appendix 1 of subpart P of part 404, but:

(i) You do not exhibit one or more of the medical findings specified in the particular listing, or

(ii) You exhibit all of the medical findings, but one or more of the findings is not as severe as specified in the listing,

we will nevertheless find that your impairment is equivalent to that listing if you have other medical findings related to your impairment that are at least of equal medical significance.

(2) If you have an impairment that is not described in the Listing of Impairments in appendix 1, or you have a combination of impairments, no one of which meets or is equivalent to a listing, we will compare your medical findings with those for closely analogous listed impairments. If the findings associated with your impairment(s) are at least of equal medical significance to those of a listed impairment, we will find that your impairment(s) is equivalent to the analogous listing.

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(3) If we cannot find equivalence under either of the foregoing provisions, we will assess the overall functional limitations that result from your impairment(s), i.e., what you cannot do because of your impairment(s). If you have more than one impairment, we will consider the combined effects of all your impairments on your overall functioning. We will compare the functional limitations(s) resulting from your impairment(s) with the functional consequences of any listed impairment which includes the same functional limitations; the listing we choose for comparison need not be medically related to your impairment(s). If the functional limitation(s) resulting from your impairment(s) is the same as the disabling functional consequences of a listed impairment, we will find that your impairment(s) is equivalent to that listed impairment. When we make a determination or decision using this rule, the primary focus will be on the disabling consequences of your impairment(s), as long as there is a direct, medically determinable cause for these consequences.

(c) *Responsibility for determining equivalence.* In cases where the State agency or other designee of the Secretary makes the initial or reconsideration disability determination, a State agency staff medical or psychological consultant or other designee of the Secretary (see § 416.1016) has the overall responsibility for determining equivalence. For cases in the disability hearing process, the responsibility for determining equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsidered determination is changed under § 416.1418, with the Associate Commissioner for Disability or his or her delegate. For cases at the Administrative Law Judge or Appeals Council level, the responsibility for deciding equivalence rests with the Administrative Law Judge or Appeals Council.

(d) *Examples of impairments of children that are functionally equivalent to the listings.* The following are some examples of consequences of impairments that are functionally equivalent to listed impairments. The consequences of each child's impairment(s) must be

assessed to determine whether they are functionally equivalent to those of a listed impairment. Findings of equivalence based on the disabling functional consequences of a child's impairment(s) should not be limited to the examples below, because these examples do not describe all the possible effects of impairments that might be found to be equivalent to a listed impairment. As with any disabling impairment, the duration requirement must also be met (see §§ 416.909 and 416.924(a)).

(1) Documented need for major organ transplant (e.g., heart, liver).

(2) Any condition that is disabling at the time of onset, requiring a series of staged surgical procedures within 12 months after onset as a life-saving measure or for salvage or restoration of function, and such major function is not restored or is not expected to be restored within 12 months after onset of the condition.

(3) Frequent need for a life-sustaining device (e.g., central venous alimentation catheter), at home or elsewhere.

(4) Marked inability to stand and walk; e.g., ambulation possible only with obligatory bilateral upper limb assistance.

(5) Any physical impairment(s) or combination of physical and mental impairments causing marked restriction of age-appropriate activities of daily living and marked difficulties in maintaining age-appropriate social functioning.

(6) Any physical impairment(s) or combination of physical and mental impairments causing complete inability to function independently outside the area of one's home within age-appropriate norms.

(7) Requirement for 24-hour-a-day supervision for medical or behavioral reasons.

(8) Infants weighing less than 1200 grams at birth, until attainment of 1 year of age.

(9) Infants weighing at least 1200 but less than 2000 grams at birth, and who are small for gestational age, until attainment of 1 year of age. (*Small for gestational age* means a birth weight that is at or more than 2 standard

deviations below the mean or that is below the 3rd growth percentile.)

(10) In an infant who has not attained age 1 year, any physical impairment(s) or combination of physical and mental impairments that satisfies the requirements of Listing 112.12.

(11) Major congenital organ dysfunction (e.g., congenital heart disease) which could be expected to result in death within the first year of life without surgical correction, and the impairment is expected to be disabling (because of residual impairment following surgery, or the recovery time required, or both) until attainment of 1 year of age.

(12) Gastrostomy in a child who has not attained age 3.

[56 FR 5561, Feb. 11, 1991, as amended at 58 FR 47586, Sept. 9, 1993; 58 FR 52367, Oct. 7, 1993]

§ 416.927 Evaluating medical opinions about your impairment(s) or disability.

(a) *General.* (1) You can only be found disabled if you are unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. See § 416.905. Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. See § 416.908.

(2) Evidence that you submit or that we obtain may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(b) *How we consider medical opinions.* In deciding whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive.

(c) *Making disability determinations.* After we review all of the evidence rel-

evant to your claim, including medical opinions, we make findings about what the evidence shows.

(1) If all of the evidence we receive, including all medical opinion(s), is consistent, and there is sufficient evidence for us to decide whether you are disabled, we will make our determination or decision based on that evidence.

(2) If any of the evidence in your case record, including any medical opinion(s), is inconsistent with other evidence or is internally inconsistent, we will weigh all of the evidence and see whether we can decide whether you are disabled based on the evidence we have.

(3) If the evidence is consistent but we do not have sufficient evidence to decide whether you are disabled, or, if after weighing the evidence we decide we cannot reach a conclusion about whether you are disabled, we will try to obtain additional evidence under the provisions of §§ 416.912 and 416.919 through 416.919h. We will request additional existing records, recontact your treating sources or any other examining sources, ask you to undergo a consultative examination at our expense, or ask you or others for more information. We will consider any additional evidence we receive together with the evidence we already have.

(4) When there are inconsistencies in the evidence that cannot be resolved, or when despite efforts to obtain additional evidence the evidence is not complete, we will make a determination or decision based on the evidence we have.

(d) *How we weigh medical opinions.* Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) *Examining relationship.* Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) *Treatment relationship.* Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a

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administrative law judge. In such circumstances, however, a remand may ordinarily be made only once.

(2) For all cases involving mental disorders at the administrative law judge hearing or Appeals Council levels, the standard document will be appended to the decision.

(Approved by the Office of Management and Budget under control number 0960-0413)

[50 FR 35070, Aug. 28, 1985, as amended at 55 FR 51236, Dec. 12, 1990]

§ 416.921 What we mean by a not severe impairment(s) in an adult.

(a) *Non-severe impairment(s)*. An impairment or combination of impairments is not severe if it does not significantly limit your physical or mental ability to do basic work activities.

(b) *Basic work activities*. When we talk about basic work activities, we mean the abilities and aptitudes necessary to do most jobs. Examples of these include—

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting.

[50 FR 8729, Mar. 5, 1985, as amended at 56 FR 5554, Feb. 11, 1991]

§ 416.922 When you have two or more unrelated impairments—initial claims.

(a) *Unrelated severe impairments*. We cannot combine two or more unrelated severe impairments to meet the 12-month duration test. If you have a severe impairment(s) and then develop another unrelated severe impairment(s) but neither one is expected to last for 12 months, we cannot find you disabled, even though the two impairments in combination last for 12 months.

(b) *Concurrent impairments*. If you have two or more concurrent impairments which, when considered in com-

bination, are severe, we must also determine whether the combined effect of your impairments can be expected to continue to be severe for 12 months. If one or more of your impairments improves or is expected to improve within 12 months, so that the combined effect of your remaining impairments is no longer severe, we will find that you do not meet the 12-month duration test.

[50 FR 8729, Mar. 5, 1985]

§ 416.923 Multiple impairments.

In determining whether your physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under the law, we will consider the combined effect of all of your impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity. If we do find a medically severe combination of impairments, the combined impact of the impairments will be considered throughout the disability determination process. If we do not find that you have a medically severe combination of impairments, we will determine that you are not disabled (see §§ 416.920 and 416.924).

[50 FR 8729, Mar. 5, 1985, as amended at 56 FR 5554, Feb. 11, 1991]

§ 416.924 How we determine disability for children.

(a) *Steps in evaluating disability*. We consider all relevant evidence in your case record when we make a determination or decision whether you are disabled. If you allege more than one impairment, we will evaluate all the impairments for which we have evidence. Thus, we will consider the combined effects of all your impairments upon your overall health and functioning. We will also evaluate any limitations in your functioning that result from your symptoms, including pain (see § 416.929). When you file a new application for benefits, we use the evaluation process set forth in (b) through (d) of this section. We follow a set order to determine whether you are disabled. If you are doing substantial gainful activity, we will determine

that you are not disabled and not review your claim further. If you are not doing substantial gainful activity, we will consider your physical or mental impairment(s) first to see if you have an impairment or combination of impairments that is severe. If your impairment(s) is not severe, we will determine that you are not disabled and not review your claim further. If your impairment(s) is severe, we will review your claim further to see if you have an impairment(s) that meets, medically equals, or functionally equals in severity any impairment that is listed in appendix 1 of subpart P of part 404 of this chapter. If you have such an impairment(s), and it meets the duration requirement, we will find that you are disabled. If you do not have such an impairment(s), or if it does not meet the duration requirement, we will find that you are not disabled.

(b) *If you are working.* If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or age, education, or work experience. (For our rules on how we decide whether you are engaging in substantial gainful activity, see §§416.971 through 416.976.)

(c) *You must have a severe impairment(s).* If your impairment(s) is a slight abnormality or a combination of slight abnormalities that causes no more than minimal functional limitations, we will find that you do not have a severe impairment(s) and are, therefore, not disabled.

(d) *Your impairment(s) must meet, medically equal, or functionally equal in severity a listed impairment in appendix 1.* An impairment(s) causes marked and severe functional limitations if it meets or medically equals in severity the set of criteria for an impairment listed in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter, or if it is functionally equal in severity to a listed impairment.

(1) Therefore, if you have an impairment(s) that is listed in appendix 1, or is medically or functionally equal in severity to a listed impairment, and that meets the duration requirement, we will find you disabled.

(2) If your impairment(s) does not meet the duration requirement, or does not meet, medically equal, or functionally equal in severity a listed impairment, we will find that you are not disabled.

(3) We explain our rules for deciding whether an impairment(s) meets a listing in §416.925. Our rules for how we decide whether an impairment(s) medically equals a listing are set forth in §416.926. Our rules for deciding whether an impairment(s) functionally equals a listing are set forth in §416.926a.

(e) *If you attain age 18 after you file your disability application but before we make a determination or decision.* For the period during which you are under age 18, we will evaluate whether you are disabled using the rules in this section. For the period starting with the day you attain age 18, we will evaluate whether you are disabled using the disability rules we use for adults filing new claims, in §416.920.

(f) *Basic considerations.* When we determine whether you are disabled, we will consider all relevant evidence in your case record. This may include medical evidence, school records, information from people who know you and can provide evidence about your functioning—such as your parents, caregivers, and teachers—and other evidence that can help us assess your functioning on a longitudinal basis.

(1) Medical evidence of your impairment(s) must describe symptoms, signs, or laboratory findings. The medical evidence may include formal testing that provides information about your development or functioning in terms of percentiles, percentages, standard deviations, or chronology (such as months of delay). Whenever possible, a medical source's findings should reflect consideration of information from your parents or other people who know you, as well as the medical source's findings and observations on examination; any discrepancies between formal test results and your customary behavior and daily activities should be duly noted and resolved.

(2) Your functional limitations may also be observed and reported by others. Parents (or other caregivers), and other family members may provide important evidence on how well you are

functioning on a day-to-day basis. Educational and other intervention programs may be important sources of evidence about your functioning, and will often have documentary evidence in the form of evaluation instruments and other evidence from a variety of disciplines.

(g) *How we will explain our findings.* When we make an initial or reconsidered determination whether you are disabled under this section or whether your disability continues under § 416.994a (except when a disability hearing officer makes the reconsideration determination), we will complete a standard form, Form SSA-538, Childhood Disability Evaluation Form. The form outlines the steps of the sequential evaluation process for individuals who have not attained age 18. In these cases, the State agency medical or psychological consultant (see § 416.1016) or other designee of the Commissioner has overall responsibility for the content of the form and must sign the form to attest that it is complete and that he or she is responsible for its content, including the findings of fact and any discussion of supporting evidence. Disability hearing officers, administrative law judges, and the administrative appeals judges on the Appeals Council (when the Appeals Council makes a decision) will not complete the form but will indicate their findings at each step of the sequential evaluation process in their determinations or decisions.

[58 FR 47577, Sept. 9, 1993, as amended at 62 FR 6421, Feb. 11, 1997]

§ 416.924a Age as a factor of evaluation in childhood disability.

(a) *General.* In this regulation, we explain how we consider age when we decide whether you are disabled. Your age may or may not be a factor in our determination whether your impairment(s) meets or equals a listing, depending on the listing we use for comparison. However, your age is always an important factor when we decide whether your impairment(s) is severe (see § 416.924(c)). Except in the case of certain premature infants, as described in paragraph (c) of this section, age means chronological age.

(1) When we determine whether you have an impairment or combination of

impairments that is severe, we will always consider the significance of your impairment(s) in relation to your age.

(2) The Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter contains examples of impairments that we consider of such significance that they cause marked and severe functional limitations. Therefore, we will usually decide whether your impairment meets a listing without giving special consideration to your age. However, several listings are divided into age categories. If the listing appropriate for evaluating your impairment includes such age categories, we will evaluate your impairment under the criteria for your age when we decide whether your impairment meets that listing.

(3) When we compare an unlisted impairment with a listed impairment to determine whether you have an impairment(s) that medically or functionally equals the severity of a listing, the way in which we consider your age will depend on the listing we use for comparison. We will use the same principles for considering your age as in paragraph (a)(2) of this section; that is, we will consider your age only if we are comparing your impairment(s) to a listing that includes specific age categories.

(4) In any disability determination, we will consider your age and whether it affects your ability to be tested. Even when your impairment(s) is not amenable to formal testing because of your age, we will consider all evidence that will help us decide whether you are disabled.

(b) *Correcting chronological age of premature infants.* We generally use chronological age (that is, a child's age based on birth date) when we decide whether, or the extent to which, a physical or mental impairment or combination of impairments causes functional limitations. However, if you were born prematurely, we may consider you to be younger than your chronological age. When we evaluate the development or linear growth of a child born prematurely, we may use a "corrected" chronological age; that is, the chronological age adjusted by a period of gestational prematurity. We consider an infant born at less than 37

weeks' gestation to be born prematurely.

(1) We apply a corrected chronological age in these situations—

(i) When we evaluate developmental delay in premature children until the child's prematurity is no longer a relevant factor; generally no later than about chronological age 2 (see paragraph (c)(2) of this section);

(ii) When we evaluate an impairment of linear growth, such as under the listings in §100.00 in appendix 1 of subpart P of part 404 of this chapter, until the child is 12 months old. In this situation, we refer to neonatal growth charts which have been developed to evaluate growth in premature infants (see paragraph (c)(2) of this section).

(2) We compute a corrected chronological age as follows—

(i) If you have not attained age 1, we will correct your chronological age. We compute the corrected chronological age by subtracting the number of weeks of prematurity (i.e., the difference between 40 weeks of full-term gestation and the number of actual weeks of gestation) from your chronological age. The result is your corrected chronological age.

(ii) If you are over age 1, have a developmental delay, and prematurity is still a relevant factor in your case (generally, no later than about chronological age 2), we will decide whether to correct your chronological age. Our decision will be based on our judgment and all the facts of your case. If we decide to correct your chronological age, we may correct it by subtracting the full number of weeks of prematurity or a lesser number of weeks. We will also decide not to correct your chronological age if we can determine from the evidence that your developmental delay is the result of your medically determinable impairment(s) and is not attributable to your prematurity.

(3) Notwithstanding the provisions in paragraph (c)(1) of this section, we will not compute a corrected chronological age if the medical evidence shows that your treating source or other medical source has already taken your prematurity into consideration in his or her assessment of your development. Also, we will not compute a corrected chronological age when we find you

disabled using the examples of functional equivalence based on low birth weight in §416.926a(d) (8) or (9).

(c) *Age and the impact of severe impairments on younger children and older adolescents.* Although a child may become disabled at any age, impairments of similar severity may have different effects on children of different ages. The following guidelines apply to determinations of disability for children of different ages, especially very young children and children approaching adulthood.

(1) We recognize that how a particular child adapts to an impairment(s) depends on many factors (e.g., the nature and severity of the impairment(s), the child's temperament, the quality of adult intervention, and the child's age at onset of the impairment(s)). By *adapting to an impairment*, we mean the child's ability to learn those skills, habits, or behaviors that allow the child to compensate for the impairment(s) and, thus, to function as well as possible despite the impairment(s). Therefore, our disability determination will consider how you are adapting to your impairment(s) and the extent to which you are able to function as set forth in this section and §§416.924 and 416.924c.

(2) When we decide whether you are disabled, we will generally consider the factor of age in a manner opposite from that described in the rules for determining whether an adult has the ability to adjust to other work (see §§416.920(f) and 416.963). Thus, we consider that the older a child is, the more he or she is like a younger adult; we consider an older adolescent (i.e., a child aged 16 to 18) to be most like a "younger person" (i.e., a person in the age category 18 to 45 (see §416.963(b)), and younger children to be most like older adults in terms of the significance of their impairments.

(3) Although various kinds of growth and development occur throughout childhood and adolescence, the earliest years, from birth to approximately attainment of age 6, are characterized by complex and rapid changes; for example, learning to walk, talk, and care for basic physical and emotional needs.

(i) The development of fundamental skills is a cumulative process founded

upon skills acquired at each stage of a child's life. A child's ability to acquire or perform these skills ultimately determines his or her ability to master learning tasks in school and more complex physical activities and, eventually, affects the ability to work. Therefore, deficits of function resulting from impairments that occur before the attainment of age 6 may have a potentially greater, more limiting effect on a child's overall growth and development than impairments that occur later in life; and such deficits are increasingly significant with decreasing age.

(ii) Furthermore, the mastery of skills in early childhood is a highly interactive and interdependent process within a child. This interdependence is especially true of development in certain areas; e.g., cognitive skill deficits may affect communication, and social and emotional deficits may affect cognitive and communicative development. This interdependent process also requires proper functioning in areas that may not be obviously relevant to the acquisition of the skill. For example, physical mobility is affected by how well a child sees; therefore, visual impairment, especially in a young child, can affect the way a child acquires certain motor skills even though the child does not have a specific motor impairment. Similarly, emotional bonding to parents can be affected by how well a child hears. Therefore, the impact of such seemingly isolated impairments can have implications for the overall development of the youngest children.

(4) As children approach adulthood—that is, by about age 16—the functional abilities, skills, and behaviors that are appropriate for them are those that are also appropriate for adults. Older adolescents generally also share with the youngest adults the same abilities to adapt to work-related activities despite a severe impairment(s). By the age of adolescence, children have developed basic physical skills and behaviors, so that impairments occurring in adolescence may not have the cumulative interactive effects on functioning that impairments occurring in infancy and early childhood do. (However, as set forth in paragraph (c)(1) of

this section, we also recognize that adolescents may experience a variety of impairments with different effects on their functioning. For instance, a child born with a degenerative disorder will experience a worsening of its effects as he or she grows older so that functioning may be more limited for the older child than it is for a younger child with the same illness or disorder.)

[58 FR 47578, Sept. 9, 1993, as amended at 62 FR 6422, Feb. 11, 1997]

§ 416.924b Functioning in children.

(a) *General.* When we evaluate whether your impairment(s) is severe and, if so, whether it causes marked and severe functional limitations, we will consider all of your mental and physical limitations that result from your impairment(s).

(b) *Terms used to describe functioning—*

(1) *Age-appropriate activities.* As used in these regulations, the term *age-appropriate activities* is a comprehensive term that refers to what a child is expected to be able to do given his or her age. A child's activities may be described in terms of the achievement of "developmental milestones," "activities of daily living," or other such terms. Information about a child's activities creates a profile of how the child is functioning, i.e., what a child does, and thus what he or she is able to do. This makes possible a comparison between the child's profile and the activities that are age-appropriate for that child.

(2) *Developmental milestones.* The term *developmental milestones* refers to a child's expected principal developmental achievements at particular points in time. Ordinarily, failures to achieve developmental milestones are most important as indicators of impaired functioning from birth until the attainment of age 3, although they may be used to evaluate older children, especially preschool children.

(3) *Activities of daily living.* The term *activities of daily living* refers to those activities of children that involve continuity of purpose and action, and goal or task orientation; that is, the practical implementation of skills mastered at earlier ages. Ordinarily, activities of daily living are most important as indicators of functional limitations in children aged 3 to attainment

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of age 16, although they may be used to evaluate children younger than age 3.

(4) *Work-related activities.* The term work-related activities refers to those physical and mental activities that are associated with, or related to, activities in the workplace, as manifested in a person's activities in contexts such as school, work, vocational programs, and organized activities. Ordinarily, inability to perform work-related activities is most important as an indicator of functional limitations in adolescents aged 16 to attainment of age 18.

[58 FR 47580, Sept. 9, 1993, as amended at 62 FR 6423, Feb. 11, 1997]

§ 416.924c Other factors we will consider.

(a) *General.* When we evaluate whether your impairment(s) is severe, and if so, whether it causes marked and severe functional limitations, we will consider all factors that are relevant to the evaluation of the effects of your impairment(s) on your functioning, such as the effects of your medications, the setting in which you live, your need for assistive devices, and your functioning in school. Therefore, when we assess your functional limitations, we will consider all evidence from medical and nonmedical sources—such as your parents, teachers, and other people who know you—that can help us to understand how your impairment(s) affects your functioning. Some of the factors we will consider include, but are not limited to, the factors in paragraphs (b) through (g) of this section.

(b) *Chronic illness.* If you have a chronic impairment(s) that is characterized by episodes of exacerbation (worsening) or remission (improvement), we will consider the frequency and severity of your episodes of exacerbation and your periods of remission as factors in our determination whether you have a severe impairment(s) and, if so, whether it meets or medically or functionally equals in severity any listing, and is therefore disabling. For instance, if you require repeated hospitalizations, or frequent outpatient care with supportive therapy for a chronic impairment(s), we will consider this need for treatment in our determination. When we determine whether you are disabled, we will con-

sider how the level of treatment you need for your chronic illness affects your functioning. We will consider whether the length and frequency of your hospitalizations or episodes of exacerbation significantly interfere with your functioning on a longitudinal basis, or whether the frequency of your outpatient care affects your functioning.

(c) *Effects of medication.* We will consider the effects of medication on your symptoms, signs, and laboratory findings, including your functioning. Although medications may control the most obvious manifestations of your condition(s), they may or may not affect the functional limitations imposed by your impairment(s). If your symptoms or signs are reduced by medications, we will consider whether any functional limitations which may nevertheless persist are marked and severe, even if there is apparent improvement from the medications. We will also consider whether your medications create any side effects which cause or contribute to your functional limitations.

(d) *Effects of structured or highly supportive settings.* Children with serious impairments may spend much of their time in structured or highly supportive settings. A structured or highly supportive setting may be your own home, in which family members make extraordinary adjustments to accommodate your impairment(s); or your classroom at school, whether a regular class in which you are accommodated or a special classroom; or a residential facility or school where you live for a period of time. Children with chronic impairments also commonly have their lives structured in such a way as to minimize stress and reduce their symptoms or signs of impairment; others may continue to have persistent pain, fatigue, decreased energy, or other symptoms or signs, though at a lesser level of severity. Such children may be more impaired in their overall functioning than their symptoms and signs would indicate. Therefore, if your symptoms or signs are controlled or reduced by the environment in which you live, we will consider your functioning outside of this highly structured setting.

(e) *Adaptations.* We will consider the nature and extent of any other adaptations that are made for you in order to enable you to function. Such adaptations may include assistive devices, appliances, or technology. Some adaptations may enable you to function normally, or almost normally (e.g., eyeglasses, hearing aids). Others may increase your functioning, even though you may still have functional limitations (e.g., ankle-foot orthoses, hand or foot splints, and specially adapted or custom-made tools, utensils, or devices for self-care activities such as bathing, feeding, toileting, and dressing). When we evaluate your overall functioning with an adaptation, we will consider the degree to which the adaptation enables you to function and any functional limitations that nevertheless persist.

(f) *Time spent in therapy.* You may need frequent and ongoing therapy from one or more kinds of health care professionals in order to maintain or improve your functional status. Therapy may include occupational, physical, or speech and language therapy, special nursing services, psychotherapy, or psychosocial counseling. Frequent therapy, although intended to improve your functioning in some ways, may also interfere with your functioning in other ways. If you receive frequent therapy at school during a normal school day, it may or may not interfere significantly with your functioning. If you must frequently interrupt your activities at school or at home for therapy, these interruptions may interfere with your functioning. We will consider the frequency of any therapy that you must have, how long you have needed the therapy or will need the therapy, and whether it interferes with your functioning.

(g) *School attendance.* (1) School records and information from people at school who know you or who have examined you, such as teachers and school psychologists, psychiatrists, or therapists, may be important sources of information about your impairment(s) and its effect on your functioning. If you attend school, we will consider this evidence when it is relevant and available to us.

(2) The fact that you are able to attend school will not, in itself, be an indication that you are not disabled. We will consider the circumstances of your school attendance, such as your functioning in a regular classroom setting. Likewise, the fact that you are in a special education classroom setting, or that you are not in such a setting, will not in itself establish your actual limitations or abilities. We will consider the fact of such placement or lack of placement in the context of the remainder of the evidence in your case record.

(3) However, if you are unable to attend school on a regular basis because of your impairment(s), we will consider this when we determine whether you are disabled.

(h) *Treatment and intervention, in general.* With adequate treatment or intervention, some children not only have their symptoms and signs reduced, but also maintain, return to or achieve a level of functioning that is not disabling. Treatment or intervention may prevent, eliminate, or reduce functional limitations; if such limitations were disabling in the absence of treatment or intervention, treatment or intervention may eliminate them or reduce them so that they are not disabling. We will, therefore, evaluate the effects of your treatment or intervention to determine the actual outcome of the treatment or intervention in your particular case.

[62 FR 6423, Feb. 11, 1997]

MEDICAL CONSIDERATIONS

§ 416.925 Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter.

(a) *Purpose of the Listing of Impairments.* The Listing of Impairments describes, for each of the major body systems, impairments that are considered severe enough to prevent an adult from doing any gainful activity or, for a child, that causes marked and severe functional limitations. Most of the listed impairments are permanent or expected to result in death, or a specific statement of duration is made. For all others, the evidence must show that the impairment has lasted or is

expected to last for a continuous period of at least 12 months.

(b) *Adult and childhood diseases.* The Listing of Impairments consists of two parts:

(1) *Part A* contains medical criteria that apply to adult persons age 18 and over. The medical criteria in part A may also be applied in evaluating impairments in persons under age 18 if the disease processes have a similar effect on adults and younger persons.

(2) *Part B* contains additional medical criteria that apply only to the evaluation of impairments of persons under age 18. Certain criteria in part A do not give appropriate consideration to the particular effects of the disease processes in childhood; i.e., when the disease process is generally found only in children or when the disease process differs in its effect on children than on adults. Additional criteria are included in part B, and the impairment categories are, to the extent possible, numbered to maintain a relationship with their counterparts in part A. In evaluating disability for a person under age 18, part B will be used first. If the medical criteria in part B do not apply, then the medical criteria in part A will be used. Although the severity criteria in part B of the Listing of Impairments are expressed in different ways for different impairments, the level of severity for impairments listed in part B is intended to be the same as that expressed in the functional severity criteria of the childhood mental disorders listings. (See listings 112.01 ff. of appendix 1 of subpart P of part 404 of this chapter.) Therefore, in general, a child's impairment(s) is of "listing-level severity" if it causes marked limitations in two broad areas of functioning or extreme limitations in one such area. (See §416.926a for definition of the terms *marked* and *extreme* as they apply to children.) However, when we decide whether your impairment(s) meets the requirements for any listed impairment, we will decide that your impairment is of "listing-level severity" even if it does not result in marked limitations in two broad areas of functioning, or extreme limitations in one such area, if the listing that we apply does not require such limitations

to establish that an impairment(s) is disabling.

(c) *How to use the Listing of Impairments.* Each section of the Listing of Impairments has a general introduction containing definitions of key concepts used in that section. Certain specific medical findings, some of which are required in establishing a diagnosis or in confirming the existence of an impairment for the purpose of this Listing, are also given in the narrative introduction. If the medical findings needed to support a diagnosis are not given in the introduction or elsewhere in the listing, the diagnosis must still be established on the basis of medically acceptable clinical and laboratory diagnostic techniques. Following the introduction in each section, the required level of severity of impairment is shown under "Category of Impairments" by one or more sets of medical findings. The medical findings consist of symptoms, signs, and laboratory findings.

(d) *Diagnoses of impairments.* We will not consider your impairment to be one listed in appendix 1 of subpart P of part 404 of this chapter solely because it has the diagnosis of a listed impairment. It must also have the findings shown in the Listing for that impairment.

(e) *Addiction to alcohol or drugs.* If you have a condition diagnosed as addiction to alcohol or drugs, this will not, by itself, be a basis for determining whether you are, or are not, disabled. As with any other medical condition, we will decide whether you are disabled based on symptoms, signs, and laboratory findings.

(f) *Symptoms as criteria of listed impairment(s).* Some listed impairment(s) include symptoms usually associated with those impairment(s) as criteria. Generally, when a symptom is one of the criteria in a listed impairment, it is only necessary that the symptom be present in combination with the other criteria. It is not necessary, unless the listing specifically states otherwise, to provide information about the intensity, persistence or limiting effects of

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the symptom as long as all other findings required by the specific listing are present.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 57944, Nov. 14, 1991; 62 FR 6424, Feb. 11, 1997; 62 FR 13539, Mar. 21, 1997]

§ 416.926 Medical equivalence for adults and children.

(a) *How medical equivalence is determined.* We will decide that your impairment(s) is medically equivalent to a listed impairment in appendix I of subpart P of part 404 of this chapter if the medical findings are at least equal in severity and duration to the listed findings. We will compare the symptoms, signs, and laboratory findings about your impairment(s), as shown in the medical evidence we have about your claim, with the corresponding medical criteria shown for any listed impairment. When we make a finding regarding medical equivalence, we will consider all relevant evidence in your case record. Medical equivalence can be found in two ways:

(1)(i) If you have an impairment that is described in the Listing of Impairments in appendix I of subpart P of part 404 of this chapter, but—

(A) You do not exhibit one or more of the medical findings specified in the particular listing, or

(B) You exhibit all of the medical findings, but one or more of the findings is not as severe as specified in the listing;

(ii) We will nevertheless find that your impairment is medically equivalent to that listing if you have other medical findings related to your impairment that are at least of equal medical significance.

(2) If you have an impairment that is not described in the Listing of Impairments in appendix I, or you have a combination of impairments, no one of which meets or is medically equivalent to a listing, we will compare your medical findings with those for closely analogous listed impairments. If the medical findings related to your impairment(s) are at least of equal medical significance to those of a listed impairment, we will find that your im-

pairment(s) is medically equivalent to the analogous listing.

(b) *Medical equivalence must be based on medical findings.* We will always base our decision about whether your impairment(s) is medically equal to a listed impairment on medical evidence only. Any medical findings in the evidence must be supported by medically acceptable clinical and laboratory diagnostic techniques. We will also consider the medical opinion given by one or more medical or psychological consultants designated by the Commissioner in deciding medical equivalence. (See § 416.1016.)

(c) *Who is a designated medical or psychological consultant.* A medical or psychological consultant designated by the Commissioner includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. A medical consultant must be a physician. A psychological consultant used in cases where there is evidence of a mental impairment must be a qualified psychologist. (See § 416.1016 for the qualifications we consider necessary for a psychologist to be a consultant.)

(d) *Responsibility for determining medical equivalence.* In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see § 416.1016) has the overall responsibility for determining medical equivalence. For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining medical equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration determination is changed under § 416.1418, with the Associate Commissioner for Disability or his or her delegate. For cases at the Administrative Law Judge or Appeals Council level, the responsibility for deciding

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the symptom as long as all other findings required by the specific listing are present.

[45 FR 55621, Aug. 20, 1980, as amended at 56 FR 57944, Nov. 14, 1991; 62 FR 6424, Feb. 11, 1997; 62 FR 13539, Mar. 21, 1997]

§ 416.926 Medical equivalence for adults and children.

(a) *How medical equivalence is determined.* We will decide that your impairment(s) is medically equivalent to a listed impairment in appendix I of subpart P of part 404 of this chapter if the medical findings are at least equal in severity and duration to the listed findings. We will compare the symptoms, signs, and laboratory findings about your impairment(s), as shown in the medical evidence we have about your claim, with the corresponding medical criteria shown for any listed impairment. When we make a finding regarding medical equivalence, we will consider all relevant evidence in your case record. Medical equivalence can be found in two ways:

(1)(i) If you have an impairment that is described in the Listing of Impairments in appendix I of subpart P of part 404 of this chapter, but—

(A) You do not exhibit one or more of the medical findings specified in the particular listing, or

(B) You exhibit all of the medical findings, but one or more of the findings is not as severe as specified in the listing;

(ii) We will nevertheless find that your impairment is medically equivalent to that listing if you have other medical findings related to your impairment that are at least of equal medical significance.

(2) If you have an impairment that is not described in the Listing of Impairments in appendix I, or you have a combination of impairments, no one of which meets or is medically equivalent to a listing, we will compare your medical findings with those for closely analogous listed impairments. If the medical findings related to your impairment(s) are at least of equal medical significance to those of a listed impairment, we will find that your im-

pairment(s) is medically equivalent to the analogous listing.

(b) *Medical equivalence must be based on medical findings.* We will always base our decision about whether your impairment(s) is medically equal to a listed impairment on medical evidence only. Any medical findings in the evidence must be supported by medically acceptable clinical and laboratory diagnostic techniques. We will also consider the medical opinion given by one or more medical or psychological consultants designated by the Commissioner in deciding medical equivalence. (See § 416.1016.)

(c) *Who is a designated medical or psychological consultant.* A medical or psychological consultant designated by the Commissioner includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. A medical consultant must be a physician. A psychological consultant used in cases where there is evidence of a mental impairment must be a qualified psychologist. (See § 416.1016 for the qualifications we consider necessary for a psychologist to be a consultant.)

(d) *Responsibility for determining medical equivalence.* In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see § 416.1016) has the overall responsibility for determining medical equivalence. For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining medical equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration determination is changed under § 416.1418, with the Associate Commissioner for Disability or his or her delegate. For cases at the Administrative Law Judge or Appeals Council level, the responsibility for deciding

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medical equivalence rests with the Administrative Law Judge or Appeals Council.

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§416.926a Functional equivalence for children.

(a) *General.* If your impairment or combination of impairments does not meet, or is not medically equivalent in severity to, any listed impairment in appendix I of subpart P of part 404 of this chapter, we will assess all functional limitations caused by your impairment(s), i.e., what you cannot do because of your impairment(s), to determine if your impairment(s) is functionally equivalent in severity to any listed impairment that includes disabling functional limitations in its criteria. While all possible impairments are not addressed within the Listing of Impairments, within the listed impairments are all the physical and mental functional limitations, i.e., what a child cannot do as a result of an impairment, that produce marked and severe functional limitations. If the functional limitation(s) caused by your impairment(s) is the same as the disabling functional limitation(s) caused by a listed impairment, we will find that your impairment(s) is equivalent in severity to that listed impairment, even if your impairment(s) is not medically related to the listed impairment. When we make a determination or decision using this rule, the primary focus will be on whether your functional limitations are disabling, as long as there is a direct, medically determinable cause for these limitations. As with any disabling impairment, the duration requirement must also be met (see §§416.909 and 416.924(a)).

(b) *How we determine functional equivalence.* We will compare any functional limitations resulting from your impairment(s) with the disabling functional limitations of any listed impairment in part A or part B of the Listing that includes the same functional limitations. The listing we use for comparison need not be medically related to your impairment(s). In paragraphs (b)(1) through (b)(4) of this section we

explain the methods we may use to decide that your impairment(s) is functionally equivalent in severity to a listing. There is no set order in which we must consider these methods and we may not consider them all if we find that your impairment(s) is functionally equivalent in severity to a listed impairment. We will use any method that is appropriate to, or best describes, your impairment(s) and functional limitations. However, we will consider all of the methods before we determine that your impairment(s) is *not* functionally equivalent in severity to any listed impairment. At the initial and reconsideration levels (except when a disability hearing officer makes the reconsideration determination), we will also complete a standard form, Form SSA-538, Childhood Disability Evaluation Form, to show how we determined whether your impairment(s) is functionally equivalent in severity to a listed impairment. (See §416.924(g).)

(1) *Limitation of specific functions.* We may find that your impairment(s) is functionally equivalent in severity to a listed impairment because of extreme limitation of one specific function, such as walking or talking. (See paragraph (c) of this section for an explanation of the term "extreme.") Some listings also include criteria requiring limitation of more than one specific function, such as limitations in walking *and* talking; each limitation in itself is not enough to show disability, but the combination of limitations establishes marked and severe functional limitations. If you have a limitation of a combination of specific functions that are the same as those in such a listed impairment, we will find that your impairment(s) is functionally equivalent in severity to that listing.

(2) *Broad areas of development or functioning.* Instead of looking at limitation of specific functions, we may evaluate the effects of your impairment(s) in broad areas of development or functioning, such as social functioning, motor functioning, or personal functioning (i.e., self-care) and determine if your functional limitations are equivalent in severity to the disabling functional limitations in listing 112.12 or listing 112.02. If you have extreme

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medical equivalence rests with the Administrative Law Judge or Appeals Council.

[45 FR 55621, Aug. 20, 1980, as amended at 52 FR 33928, Sept. 9, 1987; 56 FR 5561, Feb. 11, 1991; 62 FR 6424, Feb. 11, 1997; 62 FR 13538, Mar. 21, 1997]

§416.926a Functional equivalence for children.

(a) *General.* If your impairment or combination of impairments does not meet, or is not medically equivalent in severity to, any listed impairment in appendix I of subpart P of part 404 of this chapter, we will assess all functional limitations caused by your impairment(s), i.e., what you cannot do because of your impairment(s), to determine if your impairment(s) is functionally equivalent in severity to any listed impairment that includes disabling functional limitations in its criteria. While all possible impairments are not addressed within the Listing of Impairments, within the listed impairments are all the physical and mental functional limitations, i.e., what a child cannot do as a result of an impairment, that produce marked and severe functional limitations. If the functional limitation(s) caused by your impairment(s) is the same as the disabling functional limitation(s) caused by a listed impairment, we will find that your impairment(s) is equivalent in severity to that listed impairment, even if your impairment(s) is not medically related to the listed impairment. When we make a determination or decision using this rule, the primary focus will be on whether your functional limitations are disabling, as long as there is a direct, medically determinable cause for these limitations. As with any disabling impairment, the duration requirement must also be met (see §§416.909 and 416.924(a)).

(b) *How we determine functional equivalence.* We will compare any functional limitations resulting from your impairment(s) with the disabling functional limitations of any listed impairment in part A or part B of the Listing that includes the same functional limitations. The listing we use for comparison need not be medically related to your impairment(s). In paragraphs (b)(1) through (b)(4) of this section we

explain the methods we may use to decide that your impairment(s) is functionally equivalent in severity to a listing. There is no set order in which we must consider these methods and we may not consider them all if we find that your impairment(s) is functionally equivalent in severity to a listed impairment. We will use any method that is appropriate to, or best describes, your impairment(s) and functional limitations. However, we will consider all of the methods before we determine that your impairment(s) is *not* functionally equivalent in severity to any listed impairment. At the initial and reconsideration levels (except when a disability hearing officer makes the reconsideration determination), we will also complete a standard form, Form SSA-538, Childhood Disability Evaluation Form, to show how we determined whether your impairment(s) is functionally equivalent in severity to a listed impairment. (See §416.924(g).)

(1) *Limitation of specific functions.* We may find that your impairment(s) is functionally equivalent in severity to a listed impairment because of extreme limitation of one specific function, such as walking or talking. (See paragraph (c) of this section for an explanation of the term "extreme.") Some listings also include criteria requiring limitation of more than one specific function, such as limitations in walking *and* talking; each limitation in itself is not enough to show disability, but the combination of limitations establishes marked and severe functional limitations. If you have a limitation of a combination of specific functions that are the same as those in such a listed impairment, we will find that your impairment(s) is functionally equivalent in severity to that listing.

(2) *Broad areas of development or functioning.* Instead of looking at limitation of specific functions, we may evaluate the effects of your impairment(s) in broad areas of development or functioning, such as social functioning, motor functioning, or personal functioning (i.e., self-care) and determine if your functional limitations are equivalent in severity to the disabling functional limitations in listing 112.12 or listing 112.02. If you have extreme

limitations in one area of functioning or marked limitation in two areas of functioning, we will find that your impairment(s) is functionally equivalent in severity to a listed impairment. We explain the broad areas of development or functioning we consider and what the terms "extreme" and "marked" mean in paragraph (c) of this section.

(3) *Episodic impairments.* If you have a chronic impairment(s) that is characterized by frequent illnesses or attacks, or by exacerbations and remissions, we may evaluate your functional limitations using the methods in paragraphs (b)(1) and (b)(2) of this section. However, your functional limitations may vary and we may not be able to use the methods in paragraphs (b)(1) and (b)(2) of this section. Instead, we may compare your functional limitation(s) to those in any listing for a chronic impairment with similar episodic criteria to determine if your impairment(s) has such a serious impact on your functioning over time that it is functionally equivalent in severity to one of those listings. Limitations that are characteristic of episodic impairments are not necessarily related to a single, specific function. Episodes of disabling functional limitations may occur with specified frequency despite treatment. If your episodic impairment(s) produces disabling functional limitations that are the same as the disabling functional limitations of a listed impairment with similar episodic criteria, we will find that you are disabled even though you may be able to function adequately between episodes.

(4) *Limitations related to treatment or medication effects.* Some impairments require treatment over a long period of time (i.e., at least a year) and the treatment itself (e.g., multiple surgeries) causes marked and severe functional limitations. Marked and severe functional limitations may also result from the combined effects of limitations caused by ongoing treatment and limitations caused by an impairment(s). In many cases, we will be able to evaluate such limitations using the methods for evaluating specific functions or broad areas of development or functioning in paragraphs (b)(1) and (b)(2) of this section. But we may also compare your functional limitations(s)

to criteria in listings based on treatment (including side effects of medication) that is itself disabling or that contributes to functional limitations. If treatment of your impairment(s) produces functional limitations that are the same as the disabling functional limitations of a listed impairment, we will find that your impairment(s) is functionally equivalent in severity to that listing.

(c) *Broad areas of development or functioning.* When we determine functional equivalence based on broad areas of development or functioning, we will evaluate the functional effects of your impairment(s) in several areas of development or functioning to determine if your functional limitations are equivalent in severity to the disabling functional limitations of listing 112.12 or listing 112.02. However, instead of referring to the areas of development or functioning in those listings, we will refer to the areas of development or functioning described in paragraphs (c)(4) and (c)(5) of this section. (We describe the areas in general terms in paragraph (c)(4) and then in detail as they apply to specific age groups in paragraph (c)(5).) If you have marked limitations in two areas of development or functioning, or extreme limitation in one area, we will find that your impairment(s) is functionally equivalent in severity to listing 112.12 or listing 112.02, even if your impairment(s) is a physical impairment(s) or a combination of physical and mental impairments. We explain the meaning of the terms "marked limitation" and "extreme limitation" in paragraph (c)(3) of this section.

(1) *How we use the areas of development or functioning.* (i) When we make a finding about functional equivalence, we will consider the extent of your functional limitations in the areas affected by your impairment(s). We will also consider how your limitation(s) in one area affects your development or functioning in other areas.

(ii) In some children, some physical impairments will be evaluated most appropriately only in the areas of motor development or motor functioning. In others, the effects will be more global. If you have a physical impairment(s) that causes a functional

limitation(s) not addressed solely in the area of motor development or motor functioning, we will consider the effects of your impairment in all relevant areas in which you have limitations from the impairment(s). A physical impairment(s) may cause limitations in any or all of the areas of development or functioning.

(2) *Other considerations.* When we assess your functioning, we will consider all information in your case record that can help us determine the effect of your impairment(s) on your physical and mental functioning. We will consider the nature of your impairment(s), your age, your ability to be tested given your age, and other relevant factors (see §§416.924a through 416.924c). We will consider whether any help that you need from others to enable you to do any particular activity (e.g., dressing) is appropriate to your age.

(3) *Definitions of "marked" and "extreme" limitations—*(i) *Marked limitation* means—(A) When standardized tests are used as the measure of functional abilities, a valid score that is two standard deviations or more below the norm for the test (but less than three standard deviations); or

(B) For children from birth to attainment of age 3, functioning at more than one-half but not more than two-thirds of chronological age; or

(C) For children from age 3 to attainment of age 18, "more than moderate" and "less than extreme." Marked limitation may arise when several activities or functions are limited or even when only one is limited as long as the degree of limitation is such as to interfere seriously with the child's functioning.

(ii) *Extreme limitation* means—

(A) When standardized tests are used as the measure of functional abilities, a valid score that is three standard deviations or more below the norm for the test; or

(B) For children from birth to attainment of age 3, functioning at one-half chronological age or less; or

(C) For children from birth to attainment of age 18, no meaningful functioning in a given area. There may be extreme limitation when several activities or functions are limited or even when only one is limited.

(4) *Areas of development or functioning.* The following are the areas of development or functioning that may be addressed in a finding of functional equivalence.

(i) *Cognition/communication:* The ability or inability to learn, understand, and solve problems through intuition, perception, verbal and nonverbal reasoning, and the application of acquired knowledge; the ability to retain and recall information, images, events, and procedures during the process of thinking. The ability or inability to comprehend and produce language (e.g., vocabulary and grammar) in order to communicate (e.g., to respond, as in answering questions, following directions, acknowledging the comments of others; to request, as in demanding action, meeting needs, seeking information, requesting clarification, initiating interaction; to comment, as in sharing information, expressing feelings and ideas, providing explanations, describing events, maintaining interaction, using hearing that is adequate for conversation, and using speech (articulation, voice, and fluency) that is intelligible.

(ii) *Motor:* The ability or inability to use gross and fine motor skills to relate to the physical environment and serve one's physical purposes. It involves general mobility, balance, and the ability to perform age-appropriate physical activities involved in play, physical education, sports, and physically related daily activities other than self-care (see Personal area).

(iii) *Social:* The ability or inability to form and maintain relationships with other individuals and with groups; e.g., parents, siblings, neighborhood children, classmates, teachers. Ability is manifested in responding to and initiating social interaction with others, sustaining relationships, and participating in group activities. It involves cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity appropriate to a child's age. Ability is also manifested in the absence of inappropriate externalized actions (e.g., running away, physical aggression—but not

self-injurious actions, which are evaluated in the personal area of functioning), and the absence of inappropriate internalized actions (e.g., social isolation, avoidance of interpersonal activities, mutism). Social functioning in play, school, and work situations may involve interactions with adults, including responding appropriately to persons in authority (e.g., teachers, coaches, employers) or cooperative behaviors involving other children.

(iv) *Responsiveness to stimuli (birth to age 1 only)*: The ability or inability to respond appropriately to stimulation (visual, auditory, tactile, vestibular, proprioceptive).

(v) *Personal (age 3 to age 18 only)*: The ability or inability to help yourself and to cooperate with others in taking care of your personal needs, health, and safety (e.g., feeding, dressing, toileting, bathing; maintaining personal hygiene, proper nutrition, sleep, health habits; adhering to medication or therapy regimens; following safety precautions).

(vi) *Concentration, persistence, or pace (age 3 to age 18 only)*: The ability or inability to attend to, and sustain concentration on, an activity or task, such as playing, reading, or practicing a sport, and the ability to perform the activity or complete the task at a reasonable pace.

(5) *Descriptions for specific age groups*—(i) *Newborns and young infants (birth to attainment of age 1)*: Children in this age group are evaluated in terms of four areas of development. The following are general descriptions of development typical of this age group.

(A) *Cognitive/communicative development (birth to attainment of age 1)*: Your ability or inability to show interest in, and actively seek interaction with, your environment, first randomly, then through trial-and-error, and finally with deliberate and purposeful intent. Your ability or inability to first recognize, and then attach meaning to, routine situations and events and gradually to everyday sounds and eventually to familiar words. Your ability or inability to vocalize, both imitatively and spontaneously, using vowels and later consonants, first in isolation, and then in increasingly longer babbling strings.

(B) *Motor development (birth to attainment of age 1)*: Your ability or inability to explore and manipulate your environment by moving your body and by using your hands; e.g., by increasingly controlling position and movement of head, sitting with support, creeping or crawling, pulling to standing position, walking with hand held, standing alone briefly, waving small rattle, reaching for or grasping objects, transferring toys, picking up small objects, attempting to scribble.

(C) *Social development (birth to attainment of age 1)*: Your ability or inability to form and maintain intimate relationships, and to respond to, and eventually initiate reciprocal interactions with, your primary caregivers (e.g., through games such as pat-a-cake, peek-a-boo, so big). Your ability or inability to begin to regulate the behavior of others through intentional behavior (e.g., gestures, vocalizations). Your ability or inability to recognize and produce a variety of emotional cues (e.g., facial expressions, vocal tone changes).

(D) *Responsiveness to stimuli (birth to attainment of age 1)*: Your ability or inability to form patterns of self-regulation, i.e., to recognize internal cues (e.g., hunger, pain), and to organize external experiences (e.g., light, sound, temperature, movement), and to regulate your reactions to them (e.g., brightening in response to sights and sounds, enjoying being touched or stroked or held, enjoying gentle movement in space ("rock-a-bye-baby")).

(ii) *Older infants and toddlers (age 1 to attainment of age 3)*: Children in this age group are evaluated in terms of three areas of development. The following are general descriptions of development typical of this age group.

(A) *Cognitive/communicative development (age 1 to attainment of age 3)*: Your ability or inability to understand by responding to increasingly complex requests, instructions, and questions; to refer to yourself and things around you by pointing and eventually by naming; to form concepts and to solve simple problems through purposeful experimentation (e.g., disassembling toys), imitation (immediate and delayed), and constructive play (e.g., putting

things in and out of containers, building with blocks, exploring spaces); to demonstrate your knowledge of objects, actions, and situations you have encountered through pretend play activities; to spontaneously communicate your wishes or needs by using gestures, an increasing number of intelligible words, and eventually grammatically correct simple sentences and questions with increasingly rich and broad vocabulary.

(B) *Motor development (age 1 to attainment of age 3)*: Your ability or inability to move in your environment using your body with steadily increasing dexterity and independence from support by others, and your increasing ability to manipulate small objects and to use your hands to do, or to get, something that you want or need.

(C) *Social development (age 1 to attainment of age 3)*: Your ability or inability to exhibit normal dependence upon, and intimacy with, your primary caregivers, as well as increasing independence from them; to initiate and respond to a variety of emotional cues; to regulate and organize emotions and behaviors. Your ability or inability to be interested in initiating and maintaining interactions with others, first during brief, yet frequent encounters, and gradually increasing to longer, sustained ones. Your ability or inability to show interest in, initially watch, then play alongside, and eventually interact with similarly aged peers.

(iii) *Preschool children (age 3 to attainment of age 6)*. Children in this age group are evaluated in terms of five areas of development. The following are general descriptions of development typical of this age group.

(A) *Cognitive/communicative development (age 3 to attainment of age 6)*: Your ability or inability to learn, understand, and solve problems through intuition, perception, verbal and non-verbal reasoning, and the application of acquired knowledge; your ability or inability to retain and recall information, images, events, and procedures during the process of thinking (as in the development of readiness skills for formal learning (e.g., learning letters, shapes, colors) and skills for daily living (e.g., putting toys in proper places)). Your ability or inability to

communicate by expressing your needs, feelings, and preferences; by telling, requesting, predicting, and relating information; by describing actions and functions; by providing explanations; by following and giving directions; and by engaging in conversation in a spontaneous, interactive, and increasingly intelligible manner, using increasingly complex vocabulary and grammar.

(B) *Motor development (age 3 to attainment of age 6)*: Your ability or inability to move and use your arms and legs in increasingly more intricate and coordinated activity, and your ability or inability to use your hands with increasing coordination to manipulate small objects during play (e.g., drawing, using building blocks, constructing puzzles) and physically related daily activities other than self-care (see Personal area).

(C) *Social development (age 3 to attainment of age 6)*: Your ability or inability to initiate social exchanges, to organize and regulate your emotions and behaviors, and to respond to your social environment through appropriate and increasingly complex interactions, such as showing affection, sharing, and helping; your ability to relate to caregivers with increasing independence, to choose your own friends, and to play cooperatively with other children, one-at-a-time or in a group.

(D) *Personal development (age 3 to attainment of age 6)*: Your ability or inability to help yourself and to cooperate with others in taking care of your personal needs, health, and safety (e.g., bathing, dressing, maintaining sleep habits, crossing the street with an adult).

(E) *Concentration, persistence, or pace (age 3 to attainment of age 6)*: Your ability or inability to engage in an activity, and to sustain the activity for a period of time at a reasonable pace (e.g., playing a simple board game).

(iv) *School-age children (age 6 to attainment of age 12)*. Children in this age group are evaluated in terms of five areas of functioning. The following are general descriptions of functioning typical of this age group.

(A) *Cognitive/communicative functioning (age 6 to attainment of age 12)*: Your ability or inability to learn, understand, and solve problems through

intuition, perception, verbal and non-verbal reasoning, and the application of acquired knowledge; the ability to retain and recall information, images, events, and procedures during the process of thinking, as in formal learning situations (e.g., reading, class discussions) and in daily living (e.g., telling time, making change). Your ability or inability to comprehend and produce language (e.g., vocabulary, grammar) in order to communicate in social conversation (e.g., to express feelings, meet needs, seek information, describe events, share stories), and in learning situations (e.g., to exchange information and ideas with peers and family or with groups such as your school classes) in a spontaneous, interactive, sustained, and intelligible manner, using increasingly complex vocabulary and grammar.

(B) *Motor functioning (age 6 to attainment of age 12)*: Your ability or inability to use fine and gross motor skills in order to engage in the physical activities involved in normal mobility, school work, play, physical education, sports, and other physically related daily activities other than self-care (see Personal area).

(C) *Social functioning (age 6 to attainment of age 12)*: Your ability or inability to play alone, with another child, and in a group; to initiate and develop friendships; to respond to your social environments through appropriate and increasingly complex interpersonal behaviors, such as empathizing with others and tolerating differences; and to relate appropriately to individuals and in group situations (e.g., siblings, parents or caregivers, peers, teachers, school classes, neighborhood groups).

(D) *Personal functioning (age 6 to attainment of age 12)*: Your ability or inability to help yourself and to cooperate with others in taking care of your personal needs, health, and safety (e.g., eating, dressing, maintaining personal hygiene, following safety precautions).

(E) *Concentration, persistence, or pace (age 6 to attainment of age 12)*: Your ability or inability to engage in an activity, and to sustain the activity for a period of time and at a reasonable pace.

(v) *Adolescents (age 12 to attainment of age 18)*. Children in this age group are

evaluated in terms of five areas of functioning. The following are general descriptions of functioning typical of this age group.

(A) *Cognitive/communicative functioning (age 12 to attainment of age 18)*: Your ability or inability to learn, understand, and solve problems through intuition, perception, verbal and non-verbal reasoning, and the application of acquired knowledge; the ability or inability to retain and recall information, images, events, and procedures during the process of thinking, as in formal learning situations (e.g., composition, classroom discussion) and in daily living (e.g., using the post office, using public transportation). Your ability or inability to comprehend and produce language (e.g., vocabulary, grammar) in order to communicate in conversation (e.g., to express feelings, meet needs, seek information, describe events, tell stories), and in learning situations (e.g., to obtain and convey information and ideas) both spontaneously and interactively, in all communication environments (e.g., home, classroom, game fields, extra-curricular activities, job), and with all communication partners (e.g., parents, siblings, peers, school classes, teachers, employers).

(B) *Motor functioning (age 12 to attainment of age 18)*: Your ability or inability to use fine and gross motor skills in order to engage in the physical activities involved in normal mobility, school work, play, physical education, sports, and other physically related daily activities other than self-care (see Personal area).

(C) *Social functioning (age 12 to attainment of age 18)*: Your ability or inability to initiate and develop friendships, to relate appropriately to individual peers and adults and to peer and adult groups, and to reconcile conflicts between yourself and peers or family members or other adults outside your family.

(D) *Personal functioning (age 12 to attainment of age 18)*: Your ability or inability to help yourself in taking care of your personal needs, health, and safety (e.g., dressing, bathing, doing laundry, adhering to medication or therapy regimens).

(E) *Concentration, persistence, or pace (age 12 to attainment of age 18):* Your ability or inability to engage in an activity, and to sustain the activity for a period of time and at a reasonable pace.

(d) *Examples of impairments that are functionally equivalent in severity to a listed impairment.* The following are some examples of impairments and limitations that are functionally equivalent to listings. Findings of equivalence based on the disabling functional limitations of a child's impairment(s) are not limited to the examples in this paragraph (d), because these examples do not describe all possible effects of impairments that might be found to be functionally equivalent in severity to a listed impairment. As with any disabling impairment, the duration requirement must also be met (see §§416.909 and 416.924(a)).

(1) Documented need for major organ transplant (e.g., liver).

(2) Any condition that is disabling at the time of onset, requiring a series of staged surgical procedures within 12 months after onset as a life-saving measure or for salvage or restoration of function, and such major function is not restored or is not expected to be restored within 12 months after onset of the condition.

(3) Frequent need for a life-sustaining device (e.g., central venous alimentation catheter), at home or elsewhere.

(4) Ambulation possible only with obligatory bilateral upper limb assistance.

(5) Any physical impairment(s) or combination of physical and mental impairments causing marked restriction of age-appropriate personal functioning and marked restriction in motor functioning.

(6) Any physical impairment(s) or combination of physical and mental impairments causing complete inability to function independently outside the area of one's home within age-appropriate norms.

(7) Requirement for 24-hour-a-day supervision for medical (including psychological) reasons.

(8) Infants weighing less than 1200 grams at birth, until attainment of 1 year of age.

(9) Infants weighing at least 1200 but less than 2000 grams at birth, and who are small for gestational age, until attainment of 1 year of age. (*Small for gestational age* means a birth weight that is at or more than 2 standard deviations below the mean or that is below the 3rd growth percentile for the gestational age of the infant.)

(10) In an infant who has not attained age 1 year, and who may be too young to test, any limitations caused by a physical impairment(s) or a combination of physical and mental impairments that causes the same functional limitations in listing 112.12.

(11) Major congenital organ dysfunction which could be expected to result in death within the first year of life without surgical correction, and the impairment is expected to be disabling (because of residual impairment following surgery, or the recovery time required, or both) until attainment of 1 year of age.

(12) Gastrostomy in a child who has not attained age 3.

(e) *Responsibility for determining functional equivalence.* In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see §416.1016) has the overall responsibility for determining functional equivalence. For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining functional equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration determination is changed under §416.1418, with the Associate Commissioner for Disability or his or her delegate. For cases at the Administrative Law Judge or Appeals Council level, the responsibility for deciding functional equivalence rests with the Administrative Law Judge or Appeals Council.

[62 FR 6424, Feb. 11, 1997; 62 FR 13538, 13733, Mar. 21, 1997]

§416.927 Evaluating opinion evidence.

(a) *General.* (1) If you are an adult, you can only be found disabled if you

FAX COVER**Income Maintenance Branch**

Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503



To: ANDREA KANE / CHRISTINA HO

Organization: DPC

Fax Number: 6-7431

From: JOANNE CLANCY

Date/Time: 09-12-00

Number of Pages: Cover + 10

Notes:

Andrea and Christina,

Attached are SSA's Fact Sheet and Q&A on the kids reg.
Per my email, they did not have time to incorporate
all of our suggestions. SSA said there is a second
version of the Fact Sheet that went to the groups that
does not include the "not ab about 4000" reference.

- Joanne

Income Maintenance Fax Number: (202) 395-0851
Voice Confirmation: (202) 395-4686

FACTSHEET FINAL CHILDHOOD DISABILITY REGULATIONS

These are final rules responding to public comments on the interim final rules we have been using since February 11, 1997.

The final rules will be published on Monday, September 11, 2000. However, they won't be effective until January 2, 2001. The delayed implementation date will give us time to provide training and instructions to all of our adjudicators and to revise our forms and notices.

The interim final rules will continue to apply until the effective date of these final rules. (When the final rules become effective, we will apply them to new applications filed on or after the effective date of the rules and to claims pending at any step in our administrative process.)

Major features: These revisions are based primarily on public comments, input from medical experts in childhood disability and advocates, the 1997 top-to-bottom review, and our experience adjudicating claims.

- They contain the same standard as the 1997 interim final rules interpreting P.L. 104-193. They are based on our listing of impairments and require a child to meet, "medically" equal, or "functionally" equal the listings to be eligible for benefits. Functionally equaling the listings means a child has "marked" limitations in two domains or an "extreme" limitation in one domain.
- They provide better general instructions on the evaluation of functioning at all steps in our process. We have reorganized and expanded the existing rules based on public and expert input, and our longstanding instructions and training we conducted in 1997 and 1998. The final rules stress the comparison of a child with other children the same age who don't have medical impairments and the need to evaluate the overall effects of multiple medical impairments.
- In these rules functional equivalence is simplified and clarified. These changes are based largely on public comments that asked us to do this. For example, there is only one method for determining functional equivalence to the listings. (The prior rules had four methods that were to some extent redundant).

➤ **Changes in domains:**

--All of the domains apply to all children. (In the prior rules, children age one to three were evaluated in fewer domains.)

--The domains are revised to more clearly reflect the functional impacts of impairments. For example, "motor functioning" becomes "moving about and manipulating objects."

-- We included better rules for evaluating physical impairments. For example, we added a new domain for evaluating physical impairments based on prior methods.

- The new rules emphasize the evaluation of the whole child to help in evaluating children who have multiple medical problems, or medical problems with multiple functional effects.
- The new rules include regulatory language to codify two provisions from the 1997 Balanced Budget Act on when we can do CDRs on children who are eligible because of low-birth weight (they may be done later than age one) and an extended time limit for conducting age-18 redeterminations.

Another feature is that we tried to put these very technical rules into plain English that will be more accessible to families.

Projected effect:

- Children who should be allowed or denied under current (interim final) rules should get the same decision under the final rules.
- However, we project more accurate allowance and denial decisions because these rules are clearer and easier to use.
- Based on a small pilot, we project a net of about 4,000 additional allowances in each of the next five years. Last year, we allowed about 140,000 children.
- In December 1999, there were about 850,000 children on the rolls.

Which members of Congress will be most interested to see this final rule published?

- We expect Senators Conrad (ND), Harkin (IA), Kennedy (MA), and Rockefeller (WV), as well as Representatives Levin (MI) and Matsui (CA), will be interested in the final rule. They were interested in the publication of the interim rule and its effect on children. We are hopeful that they will support this rule which answers many of the concerns expressed by advocates for children.
- In addition, Representative McCrery (LA) will be interested as to whether the two marked standard has been maintained. It has.

Is the childhood disability standard about right?

- Yes, we believe it is. Although many commenters believed that our interpretation of the phrase "marked and severe functional limitations" in the interim final rules did not properly reflect Congressional intent, we disagree. These final rules continue to define the term "marked and severe functional limitations," as a level of severity that meets or medically or functionally equals the severity required by the listings. This is the same standard used in the interim final rules.
- We continue to define listing-level severity, as required by the Act, as "marked" limitation in two domains or an "extreme" limitation in one domain.

Additional information

- Therefore, although we de-linked our policy of functional equivalence from reference to specific listings, we continue to use the phrase "functionally equals the listings." to underscore that the impairment(s) must be of listing-level severity.

Why are the final rules being published now? Why has it taken so long?

- We believe that it is vitally important that all children who meet the SSI eligibility requirements receive their benefits. Because of this commitment, we placed a high priority on carefully considering both our experience with adjudicating cases and the comments we received on the interim final rules.
- Since the publication of the interim final rules, we have completed over 250,000 case redeterminations as required by the change in the law. In addition, we conducted a "top-to-bottom" review and re-reviewed cases where we believed such review was needed. We've also conducted training and engaged in other activities to ensure the quality of our decisions. These activities helped to identify changes that would enhance our adjudicators ability to understand these rules and apply them fairly and equitably.
- The final rules respond to extensive comments on the interim final rules that we received from a wide range of professional organizations serving children as well as advocacy, legal, and family groups. Their comments, together with our experience, support adjustments made in the interim final regulations that we publish today as the final childhood disability regulations.
- SSA believes that the final regulations are fair and fulfill our commitment to children.

Additional Information

- The top to bottom review indicated that SSA and the State agencies making disability determinations for us had done a good job of implementing the new provisions, but found some problems. Commissioner Apfel immediately ordered several corrective actions to address these concerns, including re-reviewing certain types of cases. Before these reviews began, we provided additional training to all our adjudicators on how to evaluate mental impairments other than mental retardation, and on the evaluation of speech disorders. We also issued a Social Security Ruling (SSR) on the evaluation of speech disorders in combination with cognitive limitations.
- The Balanced Budget Act of 1997, Pub. L. 105-33, enacted on August 5, 1997, contained two amendments that affect these final rules. The amendments were retroactive to August 22, 1996, the date of enactment of Pub. L. 104-193. These final rules also address these changes:

- allow us to perform age-18 redeterminations at any time in lieu of a CDR, not just during the one-year period beginning on the individual's 18th birthday; and
- allow us to wait until after age 1 to do a CDR on a child for whom low birth weight is a contributing factor material to disability if we determine that the child's impairment is not expected to improve by age 1.

Are people generally satisfied with the final regulations? Is the Congress generally satisfied that SSA has now correctly implemented the SSI childhood disability sections of the welfare reform legislation?

- In general, we believe the public is satisfied. The combination of keeping the standard at one extreme or two marked impairments while improving the functional equivalence step and the domains of functioning hits just the right balance. Combining this with our careful, inclusive approach, we do not expect any strong opposition to the final rules. While some people would prefer a looser standard, generally they recognize that our interpretation of the statutory language is an appropriate one.
- We would defer to the Congress with regard to their assessment concerning SSA's implementation of welfare reform. In addition, since the rules have just been published, it would be premature to speculate on their reaction.

What has changed from the interim final rules?

- First, these rules do not change the childhood disability standard used in the interim final rules. The final rules do make a number of changes to help us identify children who meet this standard:
- Better general instructions on evaluation of functioning at all steps in our process. Reorganized and expanded existing rules based on public and expert input, and performed training. Stresses comparison of child with other children the same age who don't have medical impairments and need to evaluate the overall effects of multiple medical impairments.
- Functional equivalence simplified and clarified based largely on public comments that asked us to do this. For example:
 - Reference to specific listings no longer required. Based on a single standard of "listing-level" severity.
 - Only 1 method for determining functional equivalence to the listings (prior rules had 4 that were to some extent redundant).
- Changes in domains:
 - All domains apply to all children (in prior rules, children age 1-3 were evaluated in fewer domains), including better rules for evaluating physical impairments.
 - Domains revised to more clearly reflect the functional impacts of impairments using less technical language. For example, "motor functioning" becomes "moving about and manipulating objects."
 - Added a new domain for evaluating physical impairments, using both prior guidance and new guidance based on public comments.
- Emphasis on evaluation of the whole child helps in evaluating children who have multiple medical problems, or medical problems with multiple functional effects.

- Includes regulatory language to codify provisions from the 1997 Balanced Budget Act on when we can do low birth weight CDRs (may be later than age 1) and extended time limit for conducting age-18 redeterminations.

What was the effect of the change in childhood rules? How many more children will be eligible under the final rule?

- SSA originally projected about 135,000 children would lose eligibility under the interim final rules after all appeals.
- This figure was revised to 100,000 as a result of the top-to-bottom review.
- Based on a small pilot, we project a net of about 4,000 additional allowances in each of the next 5 years under the final rule. Last year, we allowed about 140,000 children.

Additional Information

- There were approximately 1 million SSI childhood recipients on the rolls as of August 1996. As of December 1999, there were about 850,000 children on the rolls.
- As of July 31, 1999, 38 percent (103,980) of re-determined cases had been found no longer eligible for SSI because they did not meet the new definition of disability for children, whereas 62 percent (170,081) of redeterminations had been continued. (See attached Workload Status chart.)

Attachments: OAct graph of the estimated effects of P.L. 104-193 on the average numbers of disabled children in payment status

Workload Status Chart July 31, 1999